Understanding the Interaction Between Suicidality and Transition-Related Care: An Interpretive Phenomenological Analysis of Perspectives from Trans Individuals and Mental Health and Medical Care Providers

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Contribution of Authors and Contribution to Original Knowledge

The thesis author developed the research idea, conducted the literature review, recruited and interviewed the participants, analyzed the data, and wrote the manuscript. These elements of the thesis are considered original scholarship and distinct contributions to knowledge. The project was supervised by Dr. Nathan Smith at the Department of Educational and Counselling Psychology at McGill University and Dr. Pierre-Paul Tellier at the at the Department of Family Medicine at McGill University. Dr. Sandra Peláez acted as qualitative methodology consultant. Two volunteers from McGill University's Department of Educational and Counselling Psychology and one professional transcriber transcribed the interviews.

Abstract

The current study explored trans individuals' and medical and mental health care providers' understanding of the interactions between suicidality and transition-related care. The topic was queried using qualitative methodology, specifically interpretive phenomenological analysis (IPA). Participants included 7 trans individuals and 11 mental health and medical care providers who work with trans individuals in or around three Canadian cities. Data analysis produced 4 superordinate themes: *Contributing factors to suicidal ideation and behaviour; Factors that decrease suicidal ideation and behaviour; Clinical work with trans individuals; and Recommendations from participants regarding suicidality and transition-related care.* Each superordinate theme had 2 to 7 subordinate themes, and several subordinate themes contained subthemes. Results both support and expand on exiting literature on the topics of transition-related care and suicidality among trans individuals. For example, results show that access to timely transition-related care is a factor that decreases suicidal ideation and behaviour, as well as show that the quality of care is important, as empowering transition-related care that supports trans individuals' autonomy and self-determination was shown to be particularly beneficial towards decreasing suicidality. Lastly, implications of the results towards future research and clinical work are discussed. For example, providers who approve or deliver transition-related care are encouraged to work from a client-centered, informed consent, transparent, affirmative and culturally-competent care model, in which they work to provide care in a timely, empowering, and personalized way to trans clients.

Resumé

L'étude actuelle a exploré la compréhension des personnes trans et des prestataires de soins médicaux et de santé mentale au sujet de l’interaction entre la suicidalité et les soins liés à la transition. Le sujet a été interrogé en utilisant une méthodologie qualitative, en particulier l'analyse phénoménologique interprétative. Les participants et participantes comprenaient 7 personnes trans et 11 fournisseurs et fournisseuses de soins de santé mentale et de soins médicaux qui travaillent avec des personnes trans dans ou autour de trois villes canadiennes. L'analyse des données a produit 4 thèmes supérieurs: *Les facteurs qui contribuent aux idées et comportements suicidaires*; *Les facteurs qui diminuent les idées et les comportements suicidaires*; *Le travail clinique avec les personnes trans*; et *Les recommandations des participants et des participantes concernant la suicidalité et les soins liés à la transition*. Chaque thème supérieur comportait de deux à sept thèmes subordonnés et plusieurs thèmes subordonnés contenaient des sous-thèmes. Les résultats soutiennent et enrichissent la littérature existante sur le sujet des soins liés à la transition et de la suicidalité chez les personnes trans. Par exemple, les résultats montrent que l'accès à des soins liés à la transition en temps opportun est un facteur qui diminue les idées et les comportements suicidaires et montrent aussi que la qualité des soins est importante, car des soins liés à la transition qui soutiennent l'autonomie et l’autodétermination s'est avérée particulièrement bénéfique pour réduire la suicidalité. Enfin, les implications des résultats pour la recherche future et les travaux cliniques sont discutées. Par exemple, les prestataires qui approuvent ou fournissent des soins liés à la transition sont encouragés à travailler selon un modèle de soins axé sur la personne, de consentement éclairé, de transparence, affirmatif et culturellement compétent, dans lequel ils et elles travaillent pour fournir des soins habilitants et personnalisés en temps opportun aux personnes trans.

Acknowledgements

I owe an unquantifiable amount of gratitude and thanks to more people than I can ever name. First and foremost, thank you to my participants for sharing so generously of themselves. Thank you to my research supervisors, Drs. Nathan Smith and Pierre-Paul Tellier, whose patience, guidance, and unconditional positive regard made this project and dissertation possible. Thank you to Dr. Sandra Peláez for the years of mentorship, support, check-ins, and qualitative expertise. Thank you to Dr. Nate Fuks for the ECP support. Thank you to Ryan, my rock and my partner. Without you and your unwavering support, food, and love, this dissertation most certainly would never have been completed. Thank you to R., my kiddo, for helping me remember to pause in order to play. Thank you to all of my dear friends and family (blood, in-laws, chosen, and step) — you all played invaluable roles in keeping me going. Thank you to the now defunct McGill CORE research group and all of its past members, and to APA's community of LGBTQIA2S+ Counselling Psychology; through you I experienced a professional home and felt like I belonged in the field of psychology for the first time. Thank you to Marianne LeBreton for your generous help with translation of the material. Thank you to Olimpia Boido for your generous help with the recruitment material. Thank you to Enoch Leung and Devorah Rosenberg for painstakingly transcribing the interviews. Thank you to the three Canadian qualitative suicide researchers and to the informal community consultants whom I consulted when designing this project. Thank you to everyone else I am not able to name individually or collectively.

Please know that my gratitude is sincere, earnest, and deeply felt. The completion of this dissertation signifies that I am qualified to become a Counselling Psychologist, which has been a career dream and goal for the last 20 years. Due to invisible disabilities, numerous deaths of loved ones, several of my own difficult health situations, and a year off for parental leave, the

Ph.D. has taken me approximately 9 years to complete from start to finish. I have learned that nothing moves quickly in my world, and I have learned to accept that. As the first person (that I am aware of) in several spheres of my family to pursue a Ph.D., I often felt like I was stumbling along in the dark. While stumbling along, I would often trip and stay on the ground for long periods of time. All of you mentioned above, and many more who are not mentioned here, came along and offered me the light of your flashlights, and a hand to help me up. The diagnosis of invisible disabilities helped me work through and let go of my internalized ableism and internalized capitalism, which told me I wasn’t good enough because I wasn’t fast enough or productive enough. Having a child motivated me to model that queer, disabled, gender-nonconforming folks can and do complete things that seem unsurmountable. Losing my father, who very much wanted to see me graduate from McGill University with a Ph.D., helped me realize that there are costs to being frozen in self-doubt, perfectionism, and imposter syndrome. Finishing this dissertation during a pandemic and racial justice revolution, when I would much rather be spending all of my time caring for my family, friends, community, and clinical clients, as well as fighting for racial justice, was another lesson regarding the costs of being frozen.

Finally, thank you to the LGBTQIA2S+ folks who came before me, particularly the trans women of colour such as Marsha P. Johnson, Sylvia Rivera, and countless others, who fought for LGBTQIA2S+ rights and paved the way for this disabled, working class, gender non-conforming queer person to even dare dreaming of obtaining of graduate degree specializing in LGBTQ psychology; I am forever indebted. As we say in French “Je suis extrêmement reconnaissante.” In the words of TDOR, I aim to mourn and honour the dead, and fight like hell for the living. And lastly, in the paraphrased words of Dr. Anneliese Singh on the topic of LGBTQIA2S+ hope and resilience: I believe we are deserving of a future worth dreaming of.

Content Warning

The research project described in this manuscript focuses on suicidality, which is not an easy topic to read or to think about. The topic can be understandably difficult for many, particularly for people who have lived experiences that resonate with the topic, are currently experiencing suicidal ideation, or have unhealed emotional wounds around suicide. If you notice distressing feelings come up while reading this document, please take care of yourself and don't feel the need to continue reading this document if it is triggering or counter to your well-being and self-care/self-preservation. Please feel free to engage with the document in a way that centres your well-being — read it, skim it, or skip it completely. Please do what's best for you.

Many trans participants whose voices are heard in this document shared current suicidal ideation, and one participant shared past suicide attempts. Please know the project was planned and carried out with the utmost care, over several years, and trans participants were offered and given support before, during, and after the interviews as needed. Trans participants' well-being was prioritized, above all else, throughout the entire course of this research endeavour. The thesis author is a mental health professional and trained suicide researcher, and these skills were integrated in all contact and interactions with trans participants in order to support them, when needed. Details regarding what this looked like can be found in Chapter 3.

If you are currently in crisis or having serious thoughts of suicide, please contact one of the following resources:

-The Trans Lifeline at 1-877-330-6366 (Canadian number) or 1-877-565-8860 (US number)

-Hope for Wellness (for Indigenous people across Canada) at 1-855-242-3310

-Canada Suicide Prevention Services at 1-833-456-4566 (call) or 45645 (text)

-Your local suicide prevention service or crisis centre

1.0 Introduction

Suicidal ideation and behaviour is a global health problem that is both preventable and treatable (World Health Organization (WHO), 2011). Annually, almost 800,000 people around the world die from suicide (WHO, 2011) and the global lifetime suicide attempt rate (calculated from self-report and hospital data) is estimated to be between 0.4% and 5.1% (Nock et al., 2008). In Canada, the suicide attempt rate is 11.5 people per 100,000 (Statistics Canada, 2009) and in the U.S., the suicide attempt rate is between 1.9 and 8.7% (Nock et al., 2008). However, when certain marginalized and at-risk populations are considered, the rates of suicidal ideation and behaviour are even more alarming. It has been long known and often demonstrated that lesbian, gay, and bisexual (LGB) individuals have higher rates of suicidal ideation and behaviour when compared to their cis[1] heterosexual counterparts (Marshal et al., 2011). Since the 1990s, studies have been documenting LGB suicidality and have shown that between 20 and 53% of LGB North Americans self-report attempting suicide (Haas et al., 2011; King et al., 2008; McDaniel, Purcell, & D'Augelli, 2001; Plöderl et al., 2013). Some studies have included heterosexual control groups, and results show statistically higher ideation and attempt rates in LGB populations (e.g., Marshal et al., 2011). Trans[2] North Americans report suicidal ideation and attempt rates at levels comparable or much higher than both their cis heterosexual and cis LGB peers. As many as 43% of trans individuals report having attempted suicide, and 77% report having experienced suicidal ideation (Grant et al., 2011; Scanlon, Travers, Coleman, Bauer, & Boyce, 2010).

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[1] Cis individuals are those whose gender identity matches their sex assigned at birth (ASTT(e)Q, 2011)

[2] Trans individuals are individuals whose gender identity are different from the gender identity typically associated with their sex assigned at birth (ASTT(e)Q, 2011).

The term *trans* will be utilized throughout this document and therefore requires defining. It is an umbrella term used by members of trans communities and professionals in various fields (e.g., psychology, queer studies) to refer to transgender, transexual/transsexual, transitioned, non-binary, genderqueer, Two-Spirit, and other individuals (Istar-Lev, 2004). The term *trans* is commonly understood to refer to a person whose gender identity is different than their sex assigned at birth (ASTT(e)Q, 2011). It is important to note that *trans* and related terms are self-identification identity terms; in other words, a person whose gender identity or gender expression is different from their sex assigned at birth may use *trans* or a related term to label themselves. Furthermore, as trans is an umbrella term, people often identify in a variety of more specific ways. Examples include identifying as a trans woman, male-to-female (MTF), transfeminine, trans man, female-to-male (FTM), transmasculine, non-binary, genderfluid, agender, bigender, Two-Spirit, and genderqueer (Grant et al., 2011; Moody & Smith, 2013). Trans individuals may identify within the gender binary (e.g., man, woman) and/or outside the gender binary (e.g., non-binary, genderqueer, genderfluid). Lastly, a person who has transitioned (who has undergone social, legal, medical and/or surgical changes in order to express and embody their gender identity) may or may not identify as trans. For example, someone who was assigned male at birth and who is a woman may simply identify as a woman and not as trans woman.

Estimates of the number of trans individuals differ considerably. Earlier estimates, usually developed from gender-affirming surgery statistics, proposed that anywhere from 1 in 9,000 to 1 in 100,000 people are trans (Chope & Strom, 2008). More recently, it was estimated that 0.3-0.5% (nearly 700,000) of Americans are trans (Gates, 2011).

Trans individuals are often marginalized and face two main challenges: discrimination and the need to access transition-related care. Large-scale, contemporary research documenting these two challenges includes the National Transgender Discrimination Survey in the USA, which had a sample of 6,456 participants (Grant et al., 2011), and TransPulse in Ontario, which had a sample of 433 participants (Scanlon, Travers, Coleman, Bauer, & Boyce, 2010). From these studies, and previous research, we have learned that trans people experience high rates of discrimination, harassment, and violence, and that these events have important impacts on trans people's mental and physical health, including suicidal ideation and behaviour.

The relationship between experiences of discrimination and negative mental health outcomes has been conceptualized via minority stress theory (Brooks, 1981; Meyer, 1995, 2003), which will be reviewed in detail in Chapter 2. In short, minority stress is a unique accumulation of distal and proximal stressors that minority individuals experience both chronically and acutely. Sexual and gender minority stress has been linked to higher levels of mental and physical illnesses in LGB and trans (LGBT) populations (Institute of Medicine, 2011).

In addition to experiences of discrimination, another main challenge many trans individuals face is accessing some form of transition-related care in order to increase congruence between their gender identity and bodies. Transitioning and transition-related care will be discussed more fully in the literature review; however at this point it is important for the reader to know three main things regarding transition-related care. First, transition-related care can include psychotherapy, hormone therapy, and surgery. These services are administered or controlled by mental health and medical care providers such as psychologists, psychiatrists, family physicians, endocrinologists, and surgeons. In Canada, the majority of provincial/territorial health ministries cover some costs associated with hormone therapy and gender-affirming surgery (e.g., Ontario), while other provinces and territories cover some costs but not gender-affirming surgery (e.g., North West Territories). Second, several standards of care, guidelines, and protocols exist that outline appropriate steps in approving and delivering transition-related care (e.g., the World Professional Association of Transgender Health's Standards of Care, Version 7). Third, two main models of transition-related care exist: consent-based care and gatekeeping, with the former model positioning the trans client as the expert in their[3] own lives and regarding their own transition-related care needs, and the latter model positioning the medical or mental health care provider as the expert who must assess the trans client's mental health status and readiness to transition. Providers may choose to use one model, but frequently the care models are used in combination (Coleman et al., 2011; Kopala, 2003).

Recent research indicates that transitioning (for those who seek it) is linked with increased mental and physical health. For example, testosterone treatment for trans men has been shown to significantly lower scores on the Minnesota Multiphasic Personality Inventory 2's depression scale when comparing (a) baseline and 3-month follow up among trans men, and (b) scores from trans men and cis men controls at 3-month follow-up (Keo-Meier et al., 2014). A recent qualitative study has shown that transitioning is also a suicide protective factor among trans adults (Moody, Fuks, Peláez, & Smith, 2015). Despite these advances in the trans health care scholarship, to date no research exists that qualitatively investigates trans individuals' understanding of the intersection between transition-related care and suicidality.

The expectation of some care providers to hear a certain stereotypical gender dysphoria narrative from clients, coupled with trans individuals' fear of being denied transition-related care by health care providers, lead some trans people to present an expected narrative or script to care providers (Dahl et al., 2006; Istar-Lev, 2004). This expected narrative or script often does not

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[3] Throughout this manuscript, the pronouns *they*, *them*, and *their* are used as singular gender-neutral pronouns.

include some information, such as symptoms of depression and suicidal ideation/behaviour (Carroll, Gilroy, & Ryan, 2002; McNeil, Bailey, Ellis, Morton, & Regan, 2012). It is fair to say that these omissions and the expected narrative further complicates people's experiences of the interaction between suicidality and access to transition-related care.

The current standards of care, guidelines, and protocols for trans health care rarely address the issue of suicidality nor how to address it in the context of transition-related care (more details can be found in the literature review). Despite this, it is known that some care providers withhold transition-related care when working with trans clients who are depressed or suicidal, instead insisting on treating the person's mental health concerns before delivering or approving transition-related care (Keo-Meier et al., 2014). This staggered approach may exacerbate trans clients' depressive symptoms and suicidality and therefore, delivering transition-related care and treating mental health concerns concurrently is recommended (Keo-Meier et al., 2014). Currently, no scholarship exists regarding care providers' experiences of working with trans clients who are seeking transition-related care and who communicate their suicidal ideation or behaviour.

Thus, research has shown that (a) trans individuals experience discrimination, minority stress, and suicidal ideation and behaviour; (b) trans individuals who wish to transition need to access that care through providers who may adhere to a gatekeeping model or a consent-based model (or a combination of both); (c) the majority of the current standards of care do not clearly address suicidality, with some providers opting for a staggered approach to care and others adopting a concurrent or parallel approach to care (e.g., delivering transition-related care while treating mental and/or physical health issues concurrently); (d) and lastly, trans peoples' mental health improve after transitioning. However, as previously stated, to date no research has been conducted to investigate the lived experiences and perspectives of trans individuals and care providers regarding the interaction between suicidality and transition-related care.

The overarching purpose of the current research study was to develop an understanding of how people experience the interaction between suicidal ideation and behaviour and transition-related care. More specifically, the study sought to elicit, document, and understand trans individuals' experiences of suicidal ideation and behaviour in the context of transition-related care, as well as the experiences of the care providers who work with trans individuals, in addressing the same issues. This study sought to illuminate participants' lived experiences of the phenomenon under study in order to (a) give voice to trans participants, as trans individuals are often silenced and/or excluded; (b) contribute to the field's knowledge through a deeper understanding of the phenomenon; (c) contribute findings that may be used by care providers to enhance their care and cultural competence; and (d) solicit participants' expertise via suggestions and recommendations regarding the phenomenon at hand.

The following section will first give an overview of terminology and related constructs/concepts and then review the extant literature regarding (a) trans individuals' mental and physical health via a review of the minority stress and social determinants of health literatures, (b) transition-related care via standards of care and guidelines, and (c) suicidality among trans individuals, including risk and protective factors. Gaps and limitations will then be reviewed, and the purpose of the study will be outlined.

2.0 Literature Review

2.1 Diversity within the Trans Community

2.1.1 Intersectionality

As with any population, especially a marginalized one, it is important to consider intersectional identities and relative privilege and oppression that may be experienced due to that intersectionality. The term *intersectionality* was first coined by Crenshaw (1989, 1991) to name the interaction between the sexism and racism experienced by Black women in the USA. Today, intersectionality is understood as "the interaction of multiple identities and experiences of exclusion and subordination" (Davis, 2008, p. 67).

Like all individuals, trans individuals likely hold several social identities that shape their lives through mutual constitution. Thus, trans people have intersecting identities, such as (but not limited to) being a trans person of colour, being a trans person with a disability, and/or being a lesbian, gay, bisexual, or queer trans person. When viewed through an intersectional lens, and placed in a social-political context, trans individuals' lived experiences of oppression and relative privilege are better understood and homogenization of experiences can be avoided. For example, a recent study found that trans people of colour experience greater discrimination than White trans people, and lower-income trans individuals experience more prejudice events than higher-income trans individuals (Herman, 2013). Such can be understood as the intersectional effects of racism and transphobia, and of classism/poverty and transphobia, respectively. Furthermore, trans women were found to experience significantly higher rates of discrimination than trans men (Longman Marcellin, Scheim, Bauer, & Redman, 2013). This disparity can be understood as the intersectional effects of sexism and transphobia (known as transmisogyny). The higher rates of discrimination that trans women experience are especially alarming when homicide rates are examined. The National Coalition of Anti-Violence Programs found that 72% of LGBT homicide victims were trans women and, more specifically, that 67% of LGBT homicide victims were trans women of colour (2013). The higher rates of homicide affecting trans women of colour can be understood as the intersectional effects of racism, sexism, and transphobia (this intersection of racism, sexism, and transphobia is known as transmisogynynoir when experienced by Black trans women).

The U.S. Institute of Medicine has adopted several frameworks when making recommendations regarding the health of LGBT people, including taking an intersectional approach. As such, they urge readers to take all aspects of a person's identity and social context into account, such as race, ethnicity, economic and social positioning (Institute of Medicine, 2011). Thus, intersectionality is included in this literature review in order to meet the Institute of Medicine's above-mentioned recommendation, as well as to acknowledge and take into account the many interconnected identities individual trans people may hold and the ways that power and privilege play out in trans peoples' lives.

2.1.2. Not All Trans People Transition

It is also important to note that while this paper focuses on the interaction of suicidality and transition-related care, not all trans people transition (Istar-Lev, 2004; Tom Waddell Health Center Transgender Team, 2013). Of those who do transition, some transition socially, some transition medically (via hormone therapy), some transition surgically (via gender affirming surgery), and some do a combination or two of more as best suits their needs. A person who socially transitions may communicate their gender identity to themselves and others via verbal (e.g., coming out) and non-verbal (e.g., gender presentation) means. They may also change their first name and pronoun, as well as their gender marker on their identification (American

Psychological Association, 2015). Medical transition is generally understood as undergoing one or more medical/physical changes in order to bring one's body into congruence with one's gender identity. These changes may include administration of sex hormones and/or undergoing surgery (American Psychological Association, 2015). Both binary-identified trans people (e.g., people assigned male at birth who identify as and are women and people assigned female at birth who identify as and are men) and non-binary trans people (e.g., genderqueer people) may choose to transition socially, medically, and/or surgically. It is important to note that one's self-identification as trans does not depend on whether or not one has transitioned in any or all of the three ways one can transition, and that trans individuals have the right to socially, medically, and surgically transition (or not) to the degree that best fits with their gender identity (American Psychological Association, 2015; Coleman et al., 2011; Istar-Lev, 2004).

As this literature review focuses on transition related-care, the emphasis will be on those trans individuals who seek transition-related care from medical and mental health care providers.

2.2 Overview of Minority Stress, Social Determinants of Health, and Suicide Research

2.2.1 Minority Stress

Like all people, LGBT people experience short- and long-term stressors. However, unlike most people, LGBT people also experience short- and long-term stress due to their minority identities in a generally homophobic, biphobic, queerphobic, and transphobic society. This unique stress due to minority status is known as minority stress (Brooks, 1981; Meyer, 1995, 2003). Minority stress was first identifed and studied among sexual minorities such as lesbian, gay, and bisexual (LGB) individuals (e.g. Brooks, 1981; Lea, de Wit, & Reynolds, 2014; Meyer, 1995, 2003), and recently has also been studied among trans individuals (e.g., Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Rood, Puckett, Pantalone, & Bradford, 2015; Tebbe & Moradi, 2016). A minority stress model specific to trans and gender noncomforming people has been developed, called the Gender Minority Stress Model (Hendricks & Testa, 2012; Testa, Habarth, Peta, Balsam, & Bockting, 2015). The minority stress model is comprised of five components: prejudice events, internalized homo/bi/transphobia, anticipated rejection/vigilance, concealment, and subsequent group coping (Hendricks & Testa, 2012; Meyer, 2003).

Prejudice events include verbal and behavioural actions from others that denigrate a minority person's identity. It is important to note that prejudice events can be either macro or micro events. For example, a hate crime is a macro prejudice event and can have detrimental effects on the target's physical and mental health. However, research has shown that micro prejudice events, or microaggressions (Sue et al., 2007), though much more subtle, also have a detrimental effect on the target. Sexual orientation and gender identity microaggressions (Nadal, 2013; Nadal et al., 2011; Nadal, Skolnik, & Wong, 2012) can thus be conceptualized as part of minority stress, despite these two constructs being distinct in the literature. Examples of microaggressions include being called homo/bi/transphobic names, being told not to "act gay" in public, and being asked invasive questions about one's sexual relationships or genitals (Nadal, 2013).

Internalized homo/bi/transphobia is the result of a minority person unconsciously adopting the denigrating attitudes from the dominant culture towards the minority population. For example, a gay person may think being gay is unnatural and feel shame around their sexual orientation and a trans person may think being trans is unnatural and avoid other trans people, thus unfortunately isolating themselves from potential support networks.

Anticipated rejection, the third minority stress process, is a reasonable response to living in an intolerant society; as a result of prejudice events, LGBT people may begin to expect to be rejected and may become vigilant. This expectation of rejection may lead to concealment of one’s sexual orientation or gender identity, as a coping strategy and a way to avoid future prejudice events. This coping strategy may be both beneficial and stressful. For example, a trans person applying for a job may choose not to disclose their past transition in order to decrease their chances of experiencing transphobia, but may have to cope with the stress of possibly being “outed” via a reference check at the end of the interview process.

Compensatory group coping is an important, and positive, aspect of minority stress. Group coping is comprised of minority people, in this case trans people, coming together in solidarity against oppression from the dominant culture. Through group coping, individuals can develop important friendships and families of choice, have their lived experienced validated and normalized, and build a sense of community, as well as work to make positive societal changes. Therefore, because social belonging (Anant, 1967; Hagerty, Williams, Cyone, Early, 1996) and social ties (Kawachi & Berkman, 2001) are important factors in mental health and well-being, group coping should be considered protective in nature for LGBT individuals.

Hendricks and Testa (2012) proposed a conceptual model for mental health work with trans and genderqueer clients in which they explicitly integrated the minority stress model. In this framework, a culturally-competent mental health worker is not simply a mental health worker who accepts trans people and is aware of trans-specific terminology, but rather is someone who also has an understanding of the myriad ways trans people experience discrimination and victimization. The culturally-competent mental health worker will also understand the importance of using an intersectional lens, the various processes of minority stress that trans clients may experience, and the resilience and strengths that many trans people show in the face of these events.

2.2.2 Minority Stress Outcomes: Social Determinants of Health and Health Disparities

2.2.2.1 Social Determinants of Health. The World Health Organization (WHO) defines social determinants of health as “the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels” (2014, SDOH). Furthermore, the WHO states that “the social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries” (2014, SDOH). Likewise, Mikkonen and Raphael (2010), in a definitive text regarding social determinants of health in Canada, state that “the primary factors that shape the health of Canadians are not medical treatments or lifestyle choices but rather the living conditions they experience… [which have] been come to be known as the social determinants of health” (p. 7). There are 14 main social determinants of health that Canadians experience: Income and income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety net, health services, Aboriginal status, gender, race, and disability (Mikkonen & Raphael, 2010). Many of these social determinants of health are also social determinants of mental health and well-being, as the two are so intricately linked that it is impossible to separate them. For example, social exclusion leads to not only health concerns such as diabetes and cardiovascular disease, but also “creates a sense of powerlessness, hopelessness and depression that further diminish the possibilities of inclusion in society” (Mikkonen & Raphael, 2010, p. 33).

Social determinants of health for LGBT individuals include all of the aforementioned determinants, in addition to discrimination due to sexual orientation and/or gender identity (Rainbow Health Network, 2006). According to Rainbow Health Network (2006),

> in order to be healthy, lesbian, gay, bisexual, queer, transsexual, transgendered (sic), Two-Spirit and intersex people must be treated fairly, with dignity, and without prejudice. The places we live, work, play and learn must be supportive and affirming. We must also have health care and support services that we can access and that meet our needs (p. 2).

Furthermore, societal and systemic oppression must be taken into account when considering the social determinants of health that affects trans individuals' mental and medical well-being (ASTT(e)Q, 2011). For example, transphobia, which is "societal discrimination and stigma of individuals who do not conform to traditional notions of gender" (Sugano, Nemoto, & Operario, 2006, p. 217), is a ubiquitous oppressive force that directly impacts trans people's daily and longer-term quality of life, from employment and use of public space to housing and health care access (Bauer, Nussbaum, Travers, Munro, Pyne, & Redman, 2011; Longman Marcellin, Scheim, Bauer, & Redman, 2013; Scheim, Bauer, & Pyne, 2014).

Several studies have examined the interaction between minority stress and mental or physical health among sexual and/or gender minorities. In his influential article, Meyer (1995) showed a link between experiences of minority stress and mental distress in a sample of 741 gay men living in New York City. Lick, Durso, and Johnson (2013) have proposed a theoretical model (see Figure 1) that outlines the mechanisms underlying the relationship between minority stress and mental and physical health disparities for LGB individuals. This model takes into account the psychological appraisal in which an LGB person engages when experiencing a societal stressor, which in turn creates both psychological and physiological stress responses. These responses then lead to certain health behaviours, such as substance use, which lead to a variety of health statuses and health disparities.

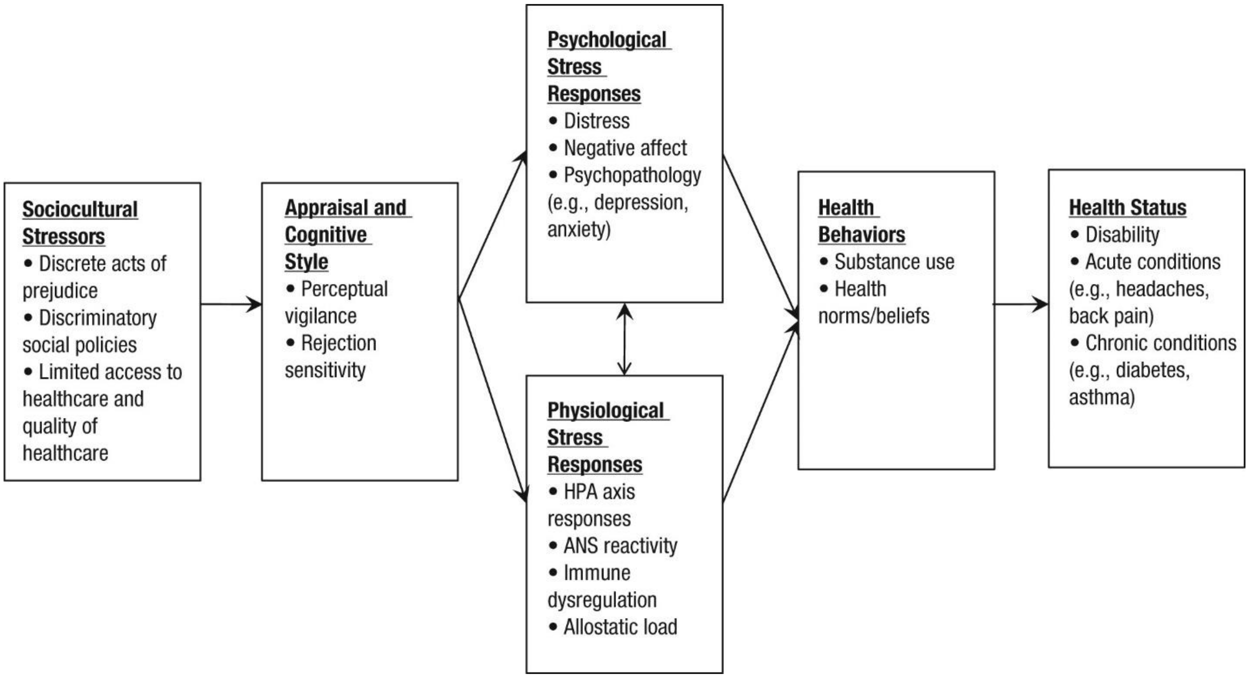

Figure 1. Conceptual model showing relationship the relationship between minority stress and health conditions (Lick, Durso, and Johnson, 2013).

2.2.2.2 Brief Description of Health Disparities in LGBT Populations. In a non-systematic review and summary of LGB health disparities (excluding HIV and other STIs), Lick et al. (2013) identified 21 studies that included heterosexual control groups and found that LGB individuals reported higher rates of many illnesses and complaints, from headaches to cancer, compared to the control groups. In addition, a non-systematic review by the Institute of Medicine (2011) indicated that LGBT individuals experience higher rates of many physical and mental health concerns and illness than their heterosexual and cis counterparts, including HIV/AIDS and other STIs. When an intersectional lens is applied, health disparities (specifically, higher rates of

HIV among trans individuals) can be teased somewhat apart. Longman Marcellin, Bauer, and Scheim (2013) found that the intersection of transphobia and racism experienced by racialized trans individuals resulted in greater odds of engaging in high-risk sexual behaviour, putting these individuals at higher risk for HIV contraction than their White peers.

Since the Institute of Medicine's report was published, several other studies have demonstrated physical and mental health disparities between trans and cis individuals. For example, Clark et al. (2014), in the first national New Zealand study to include trans youth, found that both trans youth and youth who were unsure of their gender identity (the latter being a separate group from those who were unsure what the question meant) reported significantly higher rates of depressive symptoms and suicide attempts when compared to cis youth. Likewise, a recent study examining the health disparities between trans adults and cis adults found that the trans participants were three to four times more likely to report suicidal ideation and three times more likely to attempt suicide than their cis counterparts (Reisner, White, Bradford, & Mimiaga, 2014). Reisner and colleagues also found that trans participants were six times more likely to be victimized and to experience discrimination than their cis LGB counterparts, including lifetime healthcare discrimination. Clark et al. (2014) found that trans youth and youth who were unsure of their gender identity reported significantly higher rates of alcohol use and bullying from peers than cis LGB youth.

2.2.3 Suicidality

Given the experiences of minority stress and the impact of social determinants of health, it follows that sexual and gender minorities experience higher rates of depression and suicidality when compared to heterosexual and/or cis peers. The link between minority stress, social determinants of health, and suicidality has been well documented over the past two decades and recent reports and guidelines now urge providers to take these constructs and frameworks into account when working with LGBT populations (e.g. American Psychological Association, 2015; Institute of Medicine, 2011; U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012).

2.2.3.1 Rates of Suicidal Ideation and Suicide Attempts. A recent meta-analysis found that sexual minority youth were almost three times more likely to report a history of suicidal ideation or attempts when compared to heterosexual youth (OR = 2.92; Marshal et al., 2011). Like in LGB populations, high rates of suicidal ideation and attempts have also been well documented in trans populations (e.g., Kenagy, 2005a, 2005b; Mathy, 2002; Moody & Smith, 2013). As mentioned above, a recent study determined that trans participants reported lifetime suicidal ideation and attempts at significantly higher rates than cis participants (Reisner et al., 2014). More specifically, 29% of trans participants reported a lifetime suicide attempt, compared to 8.5% of cisgender participants.

When an intersectional lens is applied, suicidal ideation and attempt rates among trans individuals become more nuanced. Suicidal ideation and attempt data from the National Transgender Discrimination Survey (2011) show that White trans people experience the lowest rates of lifetime suicide attempts (38%), while racialized individuals experience the highest rates of lifetime suicide attempts (Asian or Pacific Islander, 39%; Hispanic or Latino, 44%; Black or African American, 45%, Multiracial or mixed race, 54%; and American Indian or Alaska Native, 56%; Haas, Rodgers, & Herman, 2014). These rates can be understood as the effect of intersectional racism and transphobia. Furthermore, lower-income trans individuals and trans individuals with lower levels of completed formal education were significantly more likely to have attempted suicide in the past when compared to their higher income and more formally-educated counterparts (Haas, Rodgers, & Herman, 2014).

2.2.3.2 Risk and Protective Factors. The majority of LGBT suicidality research focuses on identifying and documenting the occurrence of risk factors. While understanding risk factors is essential, it is also important to study and be aware of suicide protective factors. Fully appreciating both risk and protective factors is important for several reasons; first, knowing risk and protective factors is essential when conducting suicide risk assessments with at-risk individuals, as well as when developing suicide prevention strategies. Furthermore, there is the potential to further stigmatize an already marginalized group such as trans individuals if researchers and clinicians focus solely on the challenges trans people face, such as minority stress, social determinants of health, and suicidality. It is important for researchers and clinicians alike to be aware of trans individuals’ strengths and resilience (which are often also suicide protective factors) in order to have a complete picture of trans individuals, and in the case of clinicians, to be able to assist trans individuals who are experiencing challenges (Singh & McKleroy, 2010).

In order to contextualize risk and protective factors, a brief review of these factors in the general population (i.e., heterosexual and cis) follows. Among cis heterosexual individuals, there are many well-documented risk factors for suicide, such as an important recent loss, past suicide attempts, mood disorders, alcohol or substance abuse or dependence, and impulsivity (Suicide Prevention Resource Center & Rodgers, 2011). Protective factors in the general population, like in all other populations, are less well understood than risk factors. However, a thorough review of the literature has found reasons for living, coping skills, and social support, among other factors, to be significant suicide protective factors (Johnson, Wood, Gooding, Taylor, & Tarrier, 2011)

Suicide risk and protective factors among cis LGB youth and adults is less researched and understood than among cis heterosexual individuals, but what research does exist identifies several risk and protective factors. Victimization has been shown to be an important suicide risk factor, especially among cis LGB youth (e.g. D'Augelli et al., 2005; Suicide Prevention Resource Center, 2008). Furthermore, a recent study showed that LGB youth’s social environments can be risk factors for suicidal ideation and behaviour. Specifically, Hatzenbuehler (2011) found that LGB youth attempted suicide significantly more than heterosexual peers (21.5% vs 4.2%) and that LGB youth in unsupportive environments were at a 20% greater risk for suicide attempts when compared to those in supportive environments, even after controlling for risk factors and demographic variables. In order to operationalize supportive/unsupportive social environments, Hatzenbuehler created a composite index of four elements (“proportion of same-sex marriages, the proportion of registered Democrats, the presence of gay-straight alliances in schools, and school policies that protected LGB students,” p. 896), highlighting the important role of minority stress and the social determinants of health in mental health. In addition, another study revealed that risk factors for LGBT youth suicidal ideation include a history of attempted suicide, impulsivity, LGBT victimization, and low social support (Liu & Mustanski, 2012). As with the general population, social support has been shown to be a significant suicide protective factor among cis LGB individuals (Eisenberg & Resnick, 2006).

Research investigating suicide risk and protective factors among trans individuals is even more recent than research looking at suicide risk and protective factors among cis LGB individuals; however, it has been well established that victimization and transphobia are significant suicide risk factors (e.g., Clements-Nolle, Marx, & Katz, 2006; Nuttbrock et al., 2010; Xavier, Bobbin, Singer, & Budd, 2005; Tebbe & Moradi, 2016), as is physical and sexual violence (e.g., Testa et al., 2012). Fewer studies have investigated suicide protective factors among trans populations; of those that have, it has been found that safe school environments (Eisenberg & Resnick, 2006), suicide resilience[4], child-related concerns, family support (Moody & Smith, 2013), acceptance and transition-related care (e.g., Moody, Fuks, Peláez, & Smith, 2015), and support from friends (e.g., Tebbe & Moradi, 2016) are important suicide protective factors. In addition, several factors have been identified as intervenable factors associated with reduced risk of suicide ideation and behaviour among trans individuals, such as social support, reduced transphobia, having one's sex designations changed on a least one piece of identification, having completed a medical transition (for those who wanted or needed to medically transition), and parental support (Bauer, Scheim, Pyne, Travers, & Hammond, 2015).

2.3 Overview of Transition-Related Care

As previously mentioned, trans individuals generally face two main challenges: discrimination, which can lead to mental health problems, including suicidal ideation and behaviour, and access to transition-related care. The following section will review transition-related care, including definitions, standards of care, and suicidality within standards of care.

2.3.1 Definition of Medical Transition

As mentioned above, some trans individuals medically transition, which usually means seeking transition-related care in order to do so (some individuals procure hormones via others means, for a variety of reasons, such as barriers to care and limited financial means; Rotondi,

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[4] Suicide resilience is defined as "the perceived ability, resources, or competence to regulate suicide-related thoughts, feelings, and attitudes'' (Osman et al., 2004, p. 1351).

Bauer, Scanlon, Kaay, Travers, & Travers, 2013). Both mental and medical health care providers play a role in most trans individuals' medical transitions, via delivery of or referral to a professional who will deliver transition-related care (among other roles). Mental health care providers may counsel trans individuals before, during, and sometimes after medical transition, due in part to the stress that medical transition can exert on a person, but also due to gender dysphoria. Gender dysphoria is both a psychological experience and a diagnostic category in the DSM 5. As a diagnostic category, gender dysphoria is applicable to people who experience a

> …marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. In children, the desire to be of the other gender must be present and verbalized. This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2013, p. 1).

The diagnosis of gender dysphoria is typically required by insurance companies or provincial insurance plans to cover the costs of transition-related care, with coverage varying from province to province.

A variety of health care providers help trans individuals access transition-related care. These providers include, but are not limited to, family physicians and endocrinologists who coordinate trans individuals' medical transitions by prescribing and/or managing hormone therapy and surgeons who perform top/upper surgery (chest reduction/mastectomy and chest masculinization for trans men or breast augmentation for trans women) or bottom/lower surgery (e.g., phalloplasty or vaginoplasty). Mental health professionals are also involved in transition-related care, as they are often the professionals who write letters of support that are often required by medical care providers and/or complete ministry of health assessments/forms for funding purposes.

Mental and physical health care practitioners who work with trans individuals usually adhere to one of two main treatment models (although many combine the two models). These are known as the medical/prescriptive (“gatekeeping”) model and the harm reduction/client-directed (“informed consent”) model (Kopala, 2003). Some experts in the field of trans health state that these two models are variations of each other, with the prescriptive model being a more strict interpretation of World Professional Association for Transgender Health (WPATH) Standards of Care, and the harm-reduction model being a more liberal interpretation of the same standards (Ehrbar & Gorton, 2010). Others view the two different treatment models as distinct from one another, while acknowledging the overlap often seen between the two (Coleman et al., 2011; Kopala, 2003).

The gatekeeping model places the health care provider in the expert role as they must determine the trans patient’s/client’s “readiness” for hormone therapy or surgery. This assessment is often done by referring to set criteria, such as those in standards of care or guidelines. The second model, the informed consent model, places the trans client in the expert role regarding their own needs. The care provider’s role is one of guiding the client and helping them make informed decisions by supplying information regarding the effects of hormone therapy and surgery. Howard Brown Health in Chicago, Illinois is an example of a health clinic that uses and promotes the informed consent model with their trans clients.

A third, and less well-known model, may also be used when working with trans clients. This model is known as the advocacy model. There is much less scholarship regarding this model, and the majority of the scholarship is produced by professionals and researchers in

Counselling Psychology (e.g., Singh & Burnes, 2010). It is similar to the harm-reduction/client-centered (consent-based) model described above, with the added aspect of the health professional advocating for trans clients and trans people in general. This advocacy takes place in settings such as medical institutions, educational institutions, and other systems. An example of clinical competencies stemming from the advocacy model are the *Competencies for Counseling with Transgender Clients* (Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2009). Although not reviewed below due to the competencies being aspirational in nature rather than standards of care or guidelines, they are mentioned here due to their importance as advocacy- and strength-based, trans-affirmative skills that mental health professionals aspire to develop.

The different models of care are mentioned here for informational purposes. As the focus of this literature review is on suicidality and access to transitioned-related care in general (rather than access to care that adheres to a specific model), and there is considerable overlap between the different models, the remainder of this section will not delineate between these three models.

2.3.2 Experiences within Transition-Related Care

Transition-related care is often delivered in one of two types of settings: in primary care, where the primary care physician may or may not have specialized knowledge, or in transition-related care specialized departments or clinics. The latter are often located in bigger urban centres and are thus not accessible to all trans people who seek transition-related care.

Several recent studies have explored people’s experiences of either receiving or delivering transition-related care. Poteat, German, and Kerrigan (2013) interviewed 55 trans individuals and 12 care providers in order to gain a deeper understanding of stigma, discrimination, and health care interactions between these two groups. Poteat and colleagues’ findings showed that both trans patients and care providers report experiencing uncertainty during interactions with each other: trans patients are uncertain whether their care providers will be competent and have the knowledge needed to care for them, and care providers are uncertain how to best care for trans patients. In addition, Poteat et al.'s finding showed that trans participants reported experiencing stigma and prejudice in health care settings and some care providers reported having stigmatizing or discriminatory views about their trans patients. These views were categorized as blaming, shaming, othering, and discriminating. The findings further showed two elements helped counter providers' negative attitudes: being a sexual minority and working collaboratively with their trans patients. Using grounded theory, Poteat et al. developed a model in which the role of power was key in these patient-provider interactions. Specifically, the lack of training regarding transition-related care created uncertainty for some providers when working with trans people. Uncertain providers who held discriminatory views towards trans individuals acted in ways that reinforced medical power and authority, which in turn maintained the stigma and discriminatory practices found in some primary care settings.

Snelgrove, Jasudavisius, Roew, Head, and Bauer (2012) conducted a qualitative study with Ontarian physicians (*N* = 13, 8 of whom had previously or were currently seeing at least one trans patient) to identify barriers experienced by the physicians to providing healthcare for trans patients. An over-arching theme of "not knowing where to go or who to talk to" (p. 1) was identified, as well as five specific barriers: accessing resources, medical knowledge deficits, ethics of transition-related medical care, diagnosis versus pathologizing trans patients, and health system determinants. Snelgrove and colleagues made several relevant recommendations, such as integrating trans heath care pedagogy in medical school curriculum and increasing providers' awareness of existing clinical standards of care and guidelines.

Less research has been conducted with regards to experiences within mental health services and gender identity clinics, but one relatively recent study addresses that gap. It is the largest study of trans participants in the UK (*N* = 889) and the qualitative findings offer some important insights. Ellis, Bailey, and McNeil (2015) found that "untreated gender dysphoria (due to delays or refusal to treatment), unnecessary and intrusive questioning/tests, prejudicial attitudes by service providers, and restrictive treatment pathways, all contribute to minority stress, which is detrimental to the health and wellbeing of trans people" (p. 4). In addition, participants reported encountering mental health care providers who were not well-informed and knowledgeable regarding trans people and thus often found themselves needing to be the educators in order to receive adequate care. Lastly, participants reported providers working in gender identity clinics often held outdated views regarding trans people that privileged the gender binary, to the point where participants often felt like they had to be disingenuous with their providers in order to secure access to transition-related care.

2.4 Overview of Established Standards of Care

There are seven established standards of care, toolkits, or guidelines that are germane to this literature review. These include the WPATH Standards of Care, Version 7; Trans Care BC's toolkit; Sherbourne Health Centre's guidelines; the Endocrine Society's guidelines; the American Psychological Association's guidelines; the University of California, San Francisco (UCSF) Transgender Care's (formerly the Center of Excellence for Transgender Health) guidelines; and the Tom Waddell Health Center's guidelines. All of the aforementioned documents are written for professional audiences with the goal of aiding said professionals in delivering competent mental or physical transition-related care to trans individuals. Each will be briefly described below.

The World Professional Association of Transgender Health (WPATH) was first established in 1979 under the name of Harry Benjamin International Gender Dysphoria Association. Long recognized as one of, if not the, leading international authorities regarding trans people's health care, the WPATH convenes tasks forces and reviews/publishes its standards of care on a regular basis. The most recent version of the standards is titled *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7.* The standards' target audience is mental and medical care providers, and the overarching goal of the standards is

> …to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments (Coleman et al., 2011, p. 165).

The standards of care include information regarding gender dysphoria, as well as guidelines regarding assessment and treatment of gender dysphoria among children, adolescents, and adults. Criteria for hormone therapy and surgery include "persistent, well-documented gender dysphoria" (Coleman et al., 2011, p. 187), among other specifications. The treatment options outlined in the standards include mental health care, hormone therapy, considerations of reproductive health, voice and communication therapy, and surgery. The necessity for care providers to have trans-related cultural competency is underlined throughout the standards and respect for and dignity towards trans people is emphasized.

The WPATH standards of care are guidelines and are meant to be flexible, as are the criteria for hormone therapy and surgery in the standards, and “individual health professionals may modify them” (Coleman et al., 2011, p. 166). As mentioned above, professionals interpret and use the standards of care in a variety of ways via their own treatment models (Ehrbar & Gorton, 2010). Some professionals interpret the standards quite literally, adhering to them with little or no flexibility, while others employ them in a flexible manner, as WPATH intended. This results in different approaches to the delivery of transition-related care among mental and medical care providers (Ehrbar & Gorton, 2010).

Trans Care BC is a program of British Columbia’s Provincial Health Services Authority. Trans Care BC organized a Primary Care Working Group, which developed the *Gender-Affirming Care for Trans, Two-Spirit, and Gender Diverse Patients in BC: A Primary Care Toolkit* (2019). The toolkit is a concise document that offers brief overviews of transition-related care for primary care providers, with a main focus on hormone therapy.

Prior to Trans Care BC’s creation, transition-related care in British Columbia was championed by Vancouver Coastal Health (VCH). In 2006, Vancouver Coastal Health’s Transgender Health Program, in collaboration with Transcend Transgender Support & Education Society, and with funding from the Canadian Rainbow Health Coalition’, e-published five sets of comprehensive guidelines regarding trans health. These guidelines were titled *Transgender Primary Medical Care: Suggested Guidelines for Clinicians in British Columbia* (Feldman & Goldberg, 2006), *Counselling and Mental Health Care of Transgender Adults and Loved Ones* (Bockting, Knudson, & Goldberg, 2006), *Endocrine Therapy for Transgender Adults in British*

Columbia: Suggested Guidelines (Dahl et al., 2006), *Caring for Transgender Adolescents in BC: Suggested Guidelines* (de Vries, Cohen-Kettenis, Delemarre-van de Waal, White Holman, & Goldberg, 2006), and *Social and Medical Advocacy with Transgender People and Loved Ones: Recommendations for BC Clinicians* (White Holman & Goldberg, 2006).

These former VCH guidelines each focused on different aspects of transition-related care (e.g., primary care, counselling, endocrinological care, and advocacy) with the overarching goal of helping professionals best meet their clients' physical and psychosocial needs. Assessing "readiness" for both hormone therapy and surgery referral were outlined, generally following WPATH's former standards of care (version 6) and the BC Ministry of Health's medical service plan's (MSP) requirements at that time.

Sherbourne Health Centre is located in Toronto and focuses on offering care to underserved communities ("Sherbourne Health Centre," n.d.). Over the years, it has become a Canadian leader in trans health care. Sherbourne has created and e-published guidelines regarding the delivery of transition-related care. Their most recent guidelines are titled *Guidelines for Gender-Affirming Primary Care with Trans and Non-Binary Patients* (2019). The guidelines began as an internal document for the family physicians and nurses working in the Centre, in order to assure treatment consistency. Due to the Centre being regarded as a source of transition-related care expertise, they decided to make their guidelines public and thus available to other professionals working with trans clients. The guidelines are comprised of three main parts: Part I: An introduction to gender-affirming care and hormone planning visits, Part II: Feminizing hormone therapy, and Part III: Masculinizing hormone therapy. The guidelines state that a diagnosis of gender dysphoria/gender incongruence by a trained mental health professional and/or trained physician is required prior to the start of hormone treatment, among other criteria.

In 2017, the Endocrine Society published their most recent clinical guidelines titled *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons* (Hembree et al., 2017). These guidelines offer the reader a graded recommendation system based on the quality of the evidence available at the time of publication. The Endocrine Society's guidelines are meant to be complementary to the WPATH standards of care (version 7) and offer endocrinologists and family physicians guidelines regarding the delivery of transition-related care, mainly the prescription and monitoring of hormones. The guidelines state that a diagnosis of gender dysphoria/gender incongruence by a trained mental health professional and/or trained physician is required prior to the start of hormone treatment, among other criteria.

The American Psychological Association (APA) convened a task force to review the extant literature and create guidelines regarding clinical work with trans and gender non-conforming individuals. The *Guidelines for Psychological Practice with Transgender and Gender Nonconforming Clients* (2015) are meant to complement existing standards of care and guidelines, like WPATH and The Endocrine Society's, and focus exclusively on the mental health of trans and gender-nonconforming people. More specifically, there are 16 guidelines that mental health providers should aim to follow in order to offer their trans and gender nonconforming clients culturally-competent care. It is the first set of guidelines published by the APA regarding competent mental health care to trans and gender non-conforming individuals.

UCSF Transgender Care is housed at the University of California, San Francisco. Its mission is to "increase access to comprehensive, effective, and affirming healthcare services for trans and gender diverse communities" ("UCSF Transgender Care," n.d.). In order to meet its aforementioned goal, the Center develops and implements trans health programs via a National Advisory Board and a Medical Advisory Board. The Center e-published their guidelines, titled

Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People (2016). The guidelines include grading of evidence and are meant to be used in conjunction with the WPATH standards of care and the Endocrine Society's guidelines. The Center's protocol includes 39 different sections, including an Initiating Hormone Therapy Section and a Mental Health Considerations section. Both sections emphasize the informed consent model, and the latter section encourages a decrease in gatekeeping of transition-related care. The latter section also briefly discusses the preoperative assessment process.

Tom Waddell Health Center is located in San Francisco and is operated by the San Francisco Department of Public Health. The Center houses and runs a transgender health clinic and has e-published guidelines regarding transition-related care, titled *Protocols for Hormonal Reassignment of Gender* (2013). The goal of the protocol was to share the expertise the staff at the Center had acquired by treating over 1200 trans individuals in San Francisco. More specifically, the Center aimed to "share our experience with health providers and their patients on the best practices for prescribing hormones for patients with gender identity issues" (Tom Waddell Health Center Transgender Team, 2013, p. 3). The introduction of the Protocol includes the statement that the Center "does not require patients to present documentation attesting to their transgender status" in order to access hormone therapy (Tom Waddell Health Center Transgender Team, 2013, p. 4).

2.5 Suicidality in the Context of Transition-Related Care

2.5.1 Within Standards of Care and Guidelines

Of interest to the current literature review is whether suicidality is listed as a contraindication to the delivery of transition-related care; if and how suicidality is attended to; and how mental health concerns (such as depression) are addressed in the various standards of care and guidelines.

Suicidality is rarely mentioned in WPATH's most recent standards of care (version 7). When it is addressed, it is not listed as a contraindication to the delivery of transition-related care. It is stated that co-morbid mental health concerns do "not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria" (Coleman et al., 2011, p. 181). Furthermore, it is stated that transition-related care should be delivered to all trans individuals, following the standards of care, including those who live in institutional environments. "The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality" (Coleman et al., 2012, p.68). Throughout the standards, depression is often contextualized as being a result of minority stress, stigma, and gender dysphoria, and the guidelines are careful to point out that depression is not inherent to the trans person.

The Endocrine Society's guidelines are based on WPATH's most recent version of the standards of care and do not specifically mention or directly address suicidality. Taken directly from the WPATH standards of care, the guidelines state that criteria for hormone treatment for adults includes the following: "Mental health concerns, if present, must be reasonably well controlled" (Hembree et al., 2017, p. 3878). The criteria for gender-affirming lower surgery includes the following: "If significant medical or mental health concerns are present, they must be well controlled" (Hembree et al., 2017, p. 3893). Like the WPATH standards of care from which these specific criteria come from, it is unclear what "reasonably well controlled" and “well controlled” mean exactly, leaving the interpretation to each clinician’s subjective clinical judgment. The guidelines encourage the clinician to screen for, and monitor if present, symptoms of depression during hormone treatment. The guidelines also specify that clinicians working with trans individuals who are seeking gender-affirming surgery “individualize treatment based on the physical and mental health status of the individual” (Hembree et al., 2017, p. 3894). Laslty, the guidelines propose that clinicans “ determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual” (Hembree et al., 2017, p. 3894) rather than using an age requirement.

Within the APA guidelines, suicidality among trans and gender non-conforming individuals is explained in the context of transphobia, family rejection, and minority stress. Suicidality, as it pertains to psychological care, is referred to as a possible co-existing mental health concern among gender-questioning adolescents. It is referred to as potentially “complicating” the client’s presenting problem, among other possible co-existing mental health concerns. There is no mention of suicidality in the context of transition-related care for adults.

Trans Care BC’s toolkit does not mention suicide or depression. The toolkit does outline the WPATH standards of care in which mental health concerns must be “reasonably well-controlled” for upper surgeries and “well controlled” for lower surgeries (Trans Care BC, 2019, p. 12). The toolkit also encourages primary care providers to “work to stabilize any physical or mental health conditions to ensure they do not pose barriers to the patient accessing gender-affirming interventions such as hormones or surgery” (Trans Care BC, 2019, p. 3).

Vancouver Coastal Health’s previous guidelines state that depression and suicidality are not absolute contraindications to hormone treatment and surgery. The guidelines go on to state that

> The clinician should be confident that supports are adequate and that any co-existing conditions are under control to the degree that (i) the introduction of a new stressor will not seriously destabilize the client, and (ii) the client has sufficiently clear thinking to be competent to consent to treatment (Bockting et al., 2006, p. 22).

Furthermore, Vancouver Coastal Health's previous counselling-specific guidelines state that depression and suicidality are common among trans individuals, and that these concerns may or may not be related to gender issues. The counselling guidelines urge mental health practitioners to work with trans clients experiencing depression and anxiety in order to help develop their resilience in the face of societal oppression and help alleviate their symptoms (Bockting et al., 2006).

Sherbourne's most recent guidelines pay a great deal more attention to suicidality than previous versions. The guidelines indicate that suicidality is not a contraindication to hormone therapy and that hormone therapy has been shown to reduce suicidal ideation and behaviour among trans individuals who seek medical transition via hormone treatment (LGBT Health Program, 2019). The 2019 guidelines inform readers that the time between a person deciding they want to medically transition and beginning that process is when they are most vulnerable to depression and suicidality, and readers are encouraged to support trans clients and patients with timely access to transition-related care. The guidelines clarify that while suicidality is not a contraindication to transition-related care, "if a patient is in acute crisis and the provider thinks they are unable to provide informed consent, then this would certainly constitute an absolute contraindication" (LGBT Health Program, 2019, p. 23). Lastly, the guidelines specify that cyproterone acetate (an androgen blocker prescribed to transfeminine individuals) is contraindicated when the patient has severe chronic depression.

There is no mention of depression or suicidality being a contraindication to hormone therapy in the UCSF Transgender Care’s guidelines. Likewise, there is no mention of depression or suicidality being a contraindication to hormone therapy in the Tom Waddell guidelines. The guidelines recommend thorough assessment and careful referral to trans-positive mental health care providers should the client need it (Tom Waddell Health Center Transgender Team, 2013).

2.5.2 Suicidality within Research/Literature

In just over the last two decades, there have been numerous studies and needs assessments conducted that document the rates of suicidal ideation and attempts among trans populations (e.g., Adams, Hitomi, & Moody, 2017; Clements-Nolle et al., 2006; Kenagy, 2005b; Kenagy & Bostwick, 2005; Mathy, 2002; Moody & Smith, 2013; Nuttbrock et al., 2010; Tebbe & Moradi, 2016). However, only a few studies have also examined transition-related care. For example, an Ontario-wide study with a total sample of 433 self-identified trans individuals found that medical transition via hormone therapy and/or surgery was associated with an absolute reduction in suicidal ideation (Bauer, Scheim, Pyne, Travers, & Hammond, 2015). Results from the same research project also showed that rates of suicidal ideation and behaviour are highest among trans individuals who plan on transitioning but have not yet begun to do so (Bauer, Pyne, Francino, & Hammond, 2013). This finding is supported by a study conducted across the United Kingdom, which found that the majority of trans participants who reported suicidal ideation or behaviour reported experiencing this suicidality the most frequently before transitioning (see Figure 2; McNeil et al., 2012).

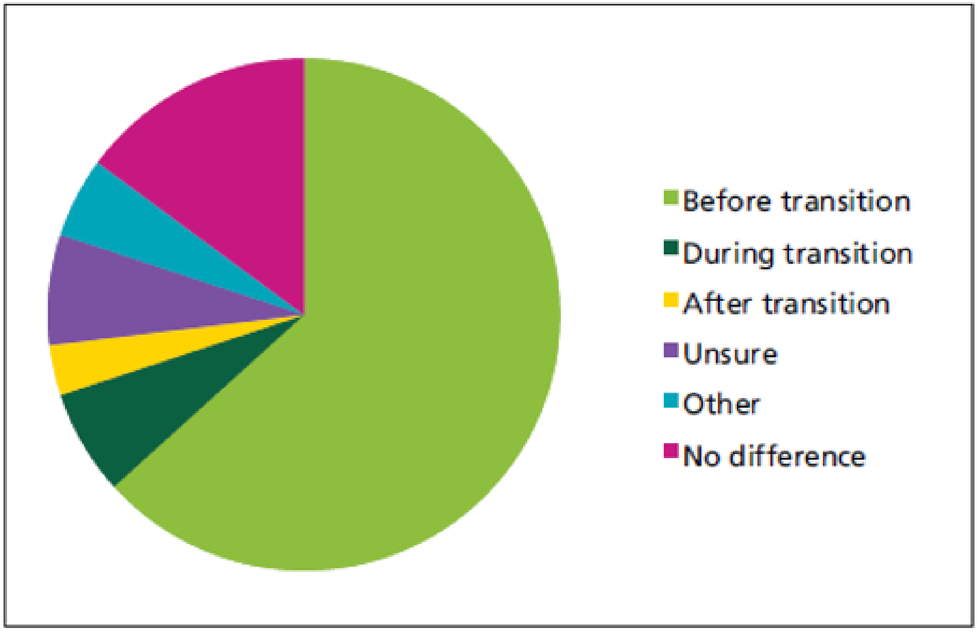

Figure 2. Responses to the question “When did you think about or attempt suicide the most?” (McNeil et al., 2012)

Furthermore, studies show that individuals who are accepted and supported in their gender identity show better mental health and quality of life outcomes (e.g., Murad et al., 2010; Pinto, Melendez, & Spector, 2008). Several studies, a systematic review, and a meta-analysis have found that hormone treatment and surgery (for those who seek it) are linked to lower rates of depression, social anxiety, general anxiety, and suicidality (Davis & Meier, 2014; Gomez-Gil et al., 2012; McNeil et al., 2012; White Hughto & Reisner, 2016) and significantly improved ratings of one’s quality of life (Murad et al., 2010; White Hughto & Reisner, 2016).

Lack of or withholding of treatment can have detrimental effects on trans individuals’ mental health. As noted earlier, the WPATH standards of care specifically detail the risks (i.e., autocastration, depression, dysphoria, or suicidality) of withholding hormone treatment from trans people in institutional environments. The detrimental effects of lack of or withholding of treatment can also be seen in the impact of the sudden closure of the Gender Dysphoria Program at Vancouver Hospital in 2002:

> Transgendered (sic) people who lack access to appropriate care experience increased stress, anxiety, and depression, with a resulting rise in high-risk behaviors such as substance use, eating disorders, self-harm, and suicide attempts; since the announcement of the closure, volunteer organizations providing support to transgendered people and families have reported a sharp increase in distress calls, including suicide calls. (Goldberg et al., 2003, p.2)

In addition to suicidality, some experts warn that a risk of not treating trans clients includes black-market hormone use (Gorton, Buth, & Spade, 2005).

Lastly, access to transition related-care appears to be a protective factor against suicidality. For example, a recent Canadian study, which used qualitative methodology to identify suicide protective factors among trans adults, identified transition-related factors to be protective (Moody, Fuks, Peláez, & Smith, 2015). Specifically, the results showed that trans participants experienced both the hope of transitioning and currently transitioning/having transitioned as having protected them against both suicidal ideation and behaviour.

2.6 Suicidal Ideation or Behaviour in the Context of Health Care (General Population)

It is recommended that all individuals who experience suicidal ideation seek help from their mental or medical health care providers (Health Canada, 2009). In a review of the literature regarding contact with mental health and primary care providers, Luoma and colleagues (2002) found that 44.43% of people who died by suicide consulted with primary care providers within one month of their death compared to 18.77% of people who consulted mental health professionals within a month of their death. These findings are interpreted by the study's authors to indicate that individuals have greater access to family physicians and seek help from these professionals for suicidal ideation more than from mental health professionals. As such, family physicians “play a key role in identifying and managing patients with suicidal tendencies” (Verger et al., 2007, p. 253).

Primary care patients rarely spontaneously report suicidal ideation or behaviour to their care providers (Nutting et al., 2005) and often under report symptoms of depression (Bell et al., 2011). In a landmark psychological autopsy study, Isometsä et al. (1995) investigated all final patient contacts with health care professionals in Finland prior to the patients’ death by suicide. Results showed that only 22% of clients communicated their suicidal ideation to their care providers during their last appointment. When setting was examined, a significant difference was found between rates of communication of suicidality among inpatient psychiatric settings, outpatient psychiatric settings, primary care, and other specialist care. Almost a third (30%) of clients communicated their suicidal ideation to their care providers in inpatient psychiatric settings; 39% did so in outpatient psychiatric settings; only 11% disclosed in primary care settings; whereas 6% disclosed in other speciality settings. The study was limited to examining contact within 28 days prior to the patients’ suicide, and results showed that almost half of patients consulted with their care providers in the week before their death (*n* = 269, 47%). Isometsä and colleagues (1995) attribute the difference in disclosure rates to several factors. One of these factors is based on the likelihood that individuals in inpatient and outpatient settings were treated by psychiatrists who may have known the patients and their history with mental health issues and suicidality. More recent studies indicate that clients and patients still rarely spontaneously disclose suicidal ideation in care settings (Nutting et al., 2005; Verger et al., 2007).

Relatedly, primary care providers do not inquire about suicidal ideation or behaviour in most doctor-patient encounters, even when the patient presents with symptoms of major depression (Verger et al., 2007). A randomized controlled study found that primary care providers inquired about suicide in 42% of cases of depression and 30% of cases of adjustment disorder with a depressed mood (Feldman et al., 2007). This study also showed that certain physician factors were significantly related to an inquiry regarding suicidal ideation. Personal experience with depression (one's own depression or someone close) and setting were both significant characteristics: physicians with personal experience with depression were more than three times more likely to inquire about suicidal ideation (adjusted odds ratio = 3.11) than those without personal experience, and physicians in academic settings were 10 times more likely to inquire (adjusted odds ratio = 10.03).

When a primary care provider does inquire about suicidal ideation or behaviour, the way the inquiry is made can affect the response elicited from the patient. Leading or closed questions (e.g. "You're not thinking of killing yourself, are you?") can act as a barrier to patient disclosure and discourage further discussion of the topic (Vannoy et al., 2010). Factors linked with primary care providers who do successfully detect suicidal ideation include having completed continuing education on the subject of suicide risk screening and conducting longer consultations with patients (Verger et al., 2007). Recent publications offer guidelines to family physicians regarding thorough suicide risk assessments, including how to individualize each assessment (e.g., Fiedorowicz, Weldon, & Bergus, 2010). Lastly, in a report prepared for the Public Health Agency of Canada by Turecki, Lesage, and Desrochers (2012), the authors ascertained that there is strong evidence that training a variety of care providers, including family doctors, in detection, treatment, and management of suicidal behaviour is one element of an effective suicide prevention strategy.

General self-disclosure communication patterns and preferences[5] appear to have a relationship with suicide attempts, although the nature of that relationship is still unknown. In a study of 100 individuals, lower scores on a general self-disclosure measure significantly differentiated between people who had made medically serious suicide attempts, those who had made medically mild suicide attempts, and those who had experienced ideation and not made any attempts (Apter, Horesh, Gothelf, Graffi, & Lepkifker, 2001). One might think that these results are perhaps due to potentially more severe depression, anxiety, or hopelessness in the individuals who made medically serious suicide attempts, or perhaps due to more severe symptoms being related to lower levels of self-disclosure (e.g., feeling depressed being related to sharing less with others). Interestingly, there were no significant differences between ideators, mild attempters, and serious attempters with regards to anxiety scores, nor with regards to hopelessness scores. In addition, there were no significant correlations between anxiety/depression and self-disclosure, nor between hopelessness and self-disclosure. These results indicate that other factors may account for the relationship between self-disclosure and serious suicide attempts, and that care providers need to keep this in mind when working with at-risk populations. The above results were supported by a study conducted in 2008 by Levi et al.; these authors found that communication factors (such as lack of self-disclosure) accounted for 29% of the variance in their model, and lack of self-disclosure specifically was a significant predictor the lethality of suicide attempts. Thus, it appears that individuals who experience suicidal ideation and who do not self-disclose personal information about themselves readily, or who disclose very little information, are at risk for attempting suicide. These findings challenge

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[5] General self-disclosure communication patterns and preferences refers to a person’s tendency to self-disclose personal information to the people closest to them (Apter, Horesh, Gothelf, Graffi, & Lepkifker, 2001).

the myth that suicidal clients and patients will self-disclose pertinent information about their suicidality when unprompted. Furthermore, the results indicate that care providers should ask clients about suicidal ideation and behaviour directly (yet with compassion and sensitivity).

While the majority of studies investigating disclosure of suicidal ideation have been conducted with nearly all White samples, some studies have included participants of colour. Of these latter studies, some racial-ethnic differences have been found regarding suicide risk and self-disclosure of suicidal ideation. Morrison and Downey (2000) investigated the rates of self-disclosure regarding suicidal ideation among White and racial-ethnic minority students accessing student counselling services. The results showed that a significantly higher number of racial-ethnic minority students were hidden ideators[6]. Morrison and Downey concluded that "clinicians must recognize that all persons with suicidal ideation may not self-disclose their feelings, and this may be particularly true for ethnic minority clients" (p. 384).

Furthermore, some racial-ethnic differences have been found with regard to risk and protective factors among Black and White at-risk individuals. Vanderwerker et al. (2007) investigated known factors associated with suicidal ideation and behaviour in a sample of 68 Black and 63 White older adults who were being treated for substance abuse and who were medically frail. The authors found that social support significantly negatively predicted suicidality in both the Black and White participants; that age negatively predicted suicidality in White participants; and that anxiety positively predicted suicidality in the White participants. The authors concluded that these results point to potential differences in factors associated with suicidality among Black and White at-risk individuals and that these difference should be taken

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[6] Hidden ideators are those individuals who do not indicate suicidal ideation on intake forms and only disclose during the clinical assessment when asked direct questions regarding suicidal ideation and behaviour.

into consideration when conducting suicide risk assessments and working with these populations in general.

The above racial-ethic differences should be considered to be cultural differences and are mentioned here in order to inform the reader of the possibility of these differences, not in order to make generalizations. In addition, the results do not take the psychological effects of racism into consideration, nor the impact of having intersecting identities (e.g., being a Black woman who is experiencing suicidal ideation). Practitioners are encouraged to interpret the results through an intersectional lens that accounts for power and privilege.

2.7 Review of "The Script"/Expected Narratives

As seen in the review of the standards of care, guidelines, and protocols above, many instances of delivering transition-related care involve assessments and/or readiness evaluations conducted by medical and mental health professionals. This model of transition-related care has led to the existence of the expected narrative or script. Fear of being denied transition-related care by health care providers leads some trans people to be cautious and guarded upon first consulting with a mental health care provider (American Psychological Association, 2015); including not disclosing some information, such as symptoms of depression and suicidal ideation/behaviour (Carroll et al., 2002; McNeil et al., 2012) and sexual orientation (Gorton et al., 2005); and providing health-care providers with information or narratives they think the providers want/need to hear (Dahl et al., 2006; Istar-Lev, 2004). For example, in a report produced with the results of a qualitative project known as Y-GAP (Youth-Gender Action Project), trans youth in Ontario reported encountering providers who hold rigid ideas regarding transition trajectories and narratives (2009). The youth reported often withholding current and historical personal information out of fear of being denied transition-related care or the care being delayed. In the largest study among trans individuals in the UK to date, 30.9% of participants reported having omitted information or lied to their care providers in gender identity clinics out of fear of their transition-related care being delayed or denied (Ellis et al., 2015). The majority of participants who reported lying or omitting information did so regarding their mental health (e.g., depression or anxiety), sexual orientation/sexuality, or employment. Uncertainty is a normal part of gender identity development for trans individuals (Devor, 2004), however the majority of the UK participants (51.4%) who felt uncertain about their gender identity while using services at a gender identity clinic did not discuss this uncertainty with their care providers out of fear of a resulting limited access to care (Ellis et al., 2015). Furthermore, in a qualitative study in which 12 care providers were interviewed, most reported seeking “a specific narrative of lifelong discomfort with natal sex as confirmation that patients met criteria for gender affirming therapies” (Poteat et al., 2013, p. 26). Thus, it is clear that some trans clients feel the need to present a certain narrative out of fear of being denied transition-related care, and that some care providers expect a certain narrative from their clients. This fear and felt need to present a certain narrative is understandable given the historical and current power imbalance between trans patients/clients and health care providers (American Psychological Association, 2015; Gorton et al., 2005; Istar-Lev, 2004), as well as the instances of being denied transition-related care that are shared via word of mouth or online among members of different trans communities (Hendricks & Testa, 2012).

2.8 Rationale for the Current Study

Although the high rates of suicidal ideation and attempts in the trans community are well documented, few studies have been undertaken to investigate the way that the current state of transition-related care delivery impacts suicidal ideation and behaviour among trans individuals.

One recent needs assessment demonstrated that some trans people experienced increased suicidality when trying to access care at gender identity clinics in the UK due to barriers to care and transprejudice experienced at those clinics (McNeil et al., 2012). However, no qualitative empirical study has yet been conducted to explore and document the relationship between suicide risk and transition-related care as it is understood by those involved.

Second, there is a clear dearth of literature regarding factors that influence the disclosure of suicidal ideation and/or behaviour to mental and medical health care providers. The felt need to present a certain narrative when seeking transition-related care has been mentioned by some researchers and practitioners (e.g., Hendricks & Testa, 2012; Istar-Lev, 2004), but this phenomenon has not been studied and is thus poorly understood. It follows that the narrative or script around suicidality among trans clients seeking transition-related care, if one exists, is even less understood. For example, if such a script exists, it is unknown whether it exists because trans individuals have been historically and currently denied transition-related care when disclosing suicidal ideation to their care providers or due to other reasons. As Hendricks and Testa (2012) explain, trans individuals often build communities online and in-person and share pertinent information with each other regarding health care providers. Furthermore, patients (in general) rarely spontaneously disclose suicidal ideation to health care providers; one can imagine that it may be much more difficult for a trans person, who is likely dependent on their provider’s assessment of their mental health to access transition-related care, to do so. In many cases, it may be a paradoxical predicament: the trans client is feeling suicidal but fears disclosing this to their provider for fear of being denied transition-related care, and thus does not receive help and continues feeling suicidal. The paradoxical predicament may also be that the suicidal trans client discloses their ideation to their health care provider in order to seek help, and is denied transition-related care, which has been shown to be life-saving (Moody et al., 2013). As Ehrbar and Gorton (2010) assert, “transclients (sic) have historically been caught in a double bind requiring simultaneous pathology sufficient to justify intervention and mental health sufficient to access intervention” (p. 203). The current state of trans-related empirical literature does not allow one to make any conclusions regarding these potential paradoxical predicaments and is thus a warranted area of research.

Similar to the dearth in the literature regarding factors that influence trans clients’ disclosure of suicidal ideation, there currently exists no literature that documents and examines mental and medical health care providers’ *views* of suicidality among trans clients who seek transition-related care. Thus, it is unknown whether providers view suicidality as a contraindication to the delivery of transition-related care or as an aspect of the client’s health that needs to be monitored and ameliorated during the delivery of transition-related care. Separate from providers’ views and treatment models, it is also unknown what providers *do in practice*; do they withhold transition-related care from suicidal individuals, deliver it in hopes of it being part of the treatment that will help alleviate their client’s distress, or perhaps some other course of action? What providers do in practice is clearly relevant to the health and well-being of trans individuals, as trans individuals are often dependent on providers for access to transition-related care.

Finally, the majority of the literature regarding trans people’s mental and physical health, as well as transition-related care, is produced in the United States. While some findings may be generalizable to Canadian trans individuals, there are some key differences between the two countries (e.g., socialized health care) that limit the generalizability of U.S.-based research to a Canadian context. Thus, additional research in the Canadian context is necessary.

2.9 Current Study

2.9.1 Purpose of the Study

The purpose of the current study was to fill the aforementioned gaps in the literature by investigating trans adults' and health care providers' experiences of the interaction between suicidality and transition-related care. Qualitative methodology was used in order to give voice to both trans individuals' and care providers' experiences with suicidality and transition-related care. Trans participants' were asked about their experiences of suicidality while accessing or trying to access transition-related care, their decisions about disclosing their ideation to care providers (or not), and what meaning they made of these experiences. Care providers' experiences were also explored: inquiries were made regarding how they understand their clients' suicidality within transition-related care and how they approach or would approach care for suicidal clients. In addition, all participants' opinions were solicited regarding improvements that can be made to the existing guidelines, systems, and delivery of care with regards to suicidality and transition-related care. Investigating this aspect of the interaction between suicidality and transition-related care not only sheds light on an overlooked area of trans health, which has the potential to improve health care providers' understanding in this area, it also allows for the possibility of future development of culturally-competent interventions aimed at the interaction between suicidality and transition-related care.

2.9.2 Research Questions

The current study's overarching research question was: How do people experience and make meaning of the interaction between suicidality and transition-related care? Also, two sub-questions guided the current study: How do trans people experience and make meaning of this interaction? How do care providers experience and make meaning of this interaction? Qualitative methodology was used to answer these questions. A rationale for the use of this methodology is presented below.

2.10 Qualitative Methodology: Review and Rationale for Use in Suicide Research

As the current project was a qualitative research project regarding suicide and health care, and was conducted using interpretive phenomenological analysis, I will briefly outline the following: (1) the importance of qualitative suicide research in general, (2) the importance of qualitative health research, and (3) the need and appropriateness of interpretive phenomenological analysis in qualitative suicide research.

2.10.1 Why Qualitative Suicide Research is Appropriate and Necessary

Suicidality is a complex subject. In order to better understand its complexities, further research using quantitative, qualitative, and mixed-methods approaches must be conducted and published. As Leenaars (2002) eloquently states:

> Suicide and suicidal behavior are multifarious events. There are biological, psychological, intrapsychic, interpersonal, cognitive, conscious and unconscious, sociological, cultural and philosophical elements in the events. Thus, research in suicide cannot be reduced to a single approach. This complexity indicates the necessity of a parallel complexity in study (p. 19).

However, to date, the vast majority of published suicide studies employ quantitative methodology. This work, usually in the form of epidemiological, psychological, sociological, and public health studies, have given us a good understanding of prevalence rates, differences in ideation rates, and descriptors of attempt rates along certain characteristics (e.g., age, sex, race/ethnicity, marital status), as well as risk and protective factors. Far fewer suicide studies have employed qualitative methods, which offer a deeper understanding of the phenomenon

(Cutcliffe, 2003); hence, there is a need for these studies (Hjelmeland & Knizek, 2010). Indeed, while quantitative studies are invaluable for helping us understand the who, why, and how (methods) of suicide, qualitative studies are vital in helping us comprehend the what of suicidality (e.g., what the experience of being suicidal was like for a person, how one recovers from being suicidal, what meaning one makes of their experiences). Furthermore, qualitative methodology privileges the participant's voice, positioning them as important holders of knowledge regarding the phenomena at hand due to their lived experience.

Hjelmeland and Knizek (2010) explain that the majority of suicide studies can be categorized in one of three groups: epidemiological research, (neuro)biological research, and intervention studies. They explain that while these forms of research are indeed important, they focus on explanations via causal relationships rather than developing an understanding of suicidality by exploring what it means to the suicidal person. Hawton (2001) states that quantitative studies "need to be accompanied by more qualitative inquiry which will help explain the hard statistical findings" (p. 82). For example, in a quantitative study regarding suicide protective factors among trans adults, Moody and Smith (2013) found that social support from family was protective (among other factors). While these findings are an important addition to the literature and can be used in developing guidelines for family therapy with trans individuals, it does not help the researcher or reader understand *how* social support from family is protective for trans individuals. In a qualitative study in the same area of research, Moody, Fuks, Peláez, and Smith (2015) found that social support from meaningful others, such as from family members, was protective through the acceptance that participants experienced from their social support network members. This finding can help tailor therapy and suicide prevention interventions by aiming to foster and develop cis family members' acceptance towards their trans loved ones, thus helping the trans person to feel a sense of safety within the family, buffering them against the unsafe transphobic society in which they live. Thus, qualitative methods in suicide research can help move the field forward regarding a deeper, more holistic understanding of suicidal ideation and behaviour.

Hjelmeland and Knizek (2010) are only two of many suicide researchers who have called for more qualitative studies to be conducted and published. For example, Cutcliffe (2003) made a strong case for qualitative suicide research, stating "… there is a clear and urgent requirement to gain a deeper understanding of the lived experiences of suicidal people" (p. 98). Furthermore, Cutcliffe states that "it is necessary to view the person and his/her situation holistically, and to understand the particular experiences or phenomena and situated meanings that lead these people to attempt suicide" (p. 99). Understanding the particular lived experiences of individuals who have experienced ideation or who have attempted suicide is a necessary step in order to holistically understand the phenomenon of suicide and thus be able to develop appropriate interventions (Cutcliffe, 2003). In order to gain the deep and holistic understanding of suicidality that is necessary, Cutcliffe advocates for a specific qualitative approach, namely a phenomenological approach, to be used in suicide research (Cutcliffe, 2003; Cutcliffe, Joyce, & Cummins, 2004). As described later in the manuscript, a phenomenological approach is well suited to the study of suicide due to its focus on developing in-depth analyses of people's lived experiences.

Using qualitative methodology and developing a rich understanding of suicidality is not only useful for developing appropriate suicide prevention interventions, but it can also inform life-enhancing interventions that arrest the suicide trajectory. For example, Moore (1997) conducted a qualitative research study using a phenomenological approach in order to better understand suicidal ideation among older adults. Her results show that ideation is often experienced when older adults report a lack of feeling connected with others who care about them. Situated in the field of nursing, Moore recommends creating life-enhancing strategies for older adults and focusing holistically on the person's well-being, as opposed to simply moving to action when the person is in crisis. Strategies could include involving the older adult's family in their care to increase a sense of connection, working collaboratively with the client when caring for their medical needs, and imparting the sense that the medical staff cares about them and their well-being.

From the literature reviewed above, it is clear that qualitative suicide research is an important addition to the general suicidology scholarship. In addition, qualitative methodologies can be extremely beneficial when conducting suicide research among vulnerable populations, in order to develop a clear understanding of their lived experiences. For example, the extant qualitative suicide research includes studies exploring suicidality among First Nation women, street-involved youth, survivors of suicide attempts, gay and bisexual men who have recently been diagnosed with HIV, and youth who are recovering from suicidal ideation and behaviour (e.g., Bennett, Coggan, & Adams, 2002; Bergmans, Langley, Links, & Lavery, 2009; Hawton, 2001; Kidd, 2004; Moore, 1997; Siegel & Meyer, 1999). Jones (2004) and Paproski (1997) conducted qualitative suicide studies with First Nations people in order to better understand the phenomenon in this population and inform culturally sensitive suicide interventions.

A further example of high quality qualitative suicide research can be seen in Everall and colleagues' work regarding the experiences of previously suicidal adolescents and young adults (e.g., Bostik & Everall, 2006, 2007; Everall, 2000; Everall, Altrows, & Paulson, 2006; Everall, Bostik, & Paulson, 2006; Paulson & Everall, 2003). Everall and her research team recruited and interviewed previously suicidal individuals in order to develop a deep and rich understanding of what that experience was like for the participants, the participants’ attachment relationships during that difficult time, and what factors led to healing for the participants. Everall et al. set a good example regarding not only how previously suicidal individuals can be recruited and interviewed, but the value of qualitative suicide research in general. For example, their results show that secure attachment can help move a person from suicidality to wellness, and that social support in of itself is not protective – it is the quality of that support and the suicidal person feeling capable of seeking it out that are protective. Everall et al.’s results also have meaningful clinical implications, such as the importance of developing a strong therapeutic alliance with suicidal teens and young adults. These findings and the resulting implications are unique to the qualitative methodology used, and allow readers to develop a strong understanding of the participants’ lived experiences and what may be helpful for them.

As outlined in Chapter 1 as well as earlier in the current chapter, there exists no published research regarding how people experience the interaction between suicidality and transition-related care. Thus, the current research project explored this interaction among both trans individuals and care providers. As previously stated, research in this area is needed due to the high rates of ideation and attempts in the trans community, the fact that these rates increase during the period before accessing transition-related care, and the fact that the majority of the standards of care and transition-related care guidelines do not address suicidality. As such, we do not understand many aspects of the phenomenon at hand, such as whether trans people adhere to a script/expected narrative and omit suicidal ideation and behaviour when accessing transition-related care; whether care providers screen for suicidal ideation; whether care providers view suicidality as a contraindication, or as an additional health issue that must be addressed concurrently to the delivery of transition-related care; and trans participants' experiences of suicidal ideation and behaviour before, during, and/or after access to transition-related care, among many other potential aspects.

2.10.2 Qualitative Health Psychology Research

Suicide is an important health problem, and as such, health psychology is an appropriate lens to investigate it through. Furthermore, qualitative health psychology can offer insight into the experiences of care providers and clients/patients regarding health, illness, or being in a health care setting. These first-person accounts and the analyses that follow are important because they enrich readers' understanding and can thus enhance clinical and medical care. As Biggerstaff and Thompson (2008) state:

> Qualitative paradigms offer the researcher the opportunity to develop an idiographic understanding of participants, and what it means to them, within their social reality, to live with a particular condition or be in a particular situation (Bryman, 1988). It thus facilitates an understanding of the complexity of bio-psycho-social phenomena and, as such, afford exciting possibilities for informing clinical practice (Boyle, 1991) (p. 215).

Smith (1996) also advocates for the use of qualitative methodology in health psychology research due to its "potential to supplement, expand and greatly enrich the existing corpus of research in health psychology" (p. 263). Smith furthers argues that the privileging of quantitative approaches to the detriment of qualitative approaches has shaped the field's distorted view of what valid research is and is not, as well as what research questions and topics are valid areas of inquiry.

Williams and Elliot (2010) make a strong case for using qualitative methods in the exploration of social inequalities in health research. While they do not refer to suicide specifically, many of their arguments and main points regarding illnesses can be applicable to suicide, as it is an important health-related problem. For example, Williams and Elliot state that:

> While intense work on the biology and genomics of diseases like heart disease and cancer continues, it is recognized that understanding these diseases and their distribution requires an exploration of the quality of the relationships between the distribution of illness, the behaviour of individuals and social groups, the experiences of class and place and the meaning that people attribute to them (p. 119).

Thus, not only is qualitative health research important and needed, it can also be used to contextualize different rates of any given health or illness phenomena seen in different populations, through its inclusion of participants' understanding of the phenomena and where they are situated in a socio-political context. This situating is in line with the intersectional paradigm that was employed in the current project (described later).

From the literature reviewed above, it is clear that suicidality and transition-related care can be two important aspects of many trans individuals' lived experiences, and that they interact in ways that are not yet fully understood. Qualitative methodology is an appropriate inquiry approach and is well suited for the current study due to its focus on understanding how individuals make meaning of their lived experiences. Interpretive phenomenological analysis (IPA), a specific type of qualitative approach, was used in the current research project and is described in the following chapter, along with all other procedures.

3.0 Methodology

3.1 IPA

3.1.1 Background

Phenomenology originated from the field of philosophy and has since been integrated into a variety of fields, such as psychology, education, and the health sciences (Creswell, 2007). At its core, phenomenology is the understanding of a phenomenon's essence, and a phenomenology study aims to "reduce individuals' experiences with a phenomenon to a description of the universal essence" (Creswell, 2007, p. 56). This approach can be traced back to the German philosopher Husserl, Husserl' student Heidegger, and two French philosophers who were influenced by Husserl and Heidegger's work, Satre and Merleau-Ponty (Smith, Flowers, & Larkin, 2009).

As mentioned earlier, phenomenology is considered an appropriate qualitative approach to employ in suicide research due to its focus on a deep understanding of a person's or people's experiences (Cutcliffe, 2003). There are many different kinds of phenomenological approaches that have been developed over the years: interpretive phenomenological analysis was used in the current study, and is described below.

Interpretative phenomenological analysis (IPA) is a combination of two theoretical approaches: phenomenology and hermeneutics, and is also strongly influenced by ideography. Phenomenology is concerned with the experience; hermeneutics is concerned with interpretation; and ideography is concerned with the particular (Smith et al., 2009). Thus, IPA is an approach that allows a researcher to develop a deep understanding (via interpretation) of an experience had by one or more people. It is important to note that the term interpretation is understood in many different ways in psychology; for example, it is often associated with psychoanalysis, as it is an analysts' main therapeutic intervention. However, interpretation is understood in a very different way in qualitative approaches, including IPA (Smith, 2004). In line with an intersectional paradigm, which assumes that there is no singular version of reality and reality is constructed within people based on their life experiences and co-constructed between people in an intersubjective way (described in greater detail in a later section), most qualitative researchers attempt to make sense of the data collected through their own meaning-making process, known as interpretation. This interpretation is based on the data and remains closely tied to it, in order to produce results that are as representative of the participants' lived experiences as possible (Smith, 2004). Interpretation and analysis are described in greater detail in a later section.

3.1.2 IPA as a Qualitative Methodological Approach

IPA is an approach that is "committed to the examination of how people make sense of their major life experiences" (Smith et al., 2009, p. 1). IPA was used to investigate the overarching research question and both sub-questions. These questions are: How do people experience and make meaning of the interaction between suicidality and transition-related care? How do trans people experience and make meaning of this interaction? How do care providers experience and make meaning of this interaction? IPA was particularly appropriate for the current study due to its focus on important life events, transitions, and life-changing moments. "IPA studies usually deal with significant existential issues of considerable moment to the participants and the researchers. Thus, many are about significant life transforming or life-threatening events, conditions or decisions…" (Smith, 2004, p. 49). Furthermore, since the publication of Smith's (1996) seminal article describing IPA and explaining the steps involved in an IPA study, IPA has been a predominant qualitative approach used in health psychology and is viewed as an especially appropriate approach in healthcare research (Biggerstaff & Thompson, 2008). Lastly, qualitative research “allows a valuing of agentic individual subjectivities and voices otherwise ignored or silenced…” and IPA “urges us to listen and understand these voices for what they are, collaboratively with researcher and participant. It urges us to ‘trust’ the responses of our participant (through interpretation), rather than deconstructing their language or relegating them to the performative” (Todorova, 2011, p.37).

3.2 Paradigm: Intersectionality

A study’s paradigm guides every aspect of the research project, from design to the final written product. This is due to a fact that a paradigm contains and makes explicit the researcher’s ontological, epistemological, axiological, and methodological assumptions (Creswell, 2007). It informs the choices the researcher makes at every step of the way, such as what method of inquiry and analysis to conduct, what questions to ask, what data to collect, what analysis to conduct, and what evaluation criteria is appropriate to gauge the study and its findings’ results regarding trustworthiness and rigor. Paradigms also help situate both the researcher and the participant in the research project, as well as the reader once the final written product is produced.

Trans individuals are a marginalized minority who often must cope with not only gender dysphoria but also unique minority stress, discrimination, and social determinants of health that cis individuals do not necessarily encounter. In order to fully take these events into account, an intersectional interpretative paradigm was used. The addition of an interpretive paradigm is permissible within IPA, and if done thoughtfully, does not lead to incoherence within the approach or analysis:

> Sensitivity to socio-cultural context in an IPA analysis is consistent with its coherent epistemological and theoretical framework, since we can identify the social meanings

> which are entwined with the personal meanings and are resources for people's sense-making in health and illness. At some point, however, researchers may feel the need to shift epistemological positions, for example when we identify limiting or stigmatising [sic] social meanings, and we find that a constructionist epistemology will more clearly explicate them and question them. (Todorova, 2011, p. 36)

Intersectionality theory was borne from critical race and feminist theories' (e.g., Crenshaw, 1989) critique of how single-category social identities are representative of only the dominant group within that identity (e.g., women are thought of as White women and Black people are thought of as Black men) and thus render invisible people with intersecting minority statuses, such as Black women. Intersectionality also posits that one is not simply Black and a woman, for example, but a Black woman whose race and gender have shaped and influenced each other in any given socio-political context. Today, intersectionality is understood in many different ways in many different fields, including but not limited to marketing (e.g., Gopaldas, 2013), sociology (McCall, 2005), feminist theory (e.g., Shields, 2008), critical race theory (Crenshaw, 1991), law (Carbado, 2013), health care (e.g., Hankivsky, 2011) and psychology (e.g., Warner, 2008).

In the field of psychology, intersectionality is generally understood as the way two or more social identities intersect in a person's life to not only shape who they experience themselves to be, but also shape how they experience the world, and how others perceive them. Thus, the focus is not only on the intersecting identities, but on the process of intersection, how structural systems in society shape that process, and the outcomes from it (Warner, 2008).

Intersectional theorists and researcher use a multitude of different labels to refer to the intersecting constructs. Some examples include *social identities* (Warner, 2008), *discourses*

(Petersen, 2012), and *categories of identity, difference, and disadvantage* (Cole, 2009). As with all language, the term one uses is not just a matter of preference, but also one of conveying meaning and intention. I use the term social identities, which is the term often used in counselling psychology. Furthermore, I assume social identities are dynamic, rather than static (Warner, 2008) and that a consideration of the historical and sociopolitical context is necessary in order to situate a person's intersectional identity and outcomes from such an identity (Christensen & Jensen, 2012). This approach posits that intersectionality is more than simply a sum of a person's two or more identities, but rather, that intersecting identities are developed through mutual constitution (Hancock, 2007).

Furthermore, intersectionality is considered by some to be an "urgent issue" (Shields, 2008), especially for "researchers invested in promoting positive social change" (Shields, 2008, p. 302) Thus, intersectionality is also in line with one of the major tenets of counselling psychology, that of advocacy (Canadian Psychological Association, 2009). Lastly, intersectionality is often well suited for qualitative methodology (Shields, 2008) due to this methodology's focus on developing a deep understanding of a phenomena and its openness to emergent categories or themes.

An intersectional interpretive lens was employed throughout the research process, from initial design of the project through to analysis. Cole (2009) suggests psychologists ask three questions during the research process in order to attend to intersectionality: "Who is included in this category? What role does inequality play? Where are there similarities?" (p. 170). Ultimately, by thinking through the three questions above in the ways outlined below (and other questions that emerged during the course of the current study), I attended to the decision making process in an intentional way, which is key when using an intersectional interpretive lens (Warner, 2008).

Asking who is included in the category leads the researcher to actively reflect on who is included in the sample in order to encourage them to include as many people of diverse intersecting identities as possible. Asking what role inequality plays “helps researchers view the participants and phenomena they study as grounded in social and historical contexts: Race, gender, sexuality, and class, as well as other social categories, structure groups’ access to social, economic, and political resources and privileges” (Cole, 2009, p. 176). This grounding in context is also known as “looking upstream” (Cole, 2009, p. 177) at social inequities in order to contextualize participants’ lived experiences of oppression and relative privilege, as opposed to simply contributing them to individual differences (experiences that happen “downstream” in this model). Asking where the similarities are “encourages researchers to reassess any presumptions that categories of identity, differences, and disadvantages define homogeneous groups as they look for similarities that cut across differences” (Cole, 2009, p. 175). Moreover,

> Looking for commonalities across difference entails viewing social categories as reflecting what individuals, institutions, and cultures do, rather than simply as characteristics of individuals. This shift opens up the possibility to recognize common ground between groups, even those deemed fundamentally different by conventional categories (Cole, 2009, p. 175).

I attended to Cole’s (2009) three questions in a number of ways. First, I attended to who is included in the research study as follows. The inclusion criteria included trans people who are over the age of majority who had experienced suicidal ideation or behaviour at approximately the same time as accessing transition-related care. By default, this excluded individuals who do not identify as trans (e.g., cis people as well as people who have transitioned and do not identify as trans), minors, people who had not experienced suicidal ideation, and people who had not accessed transition-related care (as discussed in the first chapter, not all trans people transition). However, in order to include people with two or more intersecting identities, I approached various organizations that serve a diverse lesbian, gay, bisexual, trans, queer or questioning, intersex, asexual, and Two-Spirit (LGBTQIA2S+) population in Montréal, QC, Toronto, ON, and London, ON, to inquire about posting recruitment material.

By collecting demographic data from each trans participant, I was able to answer the question of who was included not only in the results section of this dissertation, but I was also able to gauge the answer to this question while recruiting and interviewing participants. When I determined homogeneity developing in the sample regarding main social identities (e.g., race, gender identity, employment status, class, ability), I intentionally and purposefully made changes to recruitment strategies in an attempt to ensure trans and provider participants from non-dominant social identities were included.

Second, I attended to the role of inequality in the phenomenon at hand in several ways. For example, as seen in the introduction and literature review chapter, I situate the high rates of suicidal ideation and behaviour among trans individuals in the social context of transphobia and cissexism. Situating the phenomena in a socio-political context rather than in the individual and their identities is in line with recently published best practices regarding intersectional approaches in psychological research (Warner, 2008).

Third, I asked where the similarities lie between trans and provider participants in order to (a) create opportunities to notice common ground between these two groups, and (b) be mindful of the fact that all participants have valuable knowledge and experience regarding trans suicidality and transition-related care, given the fact that some of them were trans people and others were care providers. Completing steps (a) and (b) helped me avoid the pitfall of conducting an analysis that pits one group against the other or that conveys one group's experiences as more legitimate than the other's.

3.3 Participant Characteristics, Recruitment, Screening, and Referral Procedures

3.3.1 Sample Size

In order to answer the overarching question of "How have people experienced the interaction between suicidality and transition related care," I recruited and conducted semi-structured interviews with 18 participants in total, from two different sub-samples. More specifically, I interviewed seven participants who identified as trans in order to understand their perspectives regarding their experiences with the interaction of suicidality and transition-related care, and I interviewed 11 care providers in order to understand their perspectives. The two separate subsample sizes are in line with IPA guidelines regarding sample size: Smith (2004) outlines the importance of a sample consisting of approximately 5-10 participants due to the fact that "it is only possible to do the detailed, nuanced analysis associated with IPA on a small sample" (p. 42).

3.3.2 Sample Characteristics

The sample was composed of two groups of individuals: trans individuals and care providers who work with trans individuals. Although a rich analysis could have been conducted with trans participants alone, the addition of the health-care providers adds to the findings in important ways that interviews with trans participants alone could not. As Biggerstaff and Thompson (2008) explain: "…it is important to recognize that how people perceive and talk about their health is likely to vary, one to another, and may well differ from health professionals' perceptions" (p. 225).

Provider participants were medical or mental health care providers who worked in Montréal, ON, Toronto, ON, or London, ON, and surrounding areas. The majority of provider participants identified as White (*n* = 8), while other participants identified as mixed race, Latina, and Indo-Canadian. Provider participants ranged in age from 28 to 57 years old, and they reported having 2 to 20 years of experience in their professional fields. Most providers were mental health care providers, and one provider participant was a medical health care provider. The former group consisted of psychologists, sexologists, social workers, psychotherapists, counsellors, and professionals completing their qualifying processes for these professions. Provider participants worked in a variety of work settings, including individual and group private practices and private and public community health centres and hospitals. All provider participants had worked with at least one trans client who had expressed suicidal ideation. Provider participants ranged from having worked with 20 trans clients in a decade of practice, to hundreds of clients in a few years of practice. Some providers were generalists in their respected fields while others specialized in trans care.

Trans participants lived in or around Montréal, QC, Toronto, ON, or London, ON, and they ranged in age from 19 to 39 years old. The majority of participants identified as White (*n* = 6), and one participant identified as a person of colour. Four participants were in the work force, one was unemployed, and two were university students. The majority of trans participants reported incomes ranging from $20,000 to $40,000, with one outlier income reported on either side ($5,000 and $84,000). The highest education completed ranged from high school graduate (current university student) to doctoral studies completed. Trans participants' experiences with transition-related care ranged from having begun accessing care in the months prior to the interview, to having completed their desired level of transition a few years prior to the interview. All participants had experienced suicidal ideation at some point in the five-year period prior to the interview. One trans participant reported only past suicidal ideation in that time period, while the remaining participants reported current ideation at the time of the interview. When participants reported current suicidal ideation, the interviewer conducted a suicide risk assessment and the interviewer and participant engaged in safety planning if needed. No participants reported intent or a plan to engage in suicidal behaviour and thus none were in imminent risk. Please see Table 1 for participants' profiles.

Table 1

Participant Profiles

Pseudonym	**Provider or trans participant**	**Gender Identity**	**Pronouns**	**Sexual Orientation**	**Occupation**	**Age range**	**Racial/ Ethnic Identity**	**Annual income range**
Sophia	Provider participant	Female	She/her	Bisexual	Mental health care provider	40-49	White	N/A
Michelle	Provider participant	Female	She/her	Chose not to answer	Mental health care provider	50-59	White	N/A
Maxime*	Provider participant	Information omitted	Information omitted	Heterosexual	Medical care provider	30-39	White	N/A
Simone	Provider participant	Female	She/her	Queer	Mental health care provider	40-49	Mixed race	N/A
Mickey	Provider participant	Woman	She/her	Heterosexual	Mental health care provider	40-49	Latina	N/A
George	Provider participant	Male	He/him	Unsure	Mental health care provider	40-49	White	N/A
Julie	Provider participant	Woman	She/her	Bisexual	Mental health care provider	50-59	White	N/A
Sammi	Provider participant	Female	They/them & She/her	Pansexual	Mental health care provider	20-29	Indo-Canadian	N/A
Abby	Provider participant	Female	She/her	Queer	Mental health care provider	40-49	White	N/A
Sarah	Provider participant	Female	She/her	Gay	Mental health care provider	30-39	White	N/A
Gwen	Provider participant	Female	She/her	Bisexual	Mental health care provider	30-39	White	N/A
Nomi	Trans participant	Woman	She/her	Lesbian	IT	30-39	White	$40,000-$49,999
Patricia	Trans participant	Woman/	She/her	Queer/It’s complicated	Coordinator	30-39	White	$30,000-$39,999

		It’s complicated						
Oliver	Trans participant	Male/ Trans male	He/him	Bisexual	Travel	30-39	White	$30,000-$39,999
Betty	Trans participant	Woman	She/her or they/ them	Queer/ questioning	Analyst	30-39	White	$80,000-$89,999
Devon	Trans participant	Non-binary genderfluid	They/ them	Bisexual	Unemployed	30-39	White	$20,000-$29,999
Rose	Trans participant	Non-binary trans woman	She/her	Queer	University student	30-39	White	$20,000-$29,999
Collin	Trans Participant	Trans man (FTM)	He/him	Bisexual	University student	18-29	French and Jamaican	$0 – $9,999

Note: Participants’ gender identities, sexual orientations, and racial/ethnic identities are reported in their own words.

* Due to the fact that the French speaking medical trans health community is relatively small, additional steps have been taken to ensure Maxime’s confidentiality: This writer chose a gender-neutral pseudonym for this participant; their gender identity has been omitted; and the singular gender-neutral *they*/*them* is used as this participant’s pronoun instead of their actual pronouns.

3.3.3 Inclusion Criteria

Trans participants were eligible to participate if they were over the age of majority (i.e., 18 years old in Québec and 19 years old in Ontario), lived in Montréal, Toronto, or London (ON) and surrounding areas for all three cities, spoke English, French, or were willing to participate in the interview with an interpreter present if they communicated in a language other than English or French, and (a) identified as trans (e.g., trans, transgender, transsexual, Two-spirit, non-binary, genderqueer, gender fluid), (b) experienced suicidal ideation or behaviour in the past 5 years, (c) accessed or tried to access transition-related care in the past 5 years, and (d) for whom criteria (b) and (c) overlapped temporally.

Health care provider participants were eligible to participate if they worked in Montréal, Toronto, or London (ON) or surrounding areas for all three cities, and (a) had seen at least one trans client or patient in the last 5 years, and (b) had had contact with the trans client(s)/patient(s) in the context of initiating or delivering transition-related care.

3.3.4 Exclusion Criteria

Individuals who did not meet the inclusion criteria were excluded. Specifically, one trans person expressed interest in the study but did not meet criteria (d): they had not experienced suicidal ideation while trying to access transition related care, but rather before they came out.

3.3.5 Recruitment Procedures

Recruitment took place via (a) online posts of the recruitment ad on LGBT LISTSERVs, (b) posters placed in organizations that trans people frequent, and (c) a database of trans participants developed during my MA research project; these past participants agreed to be contacted for future research projects and supplied their emails addresses to me at that time. See Appendices A and B for recruitment posters.

Health care providers such as family doctors, psychologists, social workers, psychotherapists, nurse practitioners, surgeons, endocrinologists, and others who deliver transition-related care were invited to participate via (a) email recruitment to organizations, (b) trans health programs in community and medical settings, and (c) personal contacts held by either myself or members of my research committee.

3.3.6 Recruitment Material

Two sets of recruitment material were circulated, one aimed at trans individuals and the other aimed at care providers. The material aimed at the trans participants stated that the research team is conducting a study aimed at investigating people’s experiences with transition-related care and suicidality. It also stated that the research team is looking for individuals over the age of majority residing in either Montréal, Toronto, and London, ON (and surrounding areas) who (a) identify as trans (e.g., trans, transgender, transsexual, Two-spirit, non-binary, genderqueer, gender fluid) or who have transitioned, (b) who have experienced suicidal ideation or behaviour, and (c) who accessed or who tried to access transition-related care while experiencing suicidal ideation or behaviour. In addition, suicide prevention resources were included directly on the posters and in all recruitment emails, should readers have required them. Lastly, details regarding what was involved in participation were included, as well as the amount of compensation (see below) and the REB review number and contact information. A second version of this recruitment material was circulated in the latter part of the study addressed to BIPOC (Black, Indigenous, and other people of colour) trans individuals in an effort to invite BIPOC individuals to participate in the research study. This version of the recruitment material also identified this writer (Chérie Moody) as a White queer person who strives to do helpful research and clinical work using an integrative trans-affirmative, anti-racist and anti-oppressive, and intersectional feminist approach.

Recruitment material for health care providers stated that the research team was conducting a study aimed at understanding the interaction between transition-related care and suicidality in trans clients. It also stated that we were recruiting medical and mental health care providers who work with trans individuals in order to understand their experiences as care providers. Lastly, details regarding what would be involved in participation were included, as well as the REB review number and contact information.

These different approaches in recruitment were used in order to render the recruitment material interesting to their respective audiences.

3.3.7 Compensation

Trans participants were offered $25 (2015-2017) or $30 (2018-2019) per interview. Care providers participants were not offered compensation.

3.3.8 Pre-screening

Inclusion and exclusion criteria were queried during the screening process. See Appendices C and D for screening questions, which were asked over the phone (trans participants) or via email (provider participants).

3.3.9 Orientation to the Study

If participants met all inclusion criteria and none of the exclusion criteria, they were invited to participate in the study. Due to the fact that participants may have only briefly seen the recruitment ad or email, a longer description of the study was given over the phone in order to orient them to the study and give them the chance to ask any questions they may have. Some participants asked to see the consent form and/or interview protocol beforehand: these participants were emailed the documents.

3.3.10 Referral Procedures

Referral procedures for trans participants were in place if needed at the pre-screening phase, interview phase, and post-interview check-in phase. For example, had an individual disclosed psychological distress during the pre-screening interview, I was prepared to offer them the contact information for local trans-affirmative mental health services and clinicians. If the person was acutely suicidal, I was prepared to direct them to the emergency room, as well as offering them the contact information for specific psychotherapists with whom I had a pre-arranged agreement with and who had agreed to see people in a very timely manner. If the person expressed a need for transition-related services I was prepared to either help them find such services and/or offer them the contact information for specific transition-related care health providers that I had a pre-arranged agreement with and who had agreed to see people in a reasonable amount of time. For example, if the person was living in Montréal they could have been referred to Dr. Tellier (my research co-supervisor). No participant was in need of any of the above referrals.

3.3.11 Informed Consent

Informed consent was obtained prior to the administration of the demographic questionnaire. Once participants consented to participating and to being audio recorded, the interview was audio recorded. For online video interviews with providers, their oral consent was audio recorded and a consent form was emailed to them for them to sign, scan, and return. See Appendices E and F for the consent forms.

3.4 Data Collection

3.4.1 Demographic Questionnaires

Two author-generated questionnaires were used to collect demographic information: one each for trans and care provider participants. Trans participants were asked about their age, current gender identity, current sexual orientation, race and ethnicity, sex assigned at birth, citizenship, occupation, years of education, and pronouns. They were also asked to choose a pseudonym. While debriefing about the demographic questionnaire with the first trans participant, this person suggested annual income be included. Exclusion of this question had been an oversight and it was included for that participant and all other trans participants going forward. Care providers were asked the same demographic questions (except for income), and were also asked to specify the education undertaken specific to trans health and the year they started working with trans people/delivering transition-related care. Please see Appendices G and H for the demographic questionnaires.

3.4.2 Interview Protocols

In line with IPA, individual semi-structured interviews were conducted with all participants (Smith, 2004). Please see Appendices I and J for the interview protocols. Trans participants were interviewed in person in Montréal, Toronto, and London (ON). The interviews took place at McGill University, participants' homes, or in public spaces where privacy and confidentiality were possible (e.g., private study rooms in public libraries). Due to the subject being explored (suicidality), it was important to interview participants in person in order to conduct thorough risk assessments if needed. If ideation was present, steps were taken to ensure the participants' safety (e.g., suicide risk assessments were conducted by this writer). Health care providers were interviewed in person in their offices or via online video conversations. All interviews were audio recorded. Interviews ranged in duration from 45 minutes to two hours.

3.4.3 Transcription

The audio recordings of the interviews were transcribed verbatim by a volunteer or professional transcriber and de-identified. In line with IPA, information that was not intended for analysis (e.g., the length of pauses) was not transcribed. Non-verbal communication that offered depth to the interview, such as significant pauses, laughter, and hesitations, was transcribed and marked by brackets (Smith et al., 2009). I then listened to each interview while reading the transcript in order to review the transcript for accuracy. This was done to ensure accuracy as well as for me to start becoming emerged in the data, which is an initial step in analysis in IPA (Smith et al. 2009).

3.4.4 Soliciting Feedback Regarding the Demographic Questionnaire and Interview Protocol

Feedback was explicitly sought regarding the demographic questionnaire and interview protocol at the end of each interview in order to assess whether they were (a) appropriate and acceptable to the participants, (b) culturally sensitive, and (c) adequate tools to collect the data required for the current study. Examples of questions posed include “What did you think of the demographic questionnaire that you filled out at the beginning?” and “I’m interested in your opinion regarding the questions I asked you today about your experiences. Did you think the questions were respectful or did you perhaps notice some ways they could be improved?” Participants’ feedback regarding their experience while being interviewed was taken into account and necessary changes were made going forward (e.g., clarity of questions).

3.4.5 Resources

At the end of the interview trans participants were offered a list of local trans-affirmative care and community resources prepared by the research team.

3.4.6 Follow-Up Contact

Trans participants were contacted by telephone for a friendly check-in in the days following the interview, which was agreed upon at the end of the interview. One participant reported feeling “a little down” and time was taken with this participant to discuss their affective state and a suicide risk assessment was conducted. The majority of participants reported feeling well and that their experience of the interview had been quite positive (e.g., some reported a sense of being heard and feeling empowered, and others reported feeling hopeful that the results of the study could improve transition-related care). Please see Appendix K for a list of example post-interview questions that were asked.

3.4.7 Member Checking

An invitation to view the transcript or the selected quotes from their interview was extended to all participants. Two provider participants declined member checking at the time of the interview. The remaining provider participants were invited to engage in member checking via email once interviews were transcribed and/or quotes were selected as agreed upon, and 6 accepted to do so.

All trans participants were contacted and invited to engage in member checking. One participant accepted and requested no changes. The remaining participants either declined member checking, accepted and gave no feedback, or did not reply to the invitation. All participants who did not respond were invited a second time. Some participants spontaneously shared some of the reasons they declined member checking: one was very busy, one was engaging in self-care and did not want to read the transcript, and one did not feel the need. Many participants, provider and trans individuals alike, who declined the member checking process shared that they didn’t feel the need to review their transcripts due to trusting what they had said at the time of the interview, the research process itself, and/or the researcher.

3.5 Data Analysis

MAXQDA (VERBI GmbH, Germany, version 10), a qualitative data analysis software system, was used throughout the project to support and organize data management.

Smith, Flowers, and Larkin (2009) outline six steps that are meant to be flexibly followed during IPA data analysis. These steps are outlined below, as they were applied to the current research project.

1) Reading and re-reading: Each transcript was read and re-read in order to "ensure that the participant becomes the focus of the analysis" (p. 82) and that the raw data were fully engaged with. It is easy at this point to make quick conclusions regarding what one thinks the participants is saying, and so this process was meant to slow down the usual automatic interpretations and fully engage with the data as they are. The fact that I verified the accuracy of each transcript myself (i.e., I listened to the interview while reviewing the transcript) was an asset, as it allowed me to start the reading and re-reading process from that point. During the reading and re-reading I made notes regarding my initial assumptions and interpretations, in order to acknowledge them and set them aside when necessary.
2) Initial noting: Initial noting is akin to initial coding and involves "noting anything of interest within the transcript" (p. 83). It is when one "begins to identify specific ways by which the participant talks about, understand and thinks about an issue" (p. 83). This step is considered to be both the most time consuming and detailed part of the analysis and is also one of the most important parts: done properly, it allows the researcher to deeply engage with the data and thus avoid a "superficial reading" of the material, which often leads to "commenting only on what we expect to see in the text" (p. 83). Three types of

initial noting took place: descriptive, linguistic, and conceptual.

a. Descriptive comments: Descriptive comments regarding “key words, phrases or explanation which the respondent used” (p. 84) were noted. There is no interpretation at this level of noting (coding) and the participants’ words were taken as they are. An example of what this looked like for the current study was noting “past suicidal ideation” next to text in which the participant described, explained, or made sense of their past suicidal ideation.
b. Linguistic comments: Linguistic comments regarding such things as “pronoun use, pauses, laughter, functional aspects of language, repetition, tone, degree of fluency (articulate or hesitant)” (p. 88) and metaphor usage were noted. The process of making linguistic comments allows the researcher to focus on “how the transcript reflects the ways in which the content and meaning were presented” (p. 88). This process was an important part of the coding for the current study as the subject matter was quite a serious one and tone, pauses, etc. indicated emotion during speech. The fact that I conducted the interviews myself, verified the transcripts, and coded the data soon after the interviews was helpful with regards to making linguistic comments.
c. Conceptual comments: Conceptual comments are the part of noting (coding) where there is a move away from taking things at face value and moving towards interpretation. During this phase the researcher is actively trying to make sense of the participant’s meaning making of the topic at hand through a “dialogue… between your own pre-understandings, and your newly emerging understandings of the participant’s world” (p. 89). This phase involves developing a variety of

initial understandings of the participants' accounts, usually through an interrogative form. Thus, this phase is "often not about finding answers or pinning down understandings; it is about the opening up of a range of provisional meanings" (p. 89). Conceptual comments can be written in the form of summarizing and reflecting the content and emotion in the text, as well as questions that help the researcher not assume the meaning of the participant's words.

3) Developing emergent themes: The next step of data analysis involved developing emergent themes based on the coding done to date. The focus shifted from the transcripts to the codes, and thus thorough coding was a prerequisite for the development of rich emergent themes. Themes were typically short phrases that capture the "psychological essence" (p. 92) of the material in the transcript, while containing "enough particularity to be grounded and enough abstraction to be conceptual" (p. 92). This phase was particularly demanding because the researcher "simultaneously attempts to reduce the volume of detail… whilst maintaining complexity" (p. 91). Part of this process involved focusing on separate parts of the transcript at a time in order to develop themes based on the coding for those discrete parts. Importantly, while focusing on discrete parts, it was of utmost importance to also "recall what was learned through the whole process of initial noting [coding]" (p. 91). Simply put, "to understand any given part, you look to the whole; to understand the whole, you look to the parts" (p. 28). Thus the context of the participant's whole experience was kept in mind when I was focusing on developing themes based on coding from discrete parts of the transcript. Considering both the whole and the part is based on IPA's hermeneutic theoretical foundation, and is in line with

intersectional paradigm that was applied to the current project.

Due to the way emergent themes were developed (e.g., using the whole to understand the part, and the part to understand the whole), the themes reflect “not only the participant’s original words and thoughts but also the analyst’s [researcher’s] interpretation” (p. 92). In comparison to earlier coding, which may have reflected tentative understandings of the material or open more questions than answers, themes reflect a deep understanding of the participants’ experiences.

4) Searching for connections across emergent themes: The next step of data analysis involved taking stock of all the themes and clustering them together in groups based on their common meanings. Some themes were discarded at this point due to lack of fit with the research question. There are several ways one can look for patterns in order to cluster the themes, described below. Smith et al. (2009) stress the point that these are suggested strategies that a researcher can use, and that a researcher can use as few or as many strategies as necessary.
    a. Abstraction: The most basic and most often used strategy, abstraction involved grouping like themes together into a super-ordinate theme and then naming that super-ordinate theme using a term that described it and encompasses all the sub-themes.
    b. Subsumption: Very similar to abstraction, the same strategy was used with the slight modification that an already existing theme became a super-ordinate theme based on its wide scope.
    c. Polarization: This involved using the strategy of looking for differences between themes as opposed to similarities. The different themes were not placed together

in one super-ordinate theme, but rather the existence of polarized themes dictated that there may have been two separate themes that exist on either end of the pole.

d. Contextualization: Due to the fact that many participants' accounts were chronological in nature, one strategy was to identify patterns by grouping themes together according key life events.

e. Numeration: Numeration refers to reporting the frequency of each theme. Although not indicative of a theme's importance, it can be a way of noticing patterns in the data and results. This strategy is postpositivist in nature and not in line with the intersectional paradigm used in the current research project, and thus was not used.

f. Function: Grouping themes according to function entails interpreting what the function of any given part of a participant's narrative is in the interview itself and grouping them together with like themes. This strategy positions the researcher in too great of a position of power in this writer's opinion (e.g., of being powerful enough to know participants' intentions and thus the function of their narrative) and is not in line with an intersectional paradigm, and thus was not used.

5) Moving to the next case: IPA requires all of the above steps in data analysis to be undertaken one transcript at a time, which was done for the current study. When coding the next transcript, one is encouraged to put aside what they have learned from the previous transcript and start anew. Doing so helped me stay open to new themes that emerged in each new transcript. Analyzing each transcript in this way was "in keeping with IPA idiographic (sic) commitment" (p. 100). It was also in line with intersectionality, as it allowed me to fully enter each new participant's lived experience,

while attempting to fully understand the phenomena from that participant's perspective.

6) Looking for patterns across cases: This step involved examining all the super-ordinate themes and sub-themes across cases in order to notice similarities and whether themes in one case helped clarify themes in another case. In some instances, super-ordinate themes represented two or more participants' experiences, thus representing both the ideographic experience of that theme within a person's lived experience and a theme that is shared at a higher order.

3.6 Quality and Validity

3.6.1 Ensuring Quality and Validity

There are a number of ways to ensure validity and high-quality qualitative work, and several strategies were employed in the current project. It is important to note that validity in qualitative studies must be measured in ways appropriate and specific to qualitative methodology (Smith et al., 2009). Smith et al. (2009) stress that the quality of the findings is dependent on the quality of the data collected, which is dependent on the quality of the interview. Seeking feedback from participants helped ensure the quality of the findings by helping to refine the interview protocol. Furthermore, a validity strategy specific to IPA involves including many direct quotes from participants in the write-up as evidence for the themes and interpretations arrived at by the researchers. As such, this final manuscript includes several quotes per theme as evidence to support the interpretation I have made and conclusions I have come to.

Moreover, Smith et al. (2009) rely on a set of four flexible criteria by Yardley (2000) in order to evaluate quality and ensure validity; these criteria are (a) sensitivity to context, (b) commitment and rigour, (c) transparency and coherence, and (d) impact and importance. First, sensitivity to context refers to sensitivity to both the theoretical and socio-political context, to the relationship between the participant and researcher, and to the balance of power during the research. The current project includes a review of the literature, which is in line with sensitivity to the theoretical context and in part to the socio-political context in which many trans individuals and care providers are embedded. Further, I stayed abreast of current socio-political contexts via engaging with popular media and being active in the trans community as an ally. In addition, I sought to minimize the power difference between myself and trans participants in all interactions with them. For example, I shared the fact that am a member of the LGBTQIA2S+ community, I interacted with participants in a professional but not overly-formal way, I closely mirrored the language they used with regards to themselves and others, I introduced myself by my first name and shared my pronouns, and I tried to minimize my use of psychological jargon. In addition, while I shared that I specialize in LGBTQ mental health and had previously conducted research regarding suicide protective factors among trans adults, I also explicitly shared with trans participants that I consider them to be experts on the topic at hand and that their stories and understanding of the topic are important and valuable.

Second, commitment and rigour refers to immersion in both the topic and data set and the thoroughness of the data collection and subsequent analysis. I am fully immersed in the topic as I have been researching suicidality in the trans community since 2009, and I engaged with the data set for a prolonged period of time (e.g., data collection and analysis spanned from 2015 to 2019). Full immersion in the topic and data is also a quality and validity strategy suggested by Morrow (2005). Furthermore, commitment and rigour in a phenomenological analysis can be shown through “the effective use of prolonged contemplative and empathic exploration of the topic together with the sophisticated theorizing, in order to transcend superficial, ‘commonsense’ understandings” (Yardley, 2000, p. 222), which I strove to achieve in the current project. Third, transparency refers to the transparent showing of steps taken (from participant recruitment to analysis) that lead to the findings at hand, as well as the researcher engaging in a reflexive process. Coherence refers to "the fit between the research questions and the philosophical perspective adopted, and the method of analysis and investigation undertaken" (Yardley, 2000). In order to be transparent, all the relevant steps undertaken in the current project are outlined and documented in this manuscript. A separate log was kept to document the coding process and emergence of themes from the data. Reflexivity is reflected in relevant self-disclosures (see below) as well as reflexive journaling (Biggerstaff & Thompson, 2008), and regular in-depth conversations between myself and members of my committee, peers, and/or members of the trans community in order to discuss and clarify biases, presumptions, and worldviews. This activity allowed me to discuss my understanding of the data and deepen that understanding via exchanges in which others presented alternative understandings and asked me to clarify my position (Morrow, 2005). Coherence is evidenced via the fit between (a) the topic of suicidality and transition-related care (b) the use of qualitative methodology, and IPA, specifically, to explore the topic, and (c) the integration of an intersectional paradigm, which is coherent with both (a) and (b). Indeed, because IPA is an approach that is meaning-making based, it is a perfectly coherent fit for an investigation of a phenomena that is deeply subjective, such as the one in the current study. Lastly, impact and importance refer to theoretical worth and socio-political impact. Yardley underlines that one of the benefits of qualitative health research is "the emphasis on research-in-context," which "should result in a close fit between research and practice" (p. 224). Thus, the current project aims to have a socio-political impact in terms of the findings offering insight to care providers regarding best practices when working with trans clients, particularly suicidal trans clients. More specifically, although it is beyond the scope of this dissertation, I plan to disseminate the findings through academic journals and to trans communities and service providers through presentations at relevant conferences and via the creation of an accessible information sheet.

3.6.2 Reflexivity: The Researcher in Context

As part of ensuring high quality qualitative research, it is important for me to clarify my biases and worldview regarding the topic at hand. I am a White, settler, gender-nonconforming, invisibly disabled, French-Canadian queer person from a multi-racial, historically poor/working-class family. I identify as queer across both my sexual orientation and gender identity and have had personal and professional relationships with trans, non-binary, genderqueer, genderfluid, Two-Spirit, intersex, and questioning members of the trans community since 2000. My personal and professional relationships with trans individuals have influenced my understanding of trans people's lived experiences and some of my biases include the belief that trans individuals experience suicidal ideation and behaviour in large part due to transphobia, oppression, and minority stress. I do not discount the impact that gender dysphoria has on the well-being of trans people; however, I believe that if we lived in a less cis-centric, cis-sexist, transphobic, and transmisogynistic environment, which privileges the gender binary, gender dysphoria would be less distressing and thus have less of an impact on trans people's mental and physical health. My previous research regarding suicide protective factors among trans adults (Moody, Fuks, Peláez, & Smith, 2015; Moody & Smith, 2013) informs my view regarding the resilience and strength found among many trans individuals; despite alarmingly high rates of suicidal ideation and attempts, the majority of trans people not only survive in our generally transphobic society, but thrive despite it. Lastly, regarding transition-related care, I believe that harm-reduction and consent-based approaches empower trans individuals and can be lifesaving, the latter of which is informed by knowledge gained through my personal and professional relationships with trans individuals, as well as research findings that show that transitioning (for those who seek it) is a suicide protective factor (Bailey, Ellis, & McNeil, 2014; Moody et al., 2015).

The current research project was my first IPA research project, and as with any new approach or endeavour, there is a learning curve. IPA is the process of the researcher making sense of the participant making sense of the phenomena in question. Some past and current experiences provided me with some transferable skills: I had previously conducted or been involved in a small number of qualitative research projects (albeit, with different methodological approaches), and I have worked clinically as a counsellor and psychologist-in-training for almost a decade. The former granted me some knowledge of and ease with qualitative methodology in general, and the latter granted me some knowledge of and ease with sitting one-on-one with a person and engaging in a meaning-making conversation. However, IPA analysis of multiple participants, particularly from two subgroups, proved to be an exceptional challenge, in part due to its novelty for me. In addition, due to IPA's focus on in-depth interviews in order to produce in-depth understandings of participants' lived experience, there was an enormous amount of data to organize and analyze. At several points during the analysis I felt completely overwhelmed by the amount of data, and on one occasion I very literally searched "drowning in qualitative data" in an online search engine. The results were normalizing but of course did not produce the magical solution for which I was secretly hoping. During several of these times feeling stuck and overwhelmed, I found physically mapping out results and their relationships to each other on large dry-erase boards to be helpful. Lastly, through reflection I realized that I consider everything participants shared with me to be important and I was attempting to include it all in my results. Reminders from my committee to keep the focus on the research question proved to be beneficial in this regard.

3.7 Ethical Considerations

3.7.1 Ethical Considerations Regarding Participants' Well-Being

It was of utmost importance that the current research project be conducted in an ethically-sound manner and that trans participants' well-being was attended to and prioritized above all else, given the subject of the project. The potential risks associated with participating in the current project were minimized and the potential benefits were maximized, as per standard ethical guidelines as well as out of respect for the project's trans participants. Due to the fact that there was a possibility that some trans participants would report suicidal ideation at the time of initial contact or participation, several steps were designed prior to data collection to ensure their safety and wellbeing. These steps have been outlined above. To recap, these steps included listing suicide prevention resources in the recruitment material, offering all trans participants a list of local trans-affirmative care and community resources, following up with participants via phone the day after the interview, conducting a suicide risk assessment during the interview if needed and collaboratively engaging in safety planning, having a suicidality response protocol in place for all contacts (phone, email, and in person), and having a network of providers who were willing to see participants on short notice and who were willing waive their waitlists for these participants. It should be noted that I am a trained suicide researcher; have worked in this research field since 2008; have completed a Master's in Counselling Psychology; and have provided counselling to individuals since 2010. My research and clinical skills were used throughout the design and data collection processes to ensure participant well-being was prioritized.

All of the above steps have been outlined in the extant literature as steps that suicide researchers have taken and recommend in order to conduct ethical suicide research (e.g., Lakeman & Fitzgerald, 2009). Furthermore, while designing the current project, I consulted three expert Canadian qualitative suicide researchers, as well as engaged in informal consultation with several members of the trans community. Their opinions and suggestions were integrated into the design of the current project prior to data collection.

3.7.2 Ethical Considerations Regarding the Researcher’s Well-Being

The extant literature regarding qualitative inquiry into sensitive topics underlines the fact that such research is emotional work, which can take a toll on the researcher if proper self-care strategies are not intentionally planned out at the beginning of the research project (Rager, 2005). Several recommended strategies were used, including peer debriefing (while maintaining participant confidentiality) (Rager, 2005), spacing the interviews a certain amount of time apart (Rager, 2005), engaging in life-enhancing activities during my personal time (Rager, 2005), and engaging in reflexive journaling (Malacrida, 2007; Rager, 2005).

4.0 Results

As described in the previous chapter, Interpretive Phenomenological Analysis (IPA) was used throughout this research project, from study design to data analysis. IPA seeks to capture the meaning of important life events to each participant, and as such it highlights individual participants' meaning-making, sense-making, and/or understanding, with no predetermined or expected answers guiding the analysis. As such, the results laid out below were not pre-determined by the research team or interview protocol. Rather, trans participants were invited to reflect on their understanding of suicidality among trans individuals in general and their own experience(s) of suicidality, and provider participants were invited to reflect on their understanding of suicidality among trans individuals in general as well as their understanding created through their work with their trans clients. Throughout the interview process and data analysis, each participant, whether trans or provider, was viewed and considered as an expert in their own right. Trans participants were viewed as experts on the subject in large part due to their direct lived experience with the topic, as well as being part of communities where many individuals might have direct experience with this topic. Provider participants were considered experts due to their work with trans individuals and their roles in delivering transition-related care.

Data analysis resulted in four superordinate themes (*Contributing factors to suicidal ideation and behaviour; Factors that decrease suicidal ideation and behaviour; Clinical work with trans individuals; and Recommendations from participants regarding suicidality and transition-related care)*. Each superordinate theme had two to seven subordinate themes. Finally, some subordinate themes contained subthemes. The following results will walk the reader though each of these themes, following the outlines in Tables 2 and 3.

Table 2

Summary of results: Participants' understanding of the interaction between suicidality and transition-related care.

Contributing factors to suicidal ideation and behaviour
- *See Table 3*

Factors that decrease suicidal ideation and behaviour
- *Transition-related care factors*
    - Gender identity-related realizations and identity clarity
    - Having access to information regarding transition-related care and next steps
    - Access to transition-related care (including personalized transition-related care)
    - Bodily autonomy and gender self-determination
    - Hopelessness turns to hope in therapy
    - Other transition-related care factors that decrease suicidality
- *Non-transition-related care factors*
    - Broadening social networks and social support
    - Other non-transition-related care factors that decrease suicidality

Clinical work with trans individuals
- *Is suicidality a contraindication to transition-related care?*
    - Suicidality is not a contraindication to transition-related care
    - Transition-related care is often the treatment for suicidality
    - Sometimes stabilization is needed
- *Gatekeeping*
- *Working with suicidality*
    - Suicide risk assessments
    - Safety planning
    - Clinical interventions regarding suicidal ideation
- *"The script"/expected narratives/protective withholding*
    - Provider participants' accounts regarding protective withholding
    - Trans participants' accounts regarding protective withholding
    - Therapeutic interventions aimed at countering the script/expected narrative/protective withholding

Recommendations from participants regarding suicidality and transition-related care
- *Capacity Building*
    - Providers should stay up to date with the most current evidence, best practices, and standards of care
    - Increasing access to medical transition-related care and trans-competent mental health care
    - Creating professional networks
- *Reframe and depathologize suicidal ideation*
- *Providers should be advocates*
- *Therapeutic recommendations*
- *Personalize transition-related care*
- *Increased provider accountability*

- *Increased preparedness regarding surgery among both trans individuals and the providers who support them*

Note. Bold text = superordinate theme; italicized text = subordinate theme; regular text = subtheme

Table 3

Contributing factors to suicidal ideation and behaviour

	Before transition-related care	During transition-related care	After transition-related care
Subordinate Theme 1: Individual Factors			
Dysphoria			
-Gender dysphoria	X	X	
-Post-surgery bodily dysphoria			X
Shame	X	X	
Post-surgery aspects (e.g., depression, surgical complications, and chronic pain)		X	X
Subordinate Theme 2: Interpersonal Factors			
Family-related factors (e.g., rejection, non-acceptance, non-support)	X	X	X
Subordinate Theme 3: Systemic Factors			
Barriers to accessing transition-related care	X	X	
Existential erasure	X	X	X
Subordinate Theme 4: Factors that are Both Interpersonal and Systemic			
Transphobia	X	X	X
Disempowerment	X	X	X
Being gatekept		X	
Intersectional aspects	X	X	X

4.1 Superordinate Theme 1: Contributing Factors to Suicidal Ideation and Behaviour

Both trans and provider participants spoke of varied ways of understanding suicidality among trans individuals[7]. All participants were aware that the rates of suicidal ideation and behaviour are higher among trans individuals than the general population, and the majority of provider participants spoke of being aware of some of the literature on the subject. All participants spoke of the multiple factors that contribute to suicidal ideation and behaviour among trans individuals. Trans participants spoke of the multiple factors in their own lives that contributed to their suicidality, and provider participants spoke of the literature, what they had observed through their clinical work, and their professional clinical conceptualizations, which all outlined multiple contributing factors to suicidality among trans individuals. However, as the current research project focused specifically on the interaction between transition-related care and suicidality, many participants attempted to speak mainly to that interaction. Furthermore, it is important to note that while the majority of the results in the current superordinate theme are presented as independent factors (e.g., separate subordinate themes), the majority of participants spoke of how it was often several intertwined and/or cumulative factors that contributed to their

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[7] A note regarding font and punctuation in participants' quotes.

Italics: Used to indicate a participants' own vocal emphasis.

Square brackets: Used to indicate non-verbal communication, such as [pause] and [deep sigh]. Also used to indicate when additional information has been supplied by this writer for clarity. For example, square brackets are used when a participant answered a question using terms like "it" or "this" to refer to the subject being queried (e.g., Question: "In the course of your transition-related care, did your suicidal ideation change in any way?" Answer: "Yes, it got worse when…" The participant's response would be written as "Yes, [my suicidal ideation] got worse when…" to increase readers' understanding.)

Ellipses (… or ….): Used to indicate omitted parts of a quote, as some quotes were shortened for clarity. Three ellipses indicate a part omitted in the middle of a sentence and four ellipses indicate one or more omitted sentences.

Em dash (—): Used to indicate when a participant suddenly changed topic or cut themselves off midsentence.

suicidality. For example, Patricia expressed some understandable difficulty with and frustration towards being asked to speak mainly about the interaction between transition-related care and suicidality, as she reported the factors contributing to her suicidality were complex and intertwined. Patricia said:

> [Mon idéation suicidaire] fait partie d'un ensemble de facteurs, puis accéder à des soins de santé, c’est juste un facteur. Puis je pense que ça présuppose un modèle ou on dit que quand les personnes trans on accès de soins santé qui sont empowering puis affirmatif, les personne trans ont moins de chance d’avoir l'idéation suicidaire. Mais, pour moi, il y a plein d’autres facteurs aussi qui font partie de l'idéation suicidaire. C’est comme une tempête: c’est difficile de savoir c’est quel battement d'aile de papillon qui a causé l'éclaire ou la tempête.

Nomi also spoke of multiple stressors that contributed to her suicidality while she was accessing transition-related care, including interpersonal conflict with her mother and backlash from her self-advocacy work. She said:

> Mais pendant ce temps-là j’avais ma mère qui ne me parlait pas, et il y avait la moitié de la communauté qui était contre le fait que certaines personnes pouvaient avoir leurs papiers sans chirurgie pendant que l’autre moitié la voulait. Donc, j’avais de la pression du côté des trans qui ne voulaient pas que j’aie mes papiers sans me faire opérer *plus* la pression de ma mère. Il y avait beaucoup de choses en même temps qui se passaient et j’ai fini par m’écraser.

Collin spoke of how he experienced the interaction between suicidal ideation and trying to access transition-related care, specifically that his suicidality made trying to access care all the more difficult. He said:

> Like, when you want to die, it’s hard to push yourself to do things that are going to affect you in the future. Like they are not even affecting you right now, they are affecting you later, like in months or in a year or something. And it’s hard to think that far into the future when you have trouble being alive right now. And like, especially with transition care, it’s not going to help you in the moment. It’s going to help you eventually. You’ll get there, but it’s really not a very fast process. Like, hormones take a really long time especially when it takes a little while to even get started. Once you get it started, it’s not an immediate thing. So it’s really hard to keep doing that when you don’t really want to live.

Many participants’ understanding of suicidal ideation and behaviour included intrapersonal/individual psychological factors such as dysphoria, interpersonal factors such as rejection from family members, systemic factors, such as the wait-times to access transition-related care, and factors that were both interpersonal and systemic, such as transphobia and other forms of oppression,. During data analysis it became clear that many trans participants also spontaneously spoke of experiencing contributing factors to suicidality during three broad time frames relative to accessing transition-related care: suicidality before accessing transition-related care, while accessing or trying to access care, and after accessing care. Similarly, providers spontaneously spoke about their clients reporting contributing factors before they entered into their care, while they were in their care, and after they had received care. Results specific to the superordinate theme of *Contributing factors to suicidal ideation and behaviour* are summarized in Table 3.

4.1.1 Subordinate Theme 1.1: Individual Factors

Individual or intrapersonal contributing factors to suicidal ideation and behaviour among trans individuals were spoken about by the majority of participants. The majority of these factors were psychological in nature, such as dysphoria and shame, while some were physical in nature, such a surgical complications.

4.1.1.1 Subtheme 1.1.1: Bodily and/or Gender Dysphoria. The majority of providers spoke of gender dysphoria as being one of the main contributing factors to trans people's suicidality. Specifically, many providers explicitly stated that suicidal ideation and/or behaviour among trans individuals is due to gender dysphoria. For example, when asked how she understands suicidality among trans individuals, Sophia stated:

> I understand it as some very large percentage—like, there's a *direct* relationship between gender dysphoria and the degree of suffering related to your body and the way you're seen in the world not matching how you feel and who you are. And for some people it's a *very*, *very* palpably and painfully body-related. And for other people it's *very* social-related. And for most people it's probably some kind of mix of both of those things. But it's obviously excruciating for the clients [pause], their suffering related to that, so that they would feel suicidal sometimes. I understand that connection.

Sarah explained that she understood gender dysphoria—among many other factors such as wait times for transition-related care engendering a sense of lack of agency and hopelessness—to be linked to suicidal ideation and/or behaviour among trans people. She explained:

> The suicidality piece comes in because of feeling quite isolated, feeling like one doesn't have any choices, [feeling] like their body and their presentation are not where they want to be [in order] to feel confident in being themselves, and feeling like there's a such a

> disparity between where [they are] and where they want to be. And the fact that—and this is a bit of an access piece—but the fact that access might seem forever down the road or nonexistent, that just makes somebody feel like they don't have any choice, and they don't have any agency to get to where they need to be. And so feelings of hopelessness [come in], which we know can impact suicidality.

Trans participants also spoke of gender dysphoria being a contributing factor to their suicidal ideation. When Rose was asked to elaborate on her past suicidal ideation, she explained that it was due in part to experiencing distress (which can be understood as dysphoria) at the beginning of her medical transition, due to presenting as her sex assigned at birth at work. Rose said the following:

> My mental health was in a much worse place back then. There would be a lot of mood swings, both because of hormones and also because there would be some days where I would be presenting female the entire day when I wasn't at work, and then the next day I might have to go into work. So switching between those two roles—especially when one of them was a role that I really didn't want to be assuming, but I was too afraid and not ready to come out at work—was very difficult and led to a lot of emotions. A lot of suicidal ideation, a lot of sadness and crying in bathrooms at work, and just generally my moods being pretty volatile.

Rose went on to explain that she continued to experience dysphoria at work after she came out to her coworkers, due to being misgendered by members of the public with whom she interacted as part of her work responsibilities. One might assume that the member of the public misgendered her accidentally and/or unknowingly; however, it understandably had a negative impact on Rose's well-being. This dysphoria can be understood as a specific kind of gender dysphoria, namely socially-mediated gender dysphoria. When asked to speak more about the dysphoria caused by being misgendered, at work, by members of the public, Rose explained the following:

> It's sort of hard to put into words, but I felt very dysphoric. It was really upsetting that even after I came out at work and I was taking some steps—like doing some stuff with my appearance to hopefully make myself appear more feminine—and I was still being misgendered on a daily basis. That was really scary and it made me wonder whether I would ever be able to transition and to be gendered correctly and pass—even though it's a problematic term. At the time, I was worried a lot that people would never accept me in my preferred gender.

Oliver spoke of a feeling that arose for him after his most recent surgery. He shared that this feeling was hard to identify and name, and so he used the metaphor of feeling like Frankenstein. Oliver shared that feeling like Frankenstein augmented his existing feelings of despair. In addition, Oliver shared that part of the related distress he felt was due to many of his scars being visible to others, which is linked to the theme of loss of bodily privacy. All of this taken together may be interpreted as a type of post-surgery body dysphoria. Oliver said:

> I felt like Frankenstein, that was another thing I said. Because I have the chest scars, and I have the hysterectomy scar, and then I had just minor scars from the metoidioplasty, which are hidden in the hair. And then there was the scar from my first phalloplasty. But they were all livable because they all get covered. I'm hairy anyway, so if I swim without a shirt it's okay, people really don't notice the chest scars. But I'm like, "now I'm being cut up again. I have a leg scar, I have an arm scar, and I'm like Frankenstein," that was the exact word I use. I feel like I've been all cut up and sewn back together and

> everybody can see. I don’t really know how to explain it, but it adds to those feelings of despair and “how can I live with this?” And kind of feeling like a freak, which makes you feel bad about yourself and going through life and society like that.

4.1.1.2 Subtheme 1.1.2: Shame. Several participants spoke about shame and how it interacted with or impacted trans individuals’ well-being, including contributing to suicidal ideation. Shame was spoken about in three different ways: being shamed by others, feeling shame, and internalized shame in the context of internalized transphobia. Regarding internalized transphobia, Mickey (a provider participant) said:

> Souvent ce que moi je vois en clinique c'est la personne dans l'étape de “qu'est-ce que je suis/où est-ce que je m’envais?” Puis ils ont peur de ce qui s’en vient, mais ils ne veulent pas rester dans qu'est-ce qu’ils sont parce qu'ils ne peuvent plus être là. C'est là vraiment qu'on travaille beaucoup les idées suicidaires…. C'est vraiment cas au cas. Moi je pense que la période très fragile c'est vraiment quand la personne s'avoue à elle-même que oui il y a quelque chose à faire il y a une possibilité, une sortie. Mais cette sortie-là, il la voit comme transphobie intérioriser tout ça. Il voit ça comme quelque chose de trop gros à faire. Ou “personne ne va me comprendre,” “tout le monde me traite de fou, de folle.” Tous ces types de commentaires là, c'est là qu'ils sont pris.

Abby (a provider participant) explained the following:

> So in terms of trying to connect it with suicidality, I think I would connect it with the relational work around shame that I’ve been learning more about. And to kind of support people in naming it for what it might be, and perhaps for some people, giving them new words around it, new meanings and new perspectives towards what they’ve been fed. And placing the suicidality within that kind of framework. To help people externalize it,

> and say “okay, there’s this thing that I was led to believe that people who I’m now identifying with or people who are like me are ABC thing, of course that would lower my sense of self-worth and cause me to feel shame in particular areas.” And are there ways that you can push back on that and resist it?

Patricia (a trans participant) shared that both shame and disempowerment, which is a subtheme we will see later, both contributed to her suicidal ideation. She explained:

> [Suicidal ideation] is because of all those things. Trying to access transition-related care and trying to access other resources in my life follow kind of the same pattern of not feeling legitimacy, feeling shamed, feeling like you don’t deserve those things, or feeling that it can be taken away at any moment. The feeling that other people have power over you.

Betty shared that her care provider lacked experience working with individuals transitioning in young middle age such as herself. She shared that her provider’s lack of knowledge amplified the normal and typical uncertainty that many trans individuals experience about their own identities, which Betty was experiencing. In addition, Betty explains that much of her uncertainty was rooted in internalized transphobia and shame, absorbed from societal-level anti-trans bias and misogyny. Betty said:

> And at the beginning, I still had doubt in my own identity. You know, it’s hard to accept that I’m this thing, it’s hard to accept, because it sounds like—I was raised on science, it sounds to myself like I’m crazy sometimes. And that’s the only image of trans people that you ever got. People joke “oh, for 10 years I told everybody to call me Shirley” and it sounds like a joke or a mental illness that people get over. Even when I was wearing the dress, I thought “why would I do this? I’m obviously not trans, I would know if I was

> trans. I would know, I'm so old. I don't understand. And I'm not against it." But I was—I mean, I did learn transphobia. I learned this picture of what trans people were that's not real, and it's hard to fight it and it's hard to fight the shame that comes with femininity and the shame that comes with presenting and dressing the way that it's been presented to me as a sexual thing. I felt like I was going to get arrested, as a "deviant." I kept thinking "why isn't anybody arresting me?" And that's not the experience that [my care provider's] other clients had. So I thought "well, am I really trans?" Yeah, yeah, yeah that had a huge effect on my ideation!

4.1.1.3 Subtheme 1.1.3: Post-Surgery Aspects. Participants shared that certain post-surgery events and experiences contributed to their suicidal ideation, such as post-surgery depression, complications, and chronic pain. Both Oliver and Patricia shared that they experienced low mood/depression and suicidal ideation immediately after gender-affirming surgery. Patricia shared the following:

> Like, you're also kind of disabled from that surgery. You can't really leave your house or do anything or *walk* or ride your bicycle. You don't want to talk about having had genital surgery to your friends or everyone, so you cannot explain. And you're socially isolated. And I think it sets you up for a spiral of depression…. Yeah, I definitely experienced suicidal ideation at that time, I can point [to] that.

Oliver shared the following:

> So a year and a half ago, I had a phalloplasty redone, with [name of provider omitted] in [name of US state omitted]. And it, it's kind of a huge history…. So I've had metoidioplasty, multi-stage phalloplasty, and then another phalloplasty and revisions. So I was hoping that was kind of going to be the end of it. So when I got to [name of US

> state omitted], by that time I was fed up, I was disappointed, everything was being redone. And I had some complications. I had fistula and I had problems with the catheter and I had really, really bad constipation, like worst I've ever had with any surgery. Like, to the point where it felt like I was giving birth, in so much pain. And I was so sick. And my mom was actually there with me, and I told her "Mom, I just want to die," and she was really upset. Because your arm's been chopped into pieces, your leg has had a skin graft removed from it, you've got a suprapubic, you're in pain. I've already done the gamut of surgeries, you know, and that's all in addition to the chest surgeries and hysterectomy where I had complications. So by that point, I just want it to be over, I just want to die. And of course she was really upset. She's like, "it's only temporary" you know, whatever. I wasn't going to do anything, but I just wanted to give up at that point. Like, I've had it. My whole life has been spent trying to transition and get funding and work with doctors who don't care, you know. In the States, it's a business, it's all about money, and when you go there, you're just money to them…. And then that was it, I was like, "I'm done, I don't want to do this anymore."

Sarah, a provider participant, explained that long-lasting postoperative chronic pain can be a contributing factor to suicidal ideation. She explained:

> We see that in particular when folks have chronic pain related to the surgery, we've see folks be quite suicidal around that. They have chronic pain and say "well, why did I do this in the first place?" Which, them 10 years ago, they didn't know the chronic pain was going to happen. They probably would have made the same decision, they couldn't have known, but it's still hard for the person.

4.1.2 Subordinate Theme 1.2: Interpersonal Factors

Many participants spoke about interpersonal processes that contribute to trans individuals’ suicidal ideation and behaviour. While the majority of these interpersonal factors were also interpreted as systemic factors and therefore covered in the following subordinate theme (*Factors that are both interpersonal and systemic*), family-related factors is described below. Family-related factors contributing to suicidality were experienced before, during, and after care was sought.

4.1.2.1 Subtheme 1.2.1: Family-Related Factors. Many participants, trans and provider alike, spoke of a variety of family-related factors such as rejection, non-acceptance, and non-support, as they pertained to transition related care and suicidality. When queried regarding her thoughts regarding trans individuals and suicidality, Michelle succinctly said: “So I think that, as the studies have pointed out, family acceptance or rejection is a huge factor. So I work a lot with families.” Collin explained how he experienced a significant lack of support from his family, which interacted with his suicidality and access to transition related care. He said:

> My parents don’t really support me being trans, like at all. I came out to them in 2017 and they were like “You are not trans because when you were a kid, you liked skirts and etcetera.” Basically my parents were like “Trans people exist, you are just not one of them.” Which was really difficult for me to take that. And then in 2018, I was like “I want to start taking testosterone. I want to start transitioning medically” and my parents were like “this is a phase, this is too new.” Which just really angered me because I had been out to my friends since 2014, I was just very anxious to come out to my parents so I waited a really long time. But then they were like “this is a new thing, a new development, and you shouldn’t be making these impulsive or rash decisions that will affect your life.” And they never called me the right pronouns, they never called me the

> right name. They always used to call me my birth name and use she/her pronouns, which was very upsetting especially since I lived with them at the time because I was going to high school. And then in February—that was the only attempt I've ever had that was caused by something and not just me being overly impulsive on a day—in February I was just really upset because I thought that my parents would never accept me for who I was and support me and I felt like they just didn't care about me. So I tried to kill myself….

Collin later went on to explain how his parents' lack of support was experienced as a barrier to accessing hormone therapy, which he had already taken steps to start accessing with a medical care provider a few months prior. He explained that this perceived barrier, this feeling that he had to choose between the relationship with his parents and his medical transition, contributed to his suicide attempt:

> I definitely think that the fact that I was not necessarily able to access what I wanted to without feeling like my parents were going to hate me definitely impacted my decision in February to do what I did. But I guess that doesn't have anything to do with access to it. Because I did have access to it. I was just feeling like I didn't…. I already knew that I literally did have access to it. I just felt like I did not…. Yeah, it almost felt like it wasn't something I *could* do. But then after [my attempt], I realized that it doesn't matter, and that if I ruin my relationship with my parents, it's better than being dead…. Yeah, this was my thought process after. Because after, when I lived, I was like "OK, I can't not. I'm going to start testosterone in April. I can't do anything else."

The impact of family rejection on suicidality for trans individuals was understood in a similar but slightly different way by Sophia (provider participant), who placed family relationships in a broader category of attachment relationships. She said:

> So if they are in a religious community or in a particular family or in an intimate relationship where they feel or know that it is absolutely impossible for them to transition, that wall—because the importance of our attachment in our communities, our intimate relationships, our parents—if transition feels impossible in those relationships, that could lead to feeling suicidal. Because you really are trapped. Because there are two things that you desperately need to stay alive, and you can only have one of them. And that equals fantasizing about dying or actually trying to kill yourself, because life is impossible because you can't have your mother who you love so much *and* who you are, for example.

4.1.3 Subordinate Theme 1.3: Systemic Factors

Systemic factors are those factors that are external to the trans individual. They are in the social environment rather than an individual or interpersonal process. The majority of participants understood systemic factors to be present in the interaction between suicidality and transition-related care. Systemic factors were understood to occur before and while transition related care was sought.

4.1.3.1 **Subtheme 1.3.1: Barriers to Accessing Transition-Related Care[8].** Many participants—trans participants and provider participants alike—spoke about how the barriers to

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[8] The following information may be helpful to readers in order to better understand the processes surrounding accessing transition-related care in Ontario and Québec. There are generally two main ways to access hormone replacement therapy in a health care setting: from an endocrinologist or from a primary care provider. In Ontario, primary care providers can be family doctors or nurse practitioners; in Québec they are family doctors. Endocrinologists, and some primary care providers, often require an assessment letter from a mental health professional communicating a diagnosis of gender dysphoria. The mental health care professional providing the assessment is often paid out of pocket by the trans individual, and duration/number of appointments the professional will need to complete the assessment is often unknown. In addition, there are two main ways to access gender-affirming surgeries: through the health ministry approval and funding path or by paying out of pocket. Both paths require assessment letters or forms to be completed by various health professionals, sometimes including mental health professionals. These latter professionals are paid out of pocket by the trans individual with no option for reimbursement from the health ministry. Similarly, it is often unknown at the start of the assessment how many sessions or appointments the professional will need to complete their assessment. In addition, the systems differ in Ontario and Québec: In Ontario, providers will often arrange for documents to be sent directly to the ministry on the

accessing resources and transition-related care had negative effects on trans individuals' well-being. Patricia (a trans person) spoke of resources that were known for delivering affirmative transition-related care being in high demand and thus having very long waitlists, which was a barrier to accessing transition-related care. She also spoke of the existence of other services or providers who delivered transition-related care, which ranged from less affirmative to pathologizing, and the negative impact of that. Patricia said:

> You don't know where the resources are. Because then there's this one clinic but they have a waiting list. And no matter how nice they are on the phone, they won't be able to see you…. And so you don't know where else to go. And you don't have money to access a therapist that does trans care at like $75-$85 a session. And then seeing an endocrinologist where there's a 1 year waiting list. So there are waiting lists everywhere or it requires money. And all the resource that you can access, you can't because there's waiting list or they make you feel so dirty. Yeah, so that's a pretty good example of the barrier.

Lack of public access to transition-related mental health care was weaved throughout many participants' interviews and captured within many other themes. For example, the intersection between class, transition-related care, and suicidality (described in detail in the Intersectionality theme) touches on the current subtheme, as do the recommendations later in this chapter regarding increasing access to transition-related care in the public sector. Michelle (a provider) succinctly described the link between the lack of transition-related care available in the public sector and suicidality when she said:

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person's behalf. In Québec, the person is responsible for collecting the documents from the various providers and submitting them to the surgery clinic themselves (who then in turn sends them to the Ministry).

> Another thought about the suicidal piece is the lack of public access, it’s a huge piece. I’m going to say this very clearly … the lack of public access to trans-sensitive health care, mental health care, and other systems in place that are related to determinants of health, like women’s shelters, employment, counselling, etc., the lack of non-damaging, trans-sensitive public access contributes to suicidality. Because I’m not seeing all the people that cannot afford to see somebody in the private sector. At this point we still have way too few people in Québec who are in the public sector, who can see trans folks for letters and surgeries. So yeah, the lack of public access contributes to peoples’ hopelessness, isolation, lack of support for advocacy, etcetera. It's also not enough to have professionals trained, we have to create an access to them, pathways to care that are mostly inexistent at this point in the province.

Michelle went on to elaborate on this topic:

> Community groups are doing much of the frontline work that the public sector is refusing to do, with little to no resources, little to no support of any kind, and they are keeping people alive. They’re a huge, huge, huge resource. And somewhere I think we have to question how governments organize this so that fundamental services that should be available throughout the province of Québec, throughout the public system, are only available in certain places where community groups have organized and have been able to survive. Because a lot of it is systemic, because a lot of it is not mental-health related, because much of what people need to not kill themselves has to do with fundamental advocacy. How is the public system not mobilizing, and therefore, how are they contributing?

Michelle's above observation can also be interpreted as a call to action, encouraging providers and others to speak up and mobilize regarding the importance of support for trans individuals and transition-related care being offered in the public sector. Maxime, a medical provider in the public sector, had a related observation:

> Il y a une chose que j'observe, c'est un peu une parenthèse, la [provicial healthcare] va rembourser les antidépresseurs mais va pas payer pour une psychothérapie quand on sait que pour une dépression modérée, la psychothérapie est *au moins* aussi efficace que la médication. C'est vraiment un choix de société de rembourser un type de traitement versus un autre. La médication ne fait pas tout.

Maxime is not only commenting on the lack of transition-related care specifically, but on the lack of access to psychotherapy in the public system in general. When we consider how beneficial psychotherapy and psychological services can be to trans individuals, particularly due to the distress often experienced by trans individuals due to a variety of intrapersonal, interpersonal, and systemic factors such as transphobia and other forms of minority stress, the call for psychotherapy in the public sector can easily be understood as being relevant to the call for transition-related care to be available in the public sector.

In addition, Maxime spoke of being one of the few medical providers in the public system and thus having a very long waitlist of over a year, which they saw as further evidence of the lack of accessibility of transition-related care. Maxime said:

> Juste pour dire, la responsabilité me revient souvent en étant un professionnel de la première ligne. C'est ça. Parce qu'en deuxième ligne je pourrais référer à un psychiatre ou je pourrais référer à un spécialiste mais ça nécessite une référence, le psychiatre nécessite que je passe par le [community health clinic]. Donc, c'est beaucoup moins

> accessible. C’est probablement moi une des personnes les plus accessibles dans le système de santé pour une personne trans, même si ma liste d’attente c’est un an et demi. C’est pour dire à quel point les services sont peu accessibles.

Patricia spoke of the overwhelming number of complicated steps she had to complete in order to try to access surgery and how it interacted with her symptoms of depression, leading to even greater difficulty completing those steps. She said:

> To get access to surgery, for example, you need to see a therapist, but a therapist costs money [sigh]. So you try to find other ways. And there’s this clinic, and so you call it, at the [name of hospital omitted]. And, so just to get to get to [name of clinic omitted], you need to have a referral from another doctor. And to get a referral from another doctor, you need to go to [long, deep sigh]—so you need to have, like, a health card. But the health card that you have might not have your name on it, or didn’t have my name on it. And so I would be called by my deadname. And, so it’s all of this to try to get an appointment with a doctor. And you just end up going to urgent care. And [deep sigh], just, just, to get out of your bed in the morning to do that, when you’re not doing well, is already complicated. So you manage to go see a random doctor that will hopefully give you a referral. But this doctor has no knowledge of trans people and doesn’t get it. And they just want you out of their office. So they were kind of cold, and they don’t get it, and they were kind of rude. So they just sign off [on] that thing. And you leave the office, it took five minutes, but you still feel like shit. And you feel like the whole process was all that for, for not much. So you then need to fax the referral. To fax the referral—because they don’t take e-mails, you cannot call them—you either need to go to [name of hospital omitted] and give them the referral or fax it. And so to fax it, I went to [sigh] a

> convenience store, fax that thing, it's complicated. And so you put it off and off, because you don't feel like it, you're too depressed, or it's just a lot. And it just feels like it's this endless spiral of things you need to do in order to have access to a therapist. Because you have this weird idea that you *might* want to have surgery. And so you're just trying to navigate through those steps. But throughout that process, you're delegitimized [sigh]. There's all these little things that for someone who has their shit together, it's easy to manage. But because you don't, because you feel weird and depressed and you feel people look at you [pause], you don't want to leave your house. You feel [pause], yeah, it's [pause], it's a lot.

Like Patricia, Collin reported barriers to transition-related care in the form of having to complete an overwhelming amount of steps, which was particularly difficult in the context of existing mental health concerns and a physical disability that impacts his mobility. Collin shared that his suicidal ideation had returned after a three month absence and shared the following regarding his experience with barriers to transition-related care. He said:

> I think like, and right now, I'm having a lot of trouble because it's proving to be very difficult to take these steps for the top surgery. Everything is not going the way I want it to go. And like, it's been really complicated. I don't know why it's so complicated. They require so much different paper work and so many different things, that are like—I've had like five different appointments for getting the paperwork to get a consultation appointment with people that are doing the top surgery. They require this whole list of documents that I need to get. It has been really complicated to do…. I had one appointment with my general practitioner, just a doctor that was just a medical check-up. They had to make sure that I am physically well and that I can physically have this

> surgery. I had to go to the pharmacy and wait for a really long time to get a list of the medications I am currently taking. And I had an appointment with my therapist where he had to write me a letter, recommending that I am eligible, that I am good for the surgery. I had to have an appointment with the doctor that prescribes me testosterone because I needed proof that I am taking testosterone because the letter from the pharmacy wasn't enough…. And I had to get a letter from my psychiatrist because the letter from my therapist ended up not being enough. They needed it to be from someone who is a doctor. So I had to get a letter from my psychiatrist and she messed it up two separate times, so I had to wait and see her again and ask for a new letter that was like—because she didn't meet all the criteria for the letter that they were asking for so she wrote another one and then I saw her again yesterday because the other one that she wrote was also wrong. So now tomorrow I have to go pick up the new letter and send that one in…. And I had to scan all these documents in, all these separate times and send them in, email them in. And like it was really hard because at one point, I couldn't, I just couldn't get out of bed. So I was like "how am I going to go to the pharmacy? How am I going to scan all these documents at the library? How am I going to do all these things when I just literally can't get out of bed because I can't?" But yeah, they just made it really complicated…. I sent in the first documents which was just like a copy of my health insurance card and pictures of myself with no shirt on—that was really fun—I sent those in in early September…. [So two and a half months of] sending documents back and forth. And hopefully the letter that she writes works this time because it's literally all I have left. And then I'll see when I get this consultation appointment if the letter is approved, is accepted.

When asked to elaborate on the psychological effect of these barriers, Collin explained:

> It’s stressful. Because like my life is in the hands of not me. That’s what it feels like a bit. It feels like my life is in the hands of all these other people who just get to choose whether or not I get access to the resources that are meant for me…. [I feel] frustration. Like we just live in a cis world, that’s just the way it is. I’ve never interacted with someone who is trans during this whole process, at all. And I feel like during this whole process, I have interacted with one medical professional who understood the weight of the situation because I feel like all the other people are like “OK, well this is something that you want” versus something that I need…. Like sometimes I feel hopeless and sometimes I don’t, just because, I don’t know. It depends on my mood that day, I guess. I feel like, yeah, everything is just so intertwined that, on a day where something else is going bad in my life, then I am also like “oh my God, my transitioning, hopeless.”

In addition to the discouragement and distress that participants named as a result of the long, complicated process of trying to access transition-related care, Nomi spoke of the illusion of access to transition-related care and the psychological impact it had on her, such as despair and suicidality. Nomi shared:

> Plus c’est difficile, plus c’est compliqué, plus que tu désespères et plus que tu y penses [au suicide]. Tu sais, à une certaine époque la transition c’était impossible, médicalement parlant, ou légalement parlant, ou peu importe. Mais quand c’est rendu que oui tu peux le faire, mais c’est tellement bureaucratique que c’est rendu autant impossible de le faire que ça l’était avant—mais pas parce que tu ne peux pas le faire, c’est parce qu’ils ne veulent pas le faire, ils ne veulent pas t’écouter. Donc on est rendu de l’autre côté de la médaille, complètement inverse où tu as plus d’obstacles à l’accéder que de pouvoir le

> faire. Des fois ça peut être tannant.… "Ok on va vous donner accès, mais on vous rend tellement ça compliqué que vous pouvez pas y avoir accès." Ça n'a pas de sens.

4.1.3.2 Subtheme 1.3.2: Existential Erasure

Betty spoke of a contributing factor to her suicidal ideation that was deeply painful for her. She named this factor as feeling existentially isolated, and through data analysis I came to understand it as the psychological pain of isolation due to existential erasure. Erasure, as it pertains to trans healthcare, has previously been identified as informational erasure and institutional erasure (Bauer, et al., 2009). In describing her experience with erasure while trying to access transition-related care, Betty described the psychological impact of these forms of erasure. For example, she describes experiencing her doctor's uncertainty about her gender dysphoria as being "a blank in his knowledge," as he reportedly held some expertise regarding delivering transition related care but was not familiar with gender identity exploration and gender realization in young-middle aged individuals. When we spoke about the impact of her provider's uncertainty on Betty, Betty shared the following:

> I don't know how to describe it. I felt alone, like really, really isolated, really marginalized, really like [pause], like a blank space, like I was missing from everybody's understanding. And yeah, I felt angry.… Not that I ever felt comfortable going to doctors, but I had gotten more comfortable and I felt like, "well these are experts who know things" and then [pause], I knew so much more. It's such little knowledge this person seemed to have, and that made them an expert. Yeah, so existentially isolating. So I finally became a person and nobody could see me. I know who I am finally, and nobody could see that person.… Blanks. Missing spaces in people's knowledge. I'm starting to think it's because we are taboo and so people tend to look away.… Nobody wants to talk

> about trans people because we are just taboo. It didn't take much to be considered an expert, it feels like, in the medical community, and it felt like the people who were experts, I couldn't trust necessarily, to actually have my best interest, or to have much knowledge at all about transition-related care. It felt like the things that people have been saying on the internet about how they *always, always* know more than their doctors, I understood what they were saying now, that's how I felt.

Sammi (a participant provider) also touched on the fact that existential erasure is a contributing factor to suicidality among trans individuals, due to its psychological impact. Sammi said:

> The only thing that I would say is just understanding that it's a very, very common experience because the world that we live often rejects and renders invisible folks with a trans experience. Isolation and rejection are the two harshest thing that a human being can experience, right? And so when we don't see ourselves, when we don't hear ourselves, when we don't learn about ourselves, we don't see people with the same experiences as us in history or in literature or in media, it's like, how can we know that we exist and deserve to exist?

4.1.4 Subordinate Theme 1.4: Factors that are Both Interpersonal and Systemic

During data analysis it became clear that there was a group of contributing factors that were simultaneously interpersonal and systemic (e.g., transphobia; being gatekept). These factors are interpersonal because they happen between people, but also systemic because they happen between trans individuals and the systems that trans people often have to navigate in order to receive the care they require. The majority of factors that were both interpersonal and systemic were understood to occur in all three time periods (before, during, and after transition related care was sought), while one (being gatekept) occurred while care was sought. Factors that were both interpersonal and systemic are explored below across four different subthemes.

4.1.4.1 Subtheme 1.4.1: Transphobia. Devon explained that a contributing factor to their suicidal ideation was the queerphobia they experienced and transphobia they observed from their parents (in the overall context of a longstanding difficult parent-child relationship), and the subsequent loss of that relationship with their parents. Devon explained that the last time they visited their parents was particularly difficult due to their mother's transphobic comments and behaviour. They asked their mother to change her behaviour, which their mother refused to do. Specifically regarding that last interaction and the loss of the relationship, Devon said:

> But then I was talking to my mother the next day, and I put it down to her like "if you want me to keep coming around, you need to learn how to speak respectfully to trans people," and she point blank said "I shouldn't have to learn a damn thing." And I haven't been home since. I have talked to them, and then I've stopped even doing that. So my mother emails me now and again with "are you coming home for Christmas?," and I'm not. And this is the second Christmas I won't have been home. And that sucks, that's really hard. I feel like I've grieved more in this space of like the last year than I've ever grieved in my life before that…. This thing with my parents, it's kind of like a long, protracted—I've known this was coming for years and years, but it's here. I've always known it was going to end this way with my family, but now it's ending this way.

Devon also spoke about unintentional transphobia from friends contributing to their suicidal ideation, due to the feeling of no longer being understood by long-time friends. This account can be understood as a telling of a nuanced way that even unintentional transphobia negatively affects interpersonal relationships and one's sense of belonging. Devon said:

> Oh yeah, stuff related to suicidality related to transition: the other thing that has been hard is that I have some very long-term relationships with friends—and I think this might be a thing because I'm transitioning a little later in life and I'm in my 30s, so like the people I was friends with in high school are people who were really good friends for me then but now they kind of don't understand. And it's made spending time with them a little more awkward. So there's a sense that we are not as close as we were when they thought I was cis-het. And when I thought I was cis-het. And that can be really difficult both in terms of like, these are people you care about, you trust, and they are sort of unintentionally microaggressing all over the place because they just don't know, they don't get it. Not that I expect them to, you know, do a deep dive into like transness. But it's just like, you start to see this chasm opening up between you.

When explaining the multiple intertwined factors that contributed to her suicidal ideation, Patricia explained that interpersonal and systemic transphobia were barriers to her being able to access resources like social assistance, and thus negatively impacted her well-being. She said:

> Puis ça créer des situations particulières par ce que souvent, en tant que personne trans, je ressens que mon corps ou ma personnes a pas nécessairement de légitimé dans l'espace publique, ou dans le monde. Alors, il y a des scenarios ou je ne peux avoir à accès a—so a few years ago, I tried to get money through Emploi Québec. Just to get on welfare, I was trying to get on welfare. I had managed to survive for a number of time without accessing welfare, without having, like, legitimate income. And I was trying to get welfare and I could not. Like, I would just get misgendered, and like the people there were [deep sigh], they would call me sir, and there was like this, this feeling of, like, you're trying to fraud, you don't deserve anything and, yeah. … Like you need to just go

> to an office, fill this form, and talk to someone, sign a few things, and they're going to send you a cheque by the mail every month. And you need to call—it's not a big deal, it's very simple. But when you're not like doing well, and when people don't even get your name or don't understand who you are [tearful voice] and you feel like, not legitimate, you feel like you have no place in the world. You just want to stay at home, and not reach out to the resource you need to get better or to, you know, to survive.

When Simone, a provider participant, was asked to share her understanding of suicidality among trans individuals, she shared the following:

> And then there's like fucking transphobia and bullying and all of the minority stress-level effects of being trans, being gender variant in some way, or being different—but especially in a way that people have like such fundamentally fixed ideas about—that challenge people at this core level that makes them [the perpetrators] so fucked.

Simone went on to explain:

> Also, transphobia, it doesn't go away after your transition, necessarily, and for some folks it becomes profoundly more intense. And I talked about access and barriers, in terms of transition, but there's the access and barriers because of transphobia. So housing, and jobs, and safety, and relationships for some people. So there's still a shitty world that needs to be contended with.

Michelle, a provider participant, shared that she understands suicidality among trans individuals to be due, in large part, to ongoing transphobia and other forms of discrimination. Michelle said:

> You know that Swedish study that gets interpreted right and left about suicide? It says that after transition, there is still a higher rate of suicide in the trans population than in the

> general population. And it’s been used by NARTH, and other ill-willed groups to say “see, transition services don’t work, they don’t make those lives better.” The researchers say that it’s very clear that the *ongoing* discrimination is—I mean they can’t say it’s *the* factor, but it seems clearly to me as a clinician—the reason why you have trans women who are suicidal. It’s just clear. And especially if they have a PTSD history.

Michelle went on to explain:

> We know the factors that contribute [to suicidality], and it’s becoming clearer in the research. The people who don’t lose their jobs, don’t lose their family, their kids still talk to them, they’re not barred from seeing their grandchildren, if it’s a youth the parents are on board, the friends are accepting, the school does their work, are not going to be suicidal. They’re just not. There’s no intrapsychic process here of somehow people who have some kind of biological tendency to be trans, have a biological tendency to be suicidal, the whole thing is ridiculous. I’m not sure anybody would dare to go there. It’s clear where the suicidal feelings are coming from. There’s more than enough evidence that it’s the kinds of stress and invalidation that trans people feel from the start. And then starting with the gender non-conformity oftentimes the child [pause], you know about the pediatric research on gender non-conformity? … The Roberts study. It’s saying that gender non-conformity before the age of 11 predicts a higher rate of life-long PTSD. So that’s where also a lot of our clients are coming from, unfortunately.

Michelle also shared the following:

> Suicidality … comes with the territory much more than many other client populations we’ll see, because of the ongoing marginalization, discrimination issues, because of so much work needing to be done in society for people to be able to feel integrated and

> respected. So it kind of goes with the territory. And this is not to say that trans people are weaker or anything like that, I'm saying there are very negative systemic forces [at play].

Michelle summarized her understanding of suicidality among trans individuals in the following way: "I think the suicidal piece, it has to be seen in a systemic way. What are the systemic forces acting upon my client, in addition to the dysphoria, and in addition to the trauma history?"

4.1.4.2 Subtheme 1.4.2: Disempowerment. All trans participants and some provider participants spoke of disempowerment and the various forms that disempowerment took in the context of transition-related care, such as feeling dehumanized, feeling violated, and the loss of bodily autonomy. Trans participants spoke of how they personally experienced disempowerment while trying to access or while accessing transition-related care, and how that impacted their suicidality. Several of them spoke about the ways the system of accessing transition-related care was disempowering. Simone, a mental health care provider, summarized the situation by saying "It's often a very disempowering experience—or there are aspects that are super disempowering—of moving through the system to getting what you need and want." Patricia (a trans person) spoke of the experience of being disempowered and how that interacted with her suicidal ideation throughout their interview. At one point in the interview, she described the experience as being "subjugated." This subjugation can perhaps be understood as the psychological effect of feeling disempowered, as being subjugated can mean being conquered or dominated. Patricia said:

> Also you feel like you're subjugated, right? Like you either need to make your experience fit a set of criteria for those less affirmative doctors to take you seriously, and there's something very disempowering in that, or you need to actually be able to

> find the more affirmative doctors or practitioners and that's—the process of that is so difficult and violent in itself, yeah.

Oliver spoke of feeling like the surgeons had all the power in the relationship. He chose not to disclose his symptoms of depression or how upset he was with the surgeon's disregard for his bodily autonomy due to fear of then receiving sub-standard care. Specifically, Oliver said:

> I didn't want them to know anything was wrong and I wanted to be very friendly and nice, because I already knew I had complications, and I'm like, I'm probably going to end up back here, or for revisions. And if I tell them I'm depressed or if I tell them I'm unhappy with what they've done, what kind of care am I going to get when I come back? So I just hid all of this, you know?
>
> Interviewer: I'm hearing that it feels like they have a lot of the power, is that right?
>
> Oliver: They have *all* the power, basically.

Patricia spoke of a similar situation, where she felt like she had to endure disempowerment in order to receive access to the transition-related care that she required. Patricia shared:

> So, to get surgery at that time, you needed to get a letter from your endocrinologist that said you are taking hormones, and that you could actually go through with surgery. Kind of like a check of good health. And so [my endocrinologist] wrote this letter which was very inherently violent in using a name that I didn't use, using masculine gender … And telling me "oh yeah, she, oh no, he is ready for the sex change operation." That doctor would then tell me he's been seeing trans patients for multiple decades, and how great he was for them. You just need to sit there, and just nod to what he was saying. He was boasting ego by how great he is.... And like, he has his vision of what your body—and he

> talks about you having breasts, and it’s really gross, and it’s fucked up. And you just need to smile and nod, because you just want to get that letter.

In addition, Patricia spoke of the fact that there is a power imbalance not only between trans individuals and providers, but also between the different providers, and that the latter can also contribute to a feeling of disempowerment for the trans person; it certainly did for her. Patricia shared:

> It’s putting a lot of responsibility on the surgeons in [name of province omitted]. They control the whole thing, and for the other medical professionals and other providers, there’s very little feedback that goes the other way, or like, there’s very little transparency. [Name of providers omitted] control that game entirely.… I think there’s something that is very specific to that context. Like, the relationship with power, because they are the only providers in Canada. There may be someone in BC, but they’re not providing surgeries for trans women. And there’s other top surgery providers. But for phalloplasty and vaginoplasty, they’re the sole providers in Canada. So they have a lot of power over trans patients. The clinic accepts and rejects patients and so you consider yourself very lucky to get into that clinic. It’s supposed to—so there’s this construction of the surgery as something that you work toward and it takes a lot of time, and you need to jump through so many hoops, you need to [pause], it’s a process. Once you get there, once the funding is approved, the clinic wants to see you, they give you an appointment, you’re supposed to feel lucky.

Betty (a trans participant) shared that when she was first accessing hormone therapy her provider initially indicated that he would prescribe hormones to her, then later expressed uncertainty about doing so related to unfamiliarity with the diagnostic criteria for gender dysphoria in adults, before finally providing the prescription. She explained that this process created high levels of anxiety and stress for her, which had a negative impact on her ideation. Betty shared:

> Yeah, yeah, yeah that had a huge effect on my ideation! The thinking, "oh no, I found happiness, I found the meds that I was looking for, and accepting myself," I thought I had the answer. [Pause] Then "are they going to take it away from me? Are they going to take it away from me?" That's what it felt like, "they are going to take it away from me." Yeah. And it felt like he had the power to do that, sort of. Sometimes it felt like he had the power to take that away from me.

Betty was asked what she imagined would have happened if her health care provider had ultimately decided not to start her hormone therapy. Betty said:

> I would go back to where I was. I would be hopeless. I would have no future. I would still be trying to find a med that made me feel that way that I was feeling. I would have either come out again some years later when the ideation got even worse, or the ideation would have gotten bad enough that I would have completed, I guess, or attempted. Yeah, completed or attempted. I don't know. I would go from having [pause]—I would have nothing. I would have nothing. It's how I imagine it. Like, I felt like I had never been happy before. This is what happiness is, this is what it's like to just be happy some days. I could just be happy! How could they take that away? Who would that help?

Betty went on to further explain the psychological effects of the power imbalance between herself and her transition-related care provider. She shared:

> If I'm [feeling] super confident, it feels like they have the power to decide whether I can transition or not. When I'm not [feeling] confident, I feel like they have the power to tell

> me that I'm not trans.… I learned that I had to take that power for myself because I can't trust them with it. I have to empower myself to advocate for myself. I can't just trust them. They have much more power than knowledge.

Patricia spoke of feeling dehumanized by the lack of personalized transition-related care with regards to surgery options and surgery outcomes, in a general way: "They give you surgery based on their own criteria. It's kind of like a sausage factory. They do it all the same way. So there's not that much degree of—patient input doesn't really matter that much."

While discussing events that impacted her suicidality, Patricia spoke of the disempowerment she felt on several levels while preparing and prepping for surgery, as well as immediately after surgery while recovering. Patricia experienced disempowerment in terms of providers' bedside manner, lack of open information regarding medical procedures, and informed consent, all of which she reported to have been anxiety-provoking. Specifically, Patricia said:

> My relationship with [name of providers omitted] has been really not a great one, not an affirmative one. I got surgery and that's what I wanted, but I didn't really know what the surgery would be like. No one knows. And in the trans community, people don't talk about it very much. It's very hush hush. It's so personal that you don't want to ask people questions about their vulvas. It's just not a thing you do. And so [name of providers omitted] have so much power over patients. For example, you sign a number of discharge forms you never saw anymore, they don't give you any copy of it. And you get to it, and they just tell you what to do …And I get that there's procedure for surgery, but, it's very scary and there's no one to hold your hand really, and help you understand, if you're feeling anxious. So I felt so disempowered. I felt like—we talked about this idea about

> people having power over you, and not being able to gain power—so I felt so anxious and freaked out.

Patricia often spoke of providers’ lack of bedside manner throughout her interview, and how that led to deep feelings of disempowerment, as seen in the quote below.

> And then fast forward a few days. I keep bleeding and it’s never explained to me why it’s bleeding like that. It’s bleeding through bandages, through bedsheets, and through clothing, and they’re just like, "yes, it’s normal, don’t ask too many questions, like it’s okay." They put more compresses and they change bandages, and they do things, and they don’t tell you what’s going on. And [name of provider omitted] comes in and looks at you, and touches you, and "oh it’s all normal." And he keeps touching you and he never, he never ask if it’s okay. Like he just pulls the bedsheets and touches you, and pull bandages. It’s, it’s weird. They have so much power over your body and they do things, and they don’t ask you, and they don’t tell you what’s going on, and you’re just there, and you feel disempowered, and you’re freaked out because, like, you just did something very fucking scary.

Patricia summarized her experience in the following way:

> They just take control of your body entirely, and you just become a piece of meat. I understand it’s a normal experience for surgery, people say that often. But in the context of [name of providers omitted] and their practice, it seems especially fucked up because it’s also genital surgery. And so, yeah. It was freaky and I felt [pause], I don’t know what I can say about that experience. I don’t have words for that, but [pause] it was a kind of trauma.

Related to disempowerment is loss of bodily autonomy. All trans participants spoke of the experience of either trying to access transition-related care or the experience of transition-related care itself to be one infused with loss of bodily self-determination. Trans participants often reported experiencing this sense of loss of bodily autonomy while interacting with providers who held a great deal of power and authority, such as the surgeon who was going to conduct their lower surgery. They often spoke of providers being dismissive or disregarding their wants and needs entirely.

During the interview, Oliver shared that the pre-operative discussion regarding his desired lower surgery results was disregarded by the surgeon during the actual surgery, which has had far-reaching effects on Oliver's mental well-being.

> I was upset with him because I felt violated because I told him I only wanted an average size penis, which is like 3 inches. So I said "3 to 4 inches is what I want." He said "yeah, yeah, yeah, that's exactly what I'm going to give you." I even showed him a photograph that he recognized as his own work, because it was from his website. I'm like, "this is what I want." He said, "that's my work," and I'm like "yes it is, that's why I'm showing it to you." And I had already had the scrotoplasty done twice in previous surgeries so I didn't want him to touch that. I had a vaginectomy years and years prior so I didn't want him to touch that. It was on the consent form that I had wanted to scratch it out … And I'm like "I'll just cross it out because I don't need that." He said "no, don't cross it out, you need to leave it there for funding purposes." And I had heard so many horror stories about all these guys coming back with like huge bills, you know, like $50,000 or $100,000 from the States, from stuff that wasn't covered. So I left it there. And now that's part of how I blame myself for that too, I should have just crossed it out. Because

> when I woke up, he'd given me a 6 inch penis, I ended up with a much larger scar, and twice the size of what I requested. He had opened the vaginectomy, which is really painful. That had been done already back in 2009, so there was no reason to do that. And he moved the scrotum, which I also didn't want because I had gone through very painful expanders and everything with [name of provider omitted] and I was really happy with it. It's like the only part of the surgery that I was happy with, and he went and opened that too. So it was that feeling of violation. Not being respected and listened to—because you're asleep on the table for 10 or 12 hours, or however many hours, and you put your life in these people's hands, and you expect them to do as you requested.

When Oliver broached this subject with the surgeon during his recovery, he felt quickly dismissed. The psychological impact of this disregard for bodily autonomy and lack of sensitivity on the surgeon's part created feelings of worthlessness for Oliver.

> And then when I said "this is not what I asked for, I wanted it smaller" he's like "oh it can be shortened." Yeah, which means more money in your pocket, more time for me off work, more travel to a foreign country. You know, not only loss of money through wages at work, but loss of money through having to pay for flights, hotels, food, accommodations, all this stuff. And to him it was nothing. He was like "oh well." So then you feel, you feel like nothing in a way, right?

In addition to loss of bodily autonomy that trans participants spoke of, Oliver also spoke of an experience that may be understood as loss of bodily privacy. Specifically, Oliver shared that his most recent phalloplasty was distressing to him for several reason, one of them being that the surgeon disregarded Oliver's request for a 3-4 inch phallus and instead constructed a 6 inch phallus. Oliver explained that the frustration that he feels is not only due to the lack of bodily autonomy (i.e., the surgeon disregarding his request regarding the size of the phallus), but also a resulting loss of bodily privacy due to the combination of the scars on his forearm from the surgery and the noticeable size of his genitals depending on the pants he wears. Specifically, Oliver feels likes very private information about him, his body, and what surgeries he has had are visible for others to see when he is in public. Oliver explained:

> It’s more than just this is what I wanted it to look like, it’s this is how I wanted to be able to live in society without drawing extra attention to myself and having people notice size and scars and just, you know, to kind of be stealth.

Oliver later explained the impact of the loss of bodily autonomy, feeling violated, and the loss of bodily privacy cumulating and leading to suicidal ideation in more depth:

> When I first had this scar I said to my friends and family “I don’t think I can live with this scar. I don’t know what I’m going to do but I regret this scar and I can’t live with this scar.” Everybody has scars, you know, of some kind or other, but I find it such an identifying scar. Like, anybody in the community realizes that’s a trans surgery. And to me, I think it’s my own business if I have a penis, if I have a vagina, if I have nothing, if I have both. To me, that’s nobody’s business. And this scar outs me as having trans surgery and whatever. In the broader society, most people don’t know. I just say I got burned or something. But in the trans community, everybody knows, you know. And I’ve been asked about it, which is fine. I mean somebody wanted surgery, and they were like “oh, can I ask about it?” and I’m like “yeah, it’s fine.” It was a trans guy and he wants to know, not to be nosy, but to help him, and that was okay. But it’s still definitely an identifying feature and I’m like “I can’t live with that.”

Nomi (a trans participant) spoke of the high levels of frustration she felt due to the bureaucratic nature of trying to access transition-related care and the lack of personalized transition-related care. Specifically, Nomi shared that she understood transition-related care to impact her suicidal ideation in three main ways, all of which interacted with each other: experiencing depression as a side effect of the anti-androgen medication she was taking, the lack of personalized transition-related care (i.e., being denied an orchiectomy), and being pushed towards a surgery she was not yet ready for (i.e., vaginoplasty). Regarding the latter point, it is important to note that she was being pushed toward a vaginoplasty because (at that time) lower surgery was required to change one's legal identification, and vaginoplasty was the only lower surgery for trans women covered by the public health care system. All three factors were related to feelings of disempowerment for Nomi, and led to feelings of hopelessness and distress, increasing her suicidal ideation. Nomi described her experience with providers adhering strictly to pre-determined protocols and regulations, resulting in the lack of personalized transition-related care, as a sort of prison. She said:

> Il faut apprendre à doser et savoir quels sont les besoins de cette personne-là spécifique puis lui permettre de les avoir, dans l'ordre qu'elle se sent capable de le faire et non dans un espèce de prison où tu es obligé de faire exactement ce que les autres font.

Nomi reported wanting and needing updated legal identification documents and thus having experienced high levels of pressure to undergo a vaginoplasty (while just wanting an orchiectomy) due to the regulations in place at the time. She said:

> J'ai commencé à faire ma transition en 2008-2009, ça fait 10 ans. Puis pendant longtemps j'étais pas prête à la vaginoplastie, c'est-à-dire la grande opération. Puis à l'époque on n'avait pas accès aux papiers légals de femme sans la vaginoplastie. Donc je me suis

> retrouvée dans une situation où je devais subir une vaginoplastie pour obtenir mes papiers pour avoir la paix.

Nomi described her experience in the following way:

> On était encore dans l'époque où est-ce que "ah tu veux être une femme, bien on va te stériliser parce qu'on ne veut pas que tu te reproduises." C'est souvent cette impression que t'as tout au long des procédures, surtout dans le temps que la chirurgie était obligatoire pour le changement de papiers légal, ça fait beaucoup de pression sur une personne. J'en ai connu des gens qui ne l'auraient pas fait s'il n'y avait pas ça. Mais là aujourd'hui ils peuvent, c'est parfait comme ça.

In addition to sharing that she experienced the regulation described above as forced sterilization by the state, Nomi also shared that she personally knows trans individuals who underwent lower surgery because of this regulation, and would not have undergone lower surgery were it not for this regulation.

As seen in this section, disempowerment was a common experience among trans participants and recognized by at least one provider. Feeling disempowered or powerless was complex and took several different forms for participants, such as feeling dehumanized, violated, and experiencing a loss of bodily autonomy.

4.1.4.3 Subtheme 1.4.3: Being Gate-Kept. Of the trans participants who reported an increase in their suicidal ideation while accessing or trying to access transition-related care, the majority of participants shared that the increase in ideation was due, at least in part, to the psychological effect of being gatekept by their providers or the system in general. Some of the psychological effects of being gatekept shared by participants included the disempowerment described earlier, as well as hopelessness, powerless, stress, anxiety, and increased suicidal ideation. Betty described her experience being gatekept and the psychological effects, including increased suicidal ideation, as such:

> When my anxiety is higher or my mood is lower the ideation gets stronger, more frequent. And I have had a lot of stress come out of my care. My GP is a nurse practitioner who said he wasn’t comfortable administering or supervising hormone therapy. But there was a doctor who had apparently worked with some people at [name of health centre omitted], who had helped people transition who comes in to my health centre one or two days a week. And so I met with him. And it was positive, really positive, because at first I had a good meeting. And then I had another meeting with him but I hadn’t done fertility preservation yet so I wasn’t ready to start hormone therapy. And you know, I was really confident, “this is a person who has helped people transition, I don’t have to shave before I go in, I can be a little bit, you know, not super femme.” … I had a thousand little things that were evidence to me that I was trans. I mean, the feeling that I had was enough for me, but how do I know which one is going to convince this person? [Summarized for brevity: Betty described that the provider wanted her to undergo a psychological assessment for borderline personality disorder at a separate clinic, despite the fact that she had recently been assessed by a psychiatrist who ruled out borderline personality disorder.] And then we scheduled another appointment for a few weeks or a month later. And my nurse called me the next day to say that he heard that things weren’t so sure about my gender identity, and I was like “no, I am sure.” … And he’s like “oh, because Dr. [name omitted] wrote a note in your file.” I went back in to see my nurse and he showed me and it did say in the file “diagnosis of gender dysphoria not concrete.” Which meant to me that the doctor didn’t believe me. And so I told my nurse

> "no, I'm trans, I'm going to transition no matter what." He said he wasn't comfortable diagnosing gender dysphoria, which said to me that he didn't believe me either. I thought it was just he didn't know how to monitor hormone therapy, but it was that he didn't know that you can just trust us. And so for that three week or month period, it was awful. It was intense. I couldn't sleep really well, or at all for a few days before the appointment. I was just rehearsing the speech that I was going to give the doctor in my head. And my suicidal ideation, to bring it back to that, was very strong. Stress all the time, the sense of fear and the sense of having less hope and thinking about how it would be a struggle, even with this person that I thought "I'm so lucky, there's one person in this health centre who has had *any* experience at all with transition care." And so I felt lucky and suddenly I felt like I wasn't, and I was going to have to go through it all again. And it was just really overwhelming.

Betty was asked to elaborate on how she felt as a result of having the experience that she described above. She shared:

> Betrayed. I felt betrayed. I felt alone. I felt a little hopeless, felt like the rug was being pulled out from under me. I felt furious also. It turns out that when I got in, he said "oh, I meant to call you. I talked to some experts and they said it only needs to be for about 6 months", and I was like "yes, that is literally the only definition of gender dysphoria that has ever existed as far as I understand, so you clearly have not read the definition of this thing you are not sure I have." It felt like all of the medical profession was hostile all of a sudden, or can't be trusted. I was disillusioned, I felt disillusioned.

As detailed in Betty's description above, the psychological impact of being gatekept was extremely negative and distressing for her. Feelings of disappointment, hopelessness, anger, betrayal, and disillusionment, coupled with difficulty sleeping and increased suicidal ideation were some of the psychological impacts from this event. In addition, from her description, we get the sense that Betty experienced her provider as cavalier (e.g., "oh, I meant to call you").

Lastly, Betty described the outcome of the situation described above, and while doing so, elaborated on the distress she felt as a result of the initial gatekeeping. She said:

> He prescribed blockers, he was going to do hormone therapy, he believed me now.… And he's still doing my care now, actually. And he still occasionally seems to be worried that he got the diagnosis wrong. But that does not trigger suicidal ideation in the same way that it did when I felt like he was gatekeeping, like he was the person that I had to convince in order to not have to try to find a new doctor where the lineups are huge, the waiting lists are huge because of how few experts there are. I would have to wait months and months before doing any kind of transition, I would be stuck with the body that I had and with the feelings that I had.

Patricia spoke of her experience of going into a specialized clinic in the public system with the hope of accessing transition-related care (specifically, hormone therapy). She spoke of her experience of the assessment as very pathologizing and of feeling gatekept, which led to her feeling cheated out of transition-related care. Specifically, she said:

> And they tell you, "Okay, we're willing to take you into our clinic. You're going to need to come here twice a week for group therapy. It's going to cost you money for this therapy." And then you ask, "But this is not what I want. I don't want therapy, I want to access hormones." And they tell you "No, actually, we give you hormones when we think you're fit for it." And you get upset because you feel like you just got cheated out of something. And they just assert their right to decide for you. It feels unfair. You feel like

you get cheated out of something. You leave the office saying something like, "I'll think about it, thank you." And they give you their card and they wait for you to take an appointment with them. But I never did because I was lucky enough, I did some research and I knew about them after the fact, you know.… So I didn't go that way. But yeah. There's lots of shame. And you put all that energy into that one day of the [name of hospital omitted]. And yeah, you feel like you [pause], you got cheated. You feel shame. You feel like they're using you [sigh]…. You went there to hopefully get hormones or get onto a path where you would get hormones, like hopefully soon, and by the end of it, it's just, knowing that you won't access it. And there's like this man that's basically raising his tone of his voice and telling you no. And you, you feel like they're using this to train people or, and they're going to do studies. And they have like this vision of, you know, transsexuals and true transsexuals and transvestites, and this topology. And you, you just give yourself to them in the hope that you will be able to access care. But actually, they cannot deny it to you. So there's that, like not getting what you want, but also like, feeling like they misrepresented you or they ask you questions that don't fit with who you are…. It fucks with you, and you feel [pause] dirty. And you feel like you're too old. I was 24 or 23, I was really young. And I was getting really anxious because my body was getting more and more masculinized so I just wanted to do something to stop the masculinization of my body sooner than later. And the internet is full of stories about this kind of transsexual topology. Like, you feel maybe "I'm 24, I'm too old to be a true transsexual for them, so they just, they just lump me with the transvestite model" and it fucks with your head. And you start to maybe believe it, or not, [pause] and you don't need that. What you need is like for people to tell you it's okay.

> Yeah. Because just to get to that appointment, it took so much energy and so much internal turmoil…. It's a lot of work, like, by yourself, to get out of your house, and access those resources. And then to be made to feel like you're a dirty fetishist and you don't deserve that care. It's kind of violent, it's being cheated. And yeah, and then you give up.

4.1.4.4 Subtheme 1.4.4: Intersectional Factors. Trans individuals are not a homogenous group. Like any group of people, trans individuals have multiple complex intersecting identities that shape how they experience the world and how the world experiences them. Provider participants and trans participants both spoke about how intersecting identities interact with suicidality and/or accessing transition-related care.

The majority of participants spoke about how historical and current income, class, or socio-economic status (SES) impacted trans individuals' wellbeing, including their suicidality, in several ways. One of the ways that income interacts with suicidality has to do with accessing transition-related care. Participants were asked to limit their answers to the last five years; in that time period, transition-related care surgeries have been covered by the ministries of health in both Ontario and Québec, with varying degrees of requirements and wait times. However, there are some surgeries that are not covered or were not covered in the five year period before the interviews took place. Abby (a provider) spoke about this in general when she said:

> Income and how much that can affect suicidality: some people can afford to travel to get the surgery they need if it's not covered by [provincial funding]. And so if you can't afford it and if that's your marker for when things are going to start to feel better, then your level of suicidality might be persistent for a long time.

Nomi (a trans participant) spoke of having to advocate for herself and the surgery she was seeking in the public system, due to the high cost of paying for it out of pocket:

> C’est soit que je sortais de la province puis que je payais 6 000 $ pour le faire faire, de mes poches, ou que je trouvais le moyen procédural quelconque de me permettre de l’avoir. Et on a réussi à le trouver, mais ça a été tout une histoire de fou qu’il fallait trouver les bons médecins qui savaient ce qu’ils faisaient.

In addition, Patricia (a trans person) spoke about one of the nuanced ways class or SES affects one’s access to transition-related care:

> The ability to access medical resources changes a lot, according to these systemic forms of privilege that affect the way you access those things. And your experience interfacing with doctors changes a lot if you speak the same language as them. Like not English or French, but like the same—if they can relate to you, if you can relate to them, it becomes a lot easier.

Sammi (a provider) also spoke of class as being an important factor that interacts with suicidality among trans individuals. Sammi is a provider who offers affordable counselling and, as a result, they work with low-income clients and/or clients who experience marginalization in many forms and thus un- and underemployment due to societal-level stigma, oppression, and barriers to formal education and employment. This clinical experience informed Sammi’s point of view when they shared the following regarding class and suicidality:

> I think that class is a *huge, huge* factor. If you don’t have the money to get the things that you want to get done to experience yourself in your body, or to just have enough funds to actually eat well… There are just so many things that come down to access to money. And it’s one of those really invisible, it’s an invisible identity, but it’s so there. And I’ve never worked with a well-off trans client, you know. All of my clients have been

> homeless or live in poverty or are fighting day to day in having enough to eat. And their jobs are limited because of the fact that we live in a transphobic world. So I mean a lot of my clients end up doing sex work, which is precarious and you have no stability with sex work because you never know what kind of work you're going to get. So I think class is a huge factor that I believe affects suicidality too.

Sammi went on to elaborate on the interaction between class and suicidality via their understanding of the psychological effects of poverty, trauma, and substance dependence.

> I think not having enough money or not having enough steady income affects trans clients' ability to rest, to be people, to be able to do the deeper work of making connections and socializing and affording to take an evening off and actually spend money on going out, and buying clothes that they feel good in their bodies in, and going to socialize with some people that they can hopefully make a deeper connection with. All of that takes funds. And I think that there's definitely a big issue with substance use and addiction in the folks that I work with and have worked with, so that also costs money. And so there's a bit of a vicious cycle where maybe the drugs and alcohol that they're consuming are helping them get through day-to-day, but that's maybe the remains of the extra funds that they might have. And that they're not able to have any more funds to just, you know, have a fridge of food.… Getting through the day is where the funds are going. Again, going back to suicidality and going back to trauma- because I think a lot of trans clients are trauma survivors- it is very hard to have these positive, long term health goals, like eating healthy, with "I don't give a shit about eating healthy, I'm staying drunk to like get through the day." And that, I think, is part of being in the cycle of poverty. That's, I think, exactly what a cycle of poverty is. You don't have savings account, you

> don't have a fund to fall back on when things get hard.

Oliver (a trans participant) also spoke about the interaction between income and mental health. He spoke about the financial stress of living in Toronto and the fact that he worked multiple jobs in order to be able to pay basic living expenses, which did not leave him any funds or time to access mental health support. In addition, Oliver reported earning a raise at work and the positive impact that having a higher income has had. Specifically, and similarly to Sammi, Oliver spoke about the interaction between income and the ability to engage in hobbies, socialization, and self-care, all of which have had a positive impact on his mental health. He said:

> Because a lot of the mental health resources are not free. I have an EAP [employee assistance program] plan at work where I can get six counselling sessions for free, but if I want to continue after that, I would have to pay, right? Private practice is not cheap for people to run, in which case, it's not cheap for people to access either, right? … When I'm taking ukulele lessons all I'm thinking about is music and enjoying myself and practicing, seeing myself improve, I'm not worried about being trans or I'm not worried about, you know, depression. Same thing when I'm swimming, I'm doing something for my physical health, and my mental health, you know…. So income definitely affects the help you get.

Michelle (a provider participant) also spoke of income interacting with well-being, mental health, and suicidality. Specifically, Michelle spoke how of income, gender, and age can interact with transmisogyny and ageism to create economic instability for older trans women. Michelle shared this aspect of her work in the context of discussing risk factors for hopelessness and suicidality among her clients. She said:

> At this point, because of the Trans Pulse data, but also my observation, when I'm dealing with an older trans woman for example, we're going to be talking about economic security and the fact that the job situation may or may not last. The number of trans women in their 40s or 50s who have *never* found another job [after transitioning] even though they were professionals with impressive CVs—I mean, it's very, very serious transphobia that's out there.

Income was but one intersectional factor that participants spoke of interacting with transition-related care and suicidality. Ability/disability status was also spoken about as an intersectional factor. Collin shared that he has a painful physical disability, which unexpectedly and spontaneously affects his mobility. He went on to explain how his physical disability and mental health difficulties (specifically, depression) interact with each other and with transition-related care. He said:

> I am an immigrant and I am a person of colour…. I am also disabled which impacts my access to care, like pretty much all of the time…. I have [name of physical disability omitted], which makes it pretty difficult for me to walk especially up the stairs or hills…. We're close to [name of health centre removed], which is where I have to go for all of these appointments. Like, that's where I have my counselling appointments, my psychiatrist appointments, my doctor's appointments, and appointments for my hormones. And sometimes walking up the hill is very difficult for me to do, and it has kept me from going to a few of my appointments and I had to reschedule them because some days I wake up and my [body] is just not able to do it…. It usually brings me back at least a week or two, which can be a lot when you are just trying to move forward. One of the days that I missed an appointment that was for getting a paper for my top surgery, I

> was so upset at myself for missing that appointment, like I felt so fucking bad because I missed an appointment that was going to get me closer to my goal. And it was just really difficult and I just stayed in bed all day…. Like, I can always get up. But some days [my body] hurts so bad that I can't do stairs, or I can't do hills, or I can't walk for extended periods of time. But I'm always able to walk across my apartment. When I can't get up it's because of mental health. When I can't get up, it's because depression says "stare at the wall." And then I stare at the wall.

In addition to class/income/social economic status and ability/disability status, religion was also understood by some participants to be an intersectional aspect that plays a role in suicidality. Abby (a provider participant) spoke about the ways that conservative religious backgrounds can interact with trans identities, specifically around shame.

> I think with trans people I've worked with who were raised really religious, I mean conservative religious … there would some moralizing around suicidality. So that would be something that would need to come into play in terms of checking out levels of shame around that, in terms of, well I guess understanding all the different levels of how shame might be put on a person.

Abby (a provider participant) observed that individuals (such as people from conservative religious families, rural areas, or who had been involved in the military) whose intersecting identities had led them to be less exposed to human diversity and difference sometimes presented with high levels of shame around their trans identities. In particular, she noted that some of the trans women she has worked with seemed to have internalized high levels of misogyny if they had been in highly misogynistic environments prior to their transition (and sometimes, currently), which she noted adversely affected their mental health and well-being. Abby said:

> The other thing that I've had to work with people is—and this is trans women mainly—but it's their own internalized sense of misogyny and sexism. And how that may have been connected with their family histories, their own cultural background, their own education levels that play into it.… So that's an interesting and kind of challenging thing to work with people, the people who are wanting to transition to be something that they deem as less worthy.

Abby went on to further nuance her observation about intersectional identities, internalized oppression, and suicidality. She spoke about how she facilitates coping with or healing from internalized oppression in the clinical setting through externalization of that oppression:

> I think they would all play into a person's sense of self-worth, right? And depending on the sense of unchecked internalized racism or internalized transphobia, and/or internalized homophobia, if it's not externalized in terms of really supporting a person in identifying, like these were things that happened *to* you. It's not about who you are, it's about things that happened to you. It's about how things are organized in society, it's about how things are unequal. So there's room in there to kind of mobilize a person towards some kind of political anger and externalized sense of like, this is all toxic. You know, to shift it out of themselves. So in that sense, just in the experience of having things that happen *to you* and identities that are put onto you that you haven't necessarily chosen, in the ways that that can really degrade a person's sense of self-worth. That that would be a consideration in addressing suicidality.

In addition to the intersectional aspects outlined above, age was also considered an important factor with regards to suicidality and transition-related care. For example, while discussing suicidality among her older adults, Mickey (a provider participant) noted that a very small percentage of her older clients were sometimes disappointed with the results of their medical transition as they had been hoping for greater physical and social changes. She said:

> Tandis que chez les personnes plus âgées, 55, 60, 65 ans, je vois plus l'espèce dé-idéalisation de [pause], la désillusion de tout ce que ça voulait dire changer de sexe, la prise des hormones, et là on voit qu'il n'y a pas autant de changement. Au niveau du travail, au niveau d'être bien accepté, des choses comme ça. C'est là qui se disent "j'ai-tu prise la bonne décision ?" Mais pas dans le sens "je regret." Mais plus, "je pensais que c'était mieux" .… Mais ça c'est très minime. Ce n'est pas tout le monde qui fait ça, où pas tous les gens que je vois.

Racial and ethnic identities were also considered to be important intersectional factors when considering the interaction between suicidality and transition-related care. Like all trans participants, Collin was asked to explore his understanding of how/if his intersecting identities interact with him accessing transition-related care and/or his suicidal ideation. Collin replied that as a White-passing, mixed-race, Black immigrant, his intersecting identities indirectly impact his access to care by affecting his mental health. Specifically, he said:

> So it's a little complex because I don't think it affects my transition-related care directly because I am White-passing, so I don't think that medical professionals are treating me any differently than they would a White person just because I look like I'm White. So, like, directly it's not affecting that. But I definitely think it is impacting me, which indirectly impacts my transition-related care, because feeling like you don't belong to any

> group really does add to this sense of hopelessness. And I feel like that part of my identity does definitely add to my suicidal thoughts when they occur. Because I am an immigrant and I am Black, but when I am around Black people they don't see me as one of them, and when I am around White people they don't see me as one of them because I am an immigrant and because I'm not fully White. So I don't actually have a place anywhere, pretty much. Which is weird. It definitely affects my suicidality, but not necessarily the way that I access trans-related care because doctors don't necessarily get to know that I am an immigrant or that I am not White. But it just adds to what I was talking about before, where suicidality affects my ability to access the care that I need.

Michelle (a provider participant) reflected on the ways that intersecting identities of race, gender, and trans identities intersect for trans women of colour, who experience intersectional oppression. In the quote below, Michelle is speaking about this intersectional oppression and underemployment or unemployment, which affects her clients' mental health and suicidality.

> Trans women of color are dealing with misogyny, with racism, and transphobia, and these are huge issues. We didn't even talk about the intersectionality in all of this, but for sure, there's that piece too, in terms of superimposed vulnerabilities. But also let's not forget the superimposed resiliencies and strengths, that's also super important. Of course, of course, give them employment. It's part of the whole society that is going to not employ trans women and even less so trans women of colour. I have clients with CVs—you wouldn't believe the CVs they have, they do something that hardly anybody in the country does—and they can't get a job.

Michelle went on to elaborate on how she attends to the "superimposed vulnerabilities" that trans individuals with intersecting identities experience:

> I mean, more broadly taking into account the additional systemic challenges. For example, if I'm working with a kid of Haitian descent, it's going to be important to pay attention to the cultural particularities that might be influencing how the parents are approaching the issue. It's also important to realize that the child's transition may further marginalize their entire family, isolate them from their extended family and community, in that they don't necessarily have a community at large to turn to, in the same way. Again, it's just multiplying the awareness of the systemic factors. And moving with great care, moving with great care. And just being aware that there are layers of complexity that arise. You know, there's a difference between immigrant families versus families that have been here for five generations too, right? There's all sorts of different intersectional pieces.

Sammi (a provider) spoke about the importance of decreasing social isolation when working with trans clients. However, they observed that intersectional identities sometimes get erased in social situations, particularly for trans people of colour. Sammi said:

> I think it [accessing support groups and making connections] is quite a complicated process because you can be trans or have trans experience and it doesn't mean that you'll become BFFs with every other trans person that you meet. There's all these other factors, like race and class and religion and spirituality and gender and all these other things, but a lot of times that gets oversimplified and the trans experience gets centered. Which makes sense, because that's the thing that the individual is really putting in a lot of effort to

> have exist. But I've worked with racialized trans clients who have a really hard time connecting with White trans folks. And so there are intersectional identities at play.

Sammi went on to explain the psychological impact of their clients' salient identities being erased when trying to connect with other trans individuals:

> The biggest thing that I see is that when an individual feels isolated and is isolated, suicidal ideation increases. So, when we don't feel seen, when we don't feel heard and recognized, when we don't see our personhood reflected in the other, our sense of the worth of our life is questioned. It goes a long way just to see our self in the other, whether that be a counsellor, whether that be your neighbor, your roommate. And so I do think that there's definitely a link between finding people to reflect and validate all aspects of your intersectional identity, whether that be other working-class people, whether that be other racialized people, whether that be other trans people. But for trans folks—and I think it's very similar with any identity—if that's the identity that gets centered, then all the other ones get simplified. And basically, I feel like we need to be seen and heard and recognized for our existence in all the sides that we have, otherwise we feel isolated, we feel alone.

Sammi went on to describe a psychological phenomenon that they had observed in both their clinical and activist work: that of experiencing isolation despite socio-political connection. They linked this observed isolation despite socio-political connection with mental health concerns and suicidality. Sammi said:

> There's an array of identities within the trans experience, and that's actually

> where connection happens. It doesn't happen on the kind of superficial, "you're trans, I'm trans, therefore we're going to automatically feel connected." I think what actually happens—and it gets misconstrued or confused—is there's political alliance, right? There's a socio-political alliance of "we all come together for this political meeting or to pass this law or to fight against this law" but a thing that I've often heard in the activist communities in general is then the protest is over and everybody goes back to their individual lives, goes back to feeling isolated. So you can connect socio-politically, but it doesn't mean that that person sees you, knows you, knows your fears, knows your hopes, or has held you in your vulnerability. All of that is what actually makes us feel connected and that's actually what challenges suicidality and depression and isolation.

Simone (a provider) spoke of salient identities and how she normalizes and externalizes minority clients' experiences of mental health concerns in the broader context of socially-based oppression. She also spoke of how she understands privilege, or lack thereof, impacting clients' ability to access transition-related care and resources in general.

> With trans folks, I often want to normalize their experience with their family, but also the experience of transphobia and how that impacts on their anxiety, their depression, their experience in the world. And that would be the same thing for somebody who's racialized or has a chronic illness, for example. I follow it along as the client brings it. And I think that there are processes of normalizing and situating that are similar across intersections.… I think that one of the ways in which it might play out specifically is the way in which people have a sense

> that they can navigate a system. And that if you look for resources, you might find them. Privilege comes with it the idea that people are going to adapt to you and make things work for you and that there are resources that can be found if you dig for them. So, I might heighten a particular part of the work in terms of being either able to help people work through their anxieties, so their sense of hopelessness of accessing resources. But also just knowing resources, and/or knowing who knows resources, and be able to help people navigate just getting there. And being aware of that.

4.2 Superordinate Theme 2: Factors that Decrease Suicidal Ideation and Behaviour

Factors that decrease suicidality emerged as an important theme across interviews. Trans participants were often directly asked about this topic, in the form of being queried about any person or event that positively or negatively affected their suicidality in the last five years. Provider participants were not directly queried regarding factors they believed to decrease suicidal ideation among trans individuals; however, many of them spontaneously shared several factors during the course of the interview.

4.2.1 Subordinate Theme 2.1: Transition-Related Care Factors that Help Decrease Suicidality

Several trans participants shared that various events and/or people involved in their transition or transition-related care had a positive effect on their suicidal ideation, and thus decreased their ideation in intensity and/or frequency.

4.2.1.1 Subtheme 2.1.1: Gender Identity-Related Realizations and Identity Clarity. Several participants shared that developing greater understanding of and clarity about their gender identity was associated with a decrease in their suicidality. Betty shared that her chronic suicidal ideation abated for several weeks while she was developing clarity regarding her gender identity and she began coming out to others. Betty shared that presenting as herself, a woman, engendered a feeling of happiness and that life was worth living. Specifically, Betty said:

> And then after a couple of months I wore a dress to a work function and [pause], and decided that I *could* be me. That I could be trans. That I could present, and I would, and it was right, and it was good. It felt good. And I was able to face someone who I didn't expect to see me in the dress. And then for a few weeks the ideation was gone. It was part of how I knew I was right. "Oh this is what they meant about life being worth living! This is the way that I thought I would feel when I found the right meds. I would not feel depressed all the time. I would not feel like carrying a weight around or living in a fog, or getting 'the stabbies' all the time," which what I would call my ideation.… I tried to forget about "the stabbies" with weed and alcohol and video games, and that didn't help. But coming out did. And I knew I wanted to transition.

At the time of the interview, Betty shared that she had had an emotionally-difficult month and that the recently observed Trans Day of Remembrance had taken a toll on her well-being. While discussing her current suicidal ideation, she shared that it was a very different experience compared to her previous ideation, in that she now has clarity around her identity, wants to live, and feels hopeful about her future.

> I can see it more. And take a step back from it almost, because I'm a person now. I was depression before, is sort of how it felt. And there was no sense that I would get better, because I didn't know what was wrong with me and I tried a bunch of meds. Nothing was wrong with me, but I thought something was.… I can step out of it. And I *do* have a future. So it's worth dealing with. I can say "I have this depression and I will come out of it at some point." Before, it was "maybe I'll come out of it at some point but who cares? I

> don’t have a life, there’s no point.” But now, now I feel like there’s a future worth getting to.… I can see the ideation in a different way now and I’m motivated to do something about it in a new way. Not just so that it will stop, but because life is worth living now.

Devon reflected on how several factors helped decrease their suicidal ideation, including learning about non-binary gender identities; exploring their own gender identity; coming to the realization that they are non-binary; gradually accepting their non-binary identity; participating in a trans-specific community support group; and starting to access transition-related care at a local community health clinic (including meeting with a health care professional in preparation for hormone therapy). They simultaneously spoke of how identifying their gender dysphoria was part of this process and has allowed them to work towards decreasing the dysphoria, which has helped them decrease their suicidal ideation. For example, Devon said:

> I’ve been doing a lot of work on the mental health piece and working on defining my identity and figuring out how it fits and what it means, and do I really want to go forward with different aspects of transition, and what I do and don’t want. And finding some clarity on that has actually made me feel less suicidal and more like someone who belongs in the world, actually. I did [name of community-based program omitted], and that was very good for forming community and finding other people who were in the same stage of exploration of their gender as I am. So there’s the building of community, but there’s also becoming more aware and more knowledgeable and more sure that this is a thing I can do, which I think is really important because the mainstream narrative around transness is pretty alienating.

Devon also spoke of a decrease in their suicidal ideation when they experienced clarity and self-acceptance regarding their gender identity, and clarity regarding possible transition-related steps they could take:

> For such a long time I had been trying to deal with this depression and this suicidality, and it was like building a puzzle with only some of the pieces. And now the missing pieces are starting to fall into place and you become more able to see the picture. I think that really helped with the suicidality because before I didn't have the words to describe what I was experiencing or even the concepts. The concept of not being any gender was something I had never heard before a certain point of my life, and the idea that I could do that and be that, or that I could be genderfluid and I could move around. If you don't have the concept to be able to understand that, and you are trying to understand why you don't feel like you fit in the world, and the world is so heavily gendered but you don't really have the concept that there could be another way of doing things, then it's really hard to address. It's hard to address a reason for being suicidal when you don't even know that it exists. It's just in the air you breathe, it's just everywhere.

Like Betty, Devon explained that they still sometimes experience symptoms of depression and suicidal ideation, and like Betty, they explained that having a clear sense of their gender and a grounding in that understanding helps them feel like their distress is much more manageable. Devon said:

> But even just the ability to know what is going on, to be able to identify, to be able to put a name to "here's why I'm feeling uncomfortable in this situation", or "here's why I don't feel like I fit right now," even just being able to name it is a really big comfort that I think helps with the—you know, even when I'm going through a hard thing, if I know what I'm going through, it feels less hopeless. It can still be difficult, but if I don't feel hopeless, then I don't feel suicidal. I get suicidal when I feel like there's no future for me,

> when I feel like I don’t have a place in the world. And being able to apply these understandings of gender to my life makes me feel more like I have a place in the world.… I mean, there’s still times that feel hopeless, but it’s less. And it’s more likely that if something is difficult for me, it’s less likely to tip over into suicidality. I’m more able to have negative feelings without taking it all the way to 11 and seeing it as “I shouldn’t exist in the world.”

4.2.1.2 Subtheme 2.1.2: Having Access to Information Regarding Transition-Related Care and Next Steps. Several participants, trans and provider alike, spoke of the importance of readily available information regarding transition-related care, including expectations and timelines. Devon, a trans person, shared the following:

> So even not actually having accessed the testosterone injections or anything like that yet, just having been given the information.… [The positive impacts include] not feeling so lost. Feeling like there’s this information here and I can get a handle on what I’m feeling and I can make sense of it. And that there are options beyond just suffering with it, you know? When you feel like your body is in misalignment with your mind and with how you see yourself, there’s this sense of “but there’s nothing I can do about it, I’m kind of stuck with it,” and then going into this medical place and you are not stuck with it anymore. You know, there are ways that you can change or try different things. And people *care*. And I think that’s a really big thing.

Rose, a trans person, also shared that having information regarding transition-related care steps and timelines helps reduce her suicidal ideation. She explained that information helps decrease the unknown aspects of her transition-related care, which decreases her anxiety and helps her have a sense of control:

> I think some of the people at [name of health care centre omitted] definitely helped a lot with [my suicidal ideation]. [Name of provider omitted] especially, because he was really good about giving me all the information about transition-related care and hormone therapy. So I was able to have all that information and look through all the protocols and guidelines. And being able to have all that information helped me to understand how my transition was going and it took away a lot of that uncertainty. I think that helped.… I think a lot of the anxiety and suicidal ideation comes from uncertainty and not knowing what would happen and also worrying about not being able to access care and being gatekept. And having access to all that information and being able to know exactly what would happen and the timelines, all of the steps required in order to access hormone therapy or to access surgery or do all the legal name change stuff, it just helped me to plan stuff out, which I think just decreased a lot of anxiety and helped me feel in control.… [Feeling like I'm in control] helps with anxiety because if I'm uncertain about what's going to happen or whether I'll be able to access something or not, then that just means that my mind can jump to the worst conclusions and just catastrophize. And that can cause a lot of anxiety. But having all that information helps me to not do that and to be able to see in concrete terms exactly what is going to happen and when that's going to happen. And that helps a lot.

Several provider participants also spoke of the importance of providing clients with information pertaining to transition-related care, in part to decrease the anxiety that is understandable and common when one is undertaking a major life change such as transitioning. Gwen, a mental health care provider, explained the importance of providing information while talking about how she makes referrals to medical care providers who can provide hormone therapy for her trans clients:

> I say "I'd highly recommend this specific endocrinologist, I know they follow the WPATH standards of care. I know you've been able to read over these standards so you'll know what they're expecting." And I say, "however, there are also other endocrinologists you can see as well" and I will list out alternatives for the individual. I do not like to only give one, I want to make it the client's choice based on the information that I know about the practitioners involved. But I feel like I have confidence in the clinician if they are following something like the WPATH standards of care, because I know what approach they're likely taking and I know what criteria they're wanting my client to meet. I can discuss that with my client ahead of time, so it reduces surprises and it reduces anxiety and worry about interacting with that professional.… I think that transparency reduces the anxiety. Knowing ahead of time what they're getting into, I think that helps and makes them feel less like they have to go through gatekeepers and more like they're working with people who have their back and want to help them succeed in life.… I think with transparency, it means more information, and with more information, you feel more at ease moving forward. It's the unknowns in life that cause the stress and worry and the anxiety, and if you can try to reduce that as much as possible, it just makes the transition easier to take those steps forward.

4.2.1.3 Subtheme 2.1.3: Access to Transition-Related Care (Including Personalized Transition-Related Care). The majority of trans participants spoke of the positive effect that transition-related care had on their suicidal ideation, often times decreasing it in frequency and/or intensity. Collin explained that having access to transition-related care felt like he was moving forward in his transition and thus decreased his ideation. He said:

> I think I was good and, like, didn’t want to die for the first three months I was on T [testosterone] just because I was really happy that I was going somewhere…. Yeah, just going forward in my transition. It was nice, I felt like I was taking concrete steps towards becoming who I am supposed to be. Which is really nice.

Betty shared that the following factors having to do with transition-related care helped decrease her suicidal ideation:

> The first time I went in to see the transition doctor, awesome. You know, somebody who has experience, breaks out the informed consent form, says “we are going to get your hormone therapy, no problem.” He would have prescribed Spiro that day if I hadn’t wanted to do fertility preservation first. And so that had a really positive effect on me, like “ok, we are going to do it, this is a thing that we do, let’s do it.” Yeah. That had a positive effect. Just the doctor being confident in me, recognizing me as an expert in who I am, and recognizing that transition helps.… So that kept up the lack of suicidal ideation and had a positive effect. Him eventually prescribing [hormone therapy] helped my ideation in a positive way. Getting that prescription, oh my god, absolutely.

Betty elaborated on the above by explaining that her ideation has been positively impacted by hormone therapy, both the psychological effects of beginning hormone therapy being such as feeling relief, and the physical effects of it. She said:

> Once [my doctor] agreed to do hormone therapy, it [suicidal ideation] went down. Yeah, it went down.… It was such a relief to know that I was going to do it without having to wait, I could take my Spiro that day, I could go right now. I almost cried at the pharmacist’s, how amazing it was, how big of a step in my life, how I was finally going to be able to do it. I was going to get what I wanted, what I needed. And it was such a

> relief. And yeah, I felt better, the ideation went down. And then when I took the Spiro, it was strange to notice the physical changes as they happened…. This is another thing about the care interacting with the ideation: I was really kind of strangely scared when [pause]. It was hard to leave the house when I realized my skin was getting softer and when the hair started coming out from laser. It was strange, it was a strange experience. I don't know how strongly I associate it with ideation but maybe a little more because of a weird sense of "oh, what is this feeling? I'm scared, I don't know what's going to happen. Am I not really trans because I'm not ecstatic?" But then as soon as I got the estrogen, I felt so much better. And the ideation went down. It felt like something that the doctors couldn't explain as an effect. It feels like my body really is supposed to be running on estrogen somehow. And this happiness that I felt, this sense of rightness that I felt immediately when I started the estrogen, they couldn't predict that for me. They could describe the physical changes and they could describe the potential side-effects. They described mood swings, and mood swings aren't a side effect actually, I think for me they are a desired effect. Because once you get stuck in this dead zone of suicidality, this rut that I couldn't get out of, banging my head against a wall. And then with estrogen I would still get that way sometimes, and my mood would change! And I could actually feel happy sometimes. Like actually happy! So that decreased the frequency [of suicidal ideation].

Nomi shared how access to personalized transition-related care helped decreased her suicidal ideation. Nomi experienced negative side effects of the anti-androgen medication she was taking, which negatively impacted her suicidal ideation. Specifically, she experienced symptoms of depression, including suicidal ideation, that lasted for the duration of the time she was on anti-androgen medication. She explained that she experienced a drastic decrease in suicidal ideation when she was finally able to have an orchiectomy and thus stop taking anti-androgen medication, and then another decrease in suicidal ideation when she was able to legally change her name and gender marker on her documentation.

> Je m'étais retrouvé dans une situation où je n'avais plus d'androcur, donc je filais déjà mieux. Parce que moi l'androcur ça ne me faisait vraiment pas. Ça faisait cinq ans que j'en prenais peut-être ou plus, donc ça m'a vraiment aidé d'arrêter ça. J'ai pu enfin respirer, malgré que le côté papier n'était pas réglé. Mais ça m'aidait quand même pour pouvoir arrêter de me battre entre les antidépresseurs, les l'androcur, et toute la chimie dans le corps qui virait complètement débile.… Quand j'ai arrêté l'androcur, ça a fait du bien en maudit!

Nomi also experienced a decrease in suicidal ideation following a physician adjusting her hormone therapy prescription. She had been seeking this adjustment for quite some time, however her family doctor was not very familiar or comfortable with hormone therapy for trans individuals and was unwilling or unable to make the adjustment to her prescribed hormones. Nomi left this family doctor's care and sought care from a family doctor who specialized in trans care, who adjusted Nomi's hormone therapy. Nomi mentioned that the change in care provider and subsequent adjustment to her prescribed hormones helped tremendously, as did eventually being able to get her legal name and gender marker changed on her documents. Specifically, she said:

> Fait que j'ai dû changer de médecin de famille à cause de ça. Fait que j'ai eu de la chance encore une fois, j'ai toujours été bien 'timé' dans les affaires, d'appeler à la clinique, il y avait une clinique en ville à Montréal qui avait ouvert qui fait le traitement spécial pour les

> sidéens, les toxicomanes, et il y avait trans aussi, puis d'aller là puis de tomber sur un médecin de famille qui connait ça. Bien en fait, elle s'y connait parce qu'elle s'y intéresse, donc elle se ramasse avec juste des cas comme ça, fait qu'elle finit par connaitre ce qui se passe. Fait que j'ai eu de la chance d'avoir un médecin de famille qui sait quoi faire de nous autres. Donc c'est pour ça l'importance d'avoir des médecins, même si c'est très rare comme cas, qui savent quoi faire. Parce que veut, veut pas, jouer avec les hormones, ça joue sur le moral beaucoup. Parce que quand on perd la testostérone et on gagne l'estrogène et qu'on vient dépressif puis tu n'es pas habitué à l'émotivité féminine, ça n'aide pas beaucoup non plus. Fait que c'est pour ça que j'ai été chanceuse de me retrouver avec une bonne médecine de famille qui comprend ça puis qui m'a suivi depuis. Ça va beaucoup mieux aussi de ce côté-là parce qu'on a pu ajuster le dosage un peu plus parce qu'elle avait moins peur de le faire parce qu'elle avait les bonnes connaissances. Et ça m'a permis de pouvoir justement calmer les choses encore plus. Fait que oui les papiers m'ont aidé beaucoup, mais du côté hormonal et autre, aussi c'est important d'écouter les patients.

4.2.1.4 Subtheme 2.1.4: Bodily Autonomy and Gender Self-Determination. Nomi spoke of the psychological impact of bodily autonomy once her providers worked with her to deliver and/or approve personalized transition-related care. Specifically, she had been seeking an orchiectomy without a vaginoplasty for several years due to the severe impairment to her wellbeing and functioning that she experienced as a side effect of androgen-blockers. She was eventually able to obtain this personalized transition-related care. She explained that the positive psychological impacts of bodily autonomy included self-respect, and being able to make a true informed-consent decision regarding an eventual vaginoplasty instead of feeling forced into that particular surgery when she did not want/was not ready for one. Nomi said:

> La chose la plus facile dans tout mon parcours, ça a été quand on a commencé à me laisser tranquille puis à juste m'écouter. C'est là que ça a bien été. [Quand j'ai eu] l'autonomie de dire—faut que la personne soit capable de faire ces décisions elle-même, c'est pour ça que le suivi psychologique, moi je le considère important. Pas parce que de façon légale, mais de façon personnelle, où il y a des gens qui l'ont eu pas mal plus difficile que moi la transition, étrangement—Quand on m'a laissé aller parce que je savais ce que je voulais et je n'étais pas du genre à me mentir à moi-même. Quand je dis "je ne vais pas bien," je ne vais pas bien. Puis quand je dis "ça va bien," ça va bien. Puis quand je dis "c'est ça je veux," c'est ça je veux. Je ne me mens pas à moi-même pour essayer d'obtenir quelque chose d'autre, non, j'essaie d'être le plus honnête possible. Fait que c'est quand on m'a laissé tranquille avec tout ça, c'est là que "ahhh" [loud exhale]. Là j'avais enfin l'espèce de reconnaissance de tout le monde que je savais ce que je voulais puis qu'on pouvait me laisser tranquille. Et quand je le demandais, on me donnait, puis je le faisais, et ça allait bien. Fait que c'était la grosse différence entre les deux situations.… C'est là que j'ai senti la différence entre les deux situations. On a finalement compris qu'on me fait confiance puis là c'était vraiment le paradis parce que j'ai fait ce que je voulais, quand je voulais, comme je le voulais, dans le sens que je le voulais. Puis aujourd'hui ça fait [quelque années], ma vie va bien. Je n'ai pas de problèmes dues à ma transition, ou a des conséquences négatives de la médication, peu importe. De ce côté-là ça va bien parce que j'ai su me respecter moi-même.

Devon also spoke of the positive psychological impact of bodily autonomy and gender self-determination on their suicidal ideation. Devon shared:

> I think relief would be probably the emotion word that comes to mind first, but also

> validation. This sense that what you are saying matters and what you want for your own goddamn body matters, you know? And the sense that it's not someone on the outside saying "oh you say that, but I know what's best for you," which is really infantilising. But at this clinic they are saying "you know your body, you know your mind, and you know what you want so it's not my place to come in here and say 'you don't really want that, you can't have that.'" It's this sense of being taken seriously.… So relief that I can do what I want with my body. Relief that everybody has been telling me I can't, but it turns out that I can, and oh thank god.

Devon continued exploring the theme of the positive psychological impact of bodily autonomy and gender self-determination. They said:

> And just being able to access somebody who thinks that you are capable of making decisions about your own body. I think another narrative that's really prevalent in the media about trans people is this idea of "what if you regret it?" And somebody saying "no, we trust that you are going to do what you want, and I don't know if will you regret it, I guess we'll deal with that bridge when we come to it, but we trust that you have the capacity to deal with that too," and "this is your life and you get to make decisions." And that—especially the way it interacts with having had a very controlling upbringing and a very controlling family—I think that makes it even more of a relief and even more of a validation because I'm unused to having the opportunity to make decisions for myself and not have somebody overrule them.… There's this sense that just like, well if I get to decide, then that means that I can do *whatever*. And it just kind of spills over in every area of your life, you know? It's like, it's a sense of freedom.… Possibility and freedom. It spills over into every area of your life. Because there are all these areas where you are

> feeling blocked and you are not able to do things. I can’t find a job in my field. Ok, but I could start an Etsy store. I could write a novel. There’s just this sense of “you get to decide.” There’s no *have to* here, there’s no *should* here, you just get to figure it out. It’s the difference between being a kid and having a coloring book in front of you and having to color within the lines versus having a piece of paper and you can draw whatever you want. And that can be a little scary because it’s like, “if I can draw anything, what am I going to draw?” That’s a little scary. But it’s also *very, very* freeing. Because it means that you have stopped having the lines that society has set out for you, and now your responsibility is to dig into yourself and find your unique picture and what you want to draw. And there’s this sense that what I draw would matter. That internal sense of who I am and my internal authenticity is important, and is more important than fitting in, or going along to get along, or managing other people’s reactions. It’s just like, “no, your truth is important.”

4.2.1.5 Subtheme 2.1.5: Hopelessness Turns to Hope in Therapy. Provider participants shared that they had observed a decrease in suicidality among their clients at the outset of therapy, sometimes in the form of observable feelings of relief and hope. George stated:

> In general, suicidal ideation tends to be a result of feeling trapped and cornered and without options, and feeling like the future is bleak and there’s no hope and it’s better to end it than continuing to suffer this way. And so when a person ends up in therapy or decides to come to therapy, there’s already a change process initiated in some way for most people. I mean, some people come in suicidal and they’re suicidal and that’s it, and it takes a long time to work with them. But trans suicidality is—there’s all kinds of variance—but suicidality related specifically to the transition issues or gender identity

> issues tend to open up at that point. When they come to therapy, they're like "okay, there's something I can do about this, there's a process I can engage in" and there's a sense of hopefulness.

Mickey shared a similar observation regarding a decrease in suicidality among her trans clients due to hope related to accessing supportive trans-affirmative psychotherapy and beginning to consider taking steps to alleviates one's suffering. She also shared that she has often seen her youth clients' suicidal ideation decrease at the outset of therapy due to having the support of at least one parent and herself, a specialist:

> Je crois qu'ils ont la confiance et ils se disent "là je suis suivi par une spécialiste qui peut m'aider," et il y a un des deux parents souvent qui disent "oui, oui moi je vais t'appuyer dans ton cheminement." C'est sûr que là ça va mieux. Même s'il y a un des parents qui s'oppose, le fait qu'il y en a un plus le spécialiste, on dirait que ça leur donne espoir et ils ne pensent plus au suicide comme tel, comme solution.

Sophia shared that she has also observed clients' suffering decrease due to her helping them with what feels impossible:

> With trans clients, most often suicidal ideation is directly related to the impossibility of their transness—what feels like impossibility. So talking about that, about the ways that it's not impossible, and the ways they can access the things that they need is [pause], I've seen people change and be so relieved in front of me when they realize that I'm actually going to help them with that stuff.

4.2.1.6 Subtheme 2.1.6: Other Transition-Related Care Factors that Decrease Suicidality. Trans participants shared numerous other factors linked to transition-related care that helped alleviate some of their suicidal ideation. Rose said that "the suicidal ideation is helped by being able to access services in a reasonable time," as well as likely being helped by the hormone therapy. Patricia shared that a family doctor's client-centered and affirmative approach helped her feel cared for, and worthy of that care, which alleviated some of her suicidal ideation. She also shared that this doctor helped her access slightly more monthly funds through social assistance, via suggesting this option and completing the paperwork in support of this option. Betty, Rose, and Patricia shared that working with trans-affirmative and knowledgeable therapists had a positive impact on their well-being and helped decrease their ideation. Rose shared that the psychotherapy she participated in helped her develop self-acceptance. Rose said:

> And for a lot of that time I was also seeing a therapist who was really good. I think seeing her and doing a lot of talk therapy also helped a lot and helped me unpack a lot of feelings that I was going through and get to a place where I was better able to accept myself. So I found that really, really helpful as well.… She definitely helped me get through a lot of that, just through her being really affirming and me being able to explore that in a safe environment.

4.2.2 Subordinate Theme 2.2: Non-Transition-Related Care Factors that Decrease Suicidal Ideation

Participants spoke about a variety of factors not related to transition-related care that also helped increase their well-being and decrease their suicidal ideation. It should be noted that the following is far from exhaustive, as the focus of the research project and thus the interviews was on transition-related care, and non-transition-related care factors were not queried directly. Thus, the results below were spontaneously shared by participants.

4.2.2.1 Subtheme 2.2.1: Broadening Social Networks and Social Support. Almost all trans participants spoke of the importance of social support with regards to their well-being and mental health. Oliver spoke of not only how his relationship with his mother was a suicide protective factor, but also how the support he received from her and others such as his friends and primary care team were important to his wellbeing. He spoke of how he considered himself to be "one of the lucky people" because he had support. Rose also spoke of the importance of social support to her mental health, in a quote seen later where she describes making queer friends in an academic setting after leaving an unsupportive work environment. Nomi also spoke of how social support was a suicide protective factor: she described how lucky she felt to have a close friend check on her regularly when she was experiencing high levels of suicidal ideation. She also spoke of the support she received from a group of colleagues who came together to write a letter of support for her to help her petition for the care she needed and was being denied. Devon spoke of their transition-related care provider being "an ambassador" for a welcoming trans community and finding what they call a "queer pocket universe" in which they reported feeling like they belonged and were accepted. Betty spoke of the love and acceptance that she received from her girlfriend and friends, and how important this was to her well-being:

> I have a girlfriend and she sees me, real me, and she likes my body how it is and will like it if it changes too. And I really believe those things, and that's amazing. And I visited friends over the last weekend, and they were really great. I still have good friends. I still have good people in my life who make me happy. And who want to see me, who value me as a friend. And who do accept me too. Yeah. Who see Betty.… I really get to be me. I really do, and I will survive. And love and support and acceptance—I have them.

Several provider participants spoke of the importance of helping their clients develop or deepen their social support networks and connections with others. For example, Sammi spoke of how they help clients break social isolation and George spoke of how he will explore social support and encourage clients to develop or deepen their social connections, if need be. George shared that he takes this approach “Because it’s lonely. The medical process is completely void of any emotional support.” One of the thoughts he shared when speaking about this topic was: “you don’t transition alone, and if you do, it’s dangerous.” Julie repeatedly emphasized the importance in her work of helping clients develop or broaden their social network and ability to access social support. She shared that she understands this to be an essential part of working with trans individuals who are experiencing suicidal ideation, particularly if they are coming out to themselves and others and contemplating social and/or medical transitions. Julie explained that she strongly encourages social connection in order to help her clients decrease their isolation and expose them to “possibility models” when transitioning seem impossible. Julie shared that she will suggest that her clients attend trans community groups and drop-in programming, and will describe these options and the employees and volunteers that run these programs to her clients in a reassuring way in order to decrease her clients’ apprehension and ambivalence about attending. She viewed this intervention as a suicide prevention intervention, among other things. Julie said:

> Je ne peux pas toute faire, moi je suis juste ici quelques heures dans la vie de la personne. C’est pour ça que je disais quand les gens commencent la transition, j’essaye des envoyer à [name of community centre omited].… J’essaye des envoyer pour qu’ils puissent créer des liens puis des réseaux. Parce qu’ils ne vont pas me téléphoner à 11 heures le soir, c’est sûr. C’est normal, ce n’est pas mon mandat non-plus. Mais ils vont peut-être appeler leur ami(e)s qu’ils ont rencontré à [name of community centre omited]. C’est ça qui est important pour eux, de créer le réseau de support.

4.2.2.2 Subtheme 2.2.2: Other Non-Transition-Related Care Factors that Decreased Suicidality. Betty shared that the Trans Lifeline, a dedicated suicide prevention hotline run by and for trans individuals, helped her: “Trans Lifeline impacted [my suicidal ideation] positively for sure. There was a trans person who said that she doesn’t hate the person she sees in the mirror anymore. And so I thought it was possible.” Rose shared that the health centre she accesses for transition-related care had a positive impact on her well-being in many ways, including practices that helped decrease her anxiety related to accessing transition-related care, such as using the correct name and pronouns. She stated:

> And I should also say that at [name of health care centre omitted] they are good about making sure to use people’s preferred names and pronouns and just being really affirming of trans people. I think seeing that very early in transition was really helpful and helped dispel some of that fear around accessing services.

Rose explained that having a supportive psychiatrist at the academic institution that she attends has been helpful:

> I think also my psychiatrist helped because more recently, while I’ve been in school. I’ve sometimes had anxiety and suicidal ideation related to school stuff but I found that him being willing to like help me get accommodations and getting letters from him so I didn’t have to miss assignments, I was able to reschedule tests and stuff like that. I think that helped as well, as just knowing that that was there and knowing that is something I can access if I need to, I think that helps a lot with my mental health. Just knowing that if I do have a really bad day and I do have a panic attack and I miss a test or something on those lines, and stuff like that has happened in the past, I’ve been able to take care of it and it’s been ok.

Nomi explained that hope and perseverance helped her cope with her suicidal ideation, and that she often encourages others who are feeling hopeless with the saying “all it takes is one spark to light a forest fire.” She said:

> Mais par contre quand je vois quelqu’un qui a de la difficulté, souvent je leur dit maintenant comme expression “oui c’est difficile où tu es présentement, mais ça prend juste un étincelle pour brûler une forêt au complet.” Fait que c’est un petit geste dans ta situation présente, même le plus petit qui soit, il peut faire toute la différence et changer toute la situation au complet, c’est ça que je veux dire par là. Même si t’es plus capable, t’es fatigué, t’es tanné, des fois c’est juste faire un appel téléphonique ça fait toute la différence. Donc c’est pour ça que je dis aux gens “la plus petite étincelle peut brûler une forêt au complet,” ça ne prend pas grand-chose des fois. Ça a été un téléphone au bon médecin qui m’a donné les bonnes choses que j’avais besoin, après ça, ça a été la bonne avocate qui m’a permis de régler d’autres problèmes. Après ça c’était toujours un petit pas à la fois avec pas beaucoup d’énergie, mais en bout de ligne, ça a fini par tout corriger mes situations puis me sortir de là pareil… Ça a été la totalité des choses qui ont fait que la situation s’est réglée. Je suis sortie de là depuis ce temps-là, puis ça va bien. Il n’y en a pas de problèmes.… À moment donné, bien le feu a pris puis ça s’est réglé.… La persévérance et tout, c’est primordial.… Fait qu’il ne faut pas lâcher, c’est sûr, sûr, sûr. Et c’est pour ça que l’étincelle qui met le feu de forêt ça fait toute une différence dans ces situations-là.

Nomi elaborated on the importance of hope and perseverance by sharing the following:

> Souvent on dit “le suicide c’est une solution permanente à un problème temporaire,” mais c’était le cas. C’est difficile de le voir pendant qu’on est dedans, mais une fois que c’est passé, c’est vrai. Ce n’est pas un mensonge, c’est vraiment comme ça. Dans le moment présent c’est toujours difficile. Même s’il y a des gens qui nous entourent, souvent ce

> n’est pas ça qui va nous aider, c’est que le problème se règle. Mais souvent, le problème ce n’est pas toujours évident de le régler. C’est pour ça qu’il ne faut pas lâcher puis continuer, malgré tout.

Oliver shared that his relationship with his mother had been a suicide protective factor during his post-surgery suicidal ideation:

> But then on the positive side, having my mom there to help me take care of things impacted in a good way, right?. Because it wasn’t always like that. My first few surgeries I did on my own. And when I told her I was trans, it was really bad. And we didn’t have a good relationship. But then she didn’t want me to go to [name of country omitted] by myself [for surgery], so she came with me because she was scared. And that was a huge turning point in the relationship. So I think probably without her, my suicidal thoughts and stuff would have been far worse. I can’t imagine having gone through all that alone.

Oliver shared that the relationship with his mother continued to be a reason for living at the time of the interview:

> I don’t think I can do that to my mother. She told me once that if something happened to me, it would destroy her life, so I kind of made that promise to myself that I would live for her.… Because I wouldn’t want to die knowing that I was destroying her life, right?

Rose reflected on the decrease in suicidal ideation that she experienced with a change of environments, which allowed her to come out, experience gender affirmation (including name change), and create supportive friendships with fellow queer people. Rose said:

> It [suicidal ideation] was present a lot of the time during that year where I was working. And then as soon as I left that job, my mental health became a lot better because I was no longer presenting as male and because I wasn’t constantly getting misgendered and

> because at [name of academic institution omitted] I was able to get all of my ID and name changes and stuff done on student cards and in the computers. Also being at [name of academic institution omitted], I was able to make new friends and connect with other queer people and there were more events and more opportunities to socialize with other queer people, which I found really helpful.… After I quit that job and became a student, it definitely got better and I had a lot less suicidal ideation, generally. And before that, suicidal ideation and low mood in general was almost an everyday thing and that definitely changed when I started going to school. I still had bad days and there would occasionally still be some thoughts of suicide if I'd like had a really bad, stressful day, but that was maybe once or twice a month instead of constant.

4.3 Superordinate Theme 3: Clinical Work with Trans Individuals

Provider participants were asked to speak about their clinical work with trans individuals, with an emphasis on their work delivering or approving transition-related care while working with clients experiencing suicidal ideation and/or behaviour. Four subordinate themes were identified and will be explained in detail below.

4.3.1 Subordinate Theme 3.1: Is Suicidality a Contraindication to Transition-Related Care?

Providers were asked directly whether they consider suicidality to be a contraindication to transition-related care. As an oversight, only providers were asked this question. This writer realized after all of the interviews were completed that it would have been valuable to have asked this question when interviewing trans participants as well, in order to hear their thoughts on the subject. Three subthemes were identified in provider participants' responses, as outlined below.

4.3.1.1 Subtheme 3.1.1: Suicidality is Not a Contraindication to Transition-Related Care. The majority of provider participants shared that they did not consider suicidal ideation to be a contraindication to transition-related care, and most of them did so with certainty and emphatically. For example, when queried directly whether suicidality was considered to be a contraindication to transition-related care, Sophia explained “For me, no. I don’t think that it is. And I make that very clear with my clients.” Maxime responded to the same question by explaining that they treat the person’s suicidality and mental health concern(s), if present, in parallel to delivering transition-related care. They said:

> Non, absolument pas. Ça peut un peu changer les choses dans le traitement médical ça c’est sûr, mais c’est pas une contrindication.… Ce que moi j’interprète des lignes directrices c’est s’il y a des comorbidités psychologiques, c’est traité en parallèle, tous les aspects. Donc si la personne présente énormément d’anxiété ou de dépression, n’importe quels symptômes, stress post-traumatique, dépersonnalisation, c’est des aspects à prendre en compte et adresser, pas nécessairement avec de la médication, mais à adresser en parallèle avec les démarches pour commencer la transition. Il y a des gens qui, parce qu’ils ont l’anxiété, la dépression, ou autres troubles, ou vivent une situation qui est moins stable, qui vont préférer commencer d’une façon un peu plus graduel par exemple, et en général c’est leur choix. Il n’y a pas une dose pour tous.

Some providers suggested individualizing transition-related care if the client would be put at risk by moving forward with non-individualized transition-related care. Some providers who sometimes took this course of action emphasized that they did not deny or postpone access to or delivery of transition-related care, but rather that they individualized transition-related care while helping clients address social determinants of health that put them at great risk. For example, when asked if she considers suicidality to be a contraindication to transition-related care, Michelle was observed to think out loud while she speaking about her work with trans youth who are old enough to access and consent to care. Through her answer, we see her first say she will slow the process down if needed, but then she realizes later in her answer that rather than slowing down or postponing the process, she will develop an individualized care plan with clients who would benefit from it. She said:

> Of course not. Well no [pause], not suicidality. Well, let me think [pause] has that ever—well no.… Now, where I see slowing down a bit is if it's a youth and the family's putting tremendous pressure and the youth is very dependent on the family member, and is at risk if they move forward with blockers and/or hormones, then it means basically they're going to land in the streets in the next five minutes, right? So that's what I need to assess is what the objective risk factors are and … how can they be dealt with directly? So if it's access to school, access to housing, access to basic food and shelter, if they're at risk for being kicked out of their house … can we talk about moving to their aunt's place, you know, are there alternatives? I mean, I would say ultimately the client decides. I've never had a client say "what are you talking about? I want to start my hormones even if it means that my mother kicks me out next week." I've never had somebody say that. And I've acted quickly "so let's get your mom in, let's get your parents in right away. Let's have that discussion, okay? … I'll see you guys together, and let's move this forward so you're not at risk of getting kicked out." If the parents refuse to meet with me and are completely closed, then I will start to set up with [the youth] an alternative living situation. Because it's not going to help anything if they come home with their hormones and they're in the street 5 minutes later, it's not going to be helpful to them…. But the thing is, it takes forever to get hormones and so it's really rarely an issue, because I'll say "Well, let's call the doctor, let's get the appointment going at the same time," because it's

> going to be months before they're on hormones, right? … Oftentimes, now that I'm thinking about it, I won't postpone anything, on the contrary, we'll move forward but maybe just blockers to begin with, right? "So if we start the testosterone, this is what's going to happen and what I'm suggesting because I'm sensing that your parents *can* be mobilized here, why don't we gain a little time, we'll put you on the blockers and that's one shot a month, and … let's in the meantime see if we can set up some meetings with your parents and try and move them forwards. So by the time we start the hormones, you know, they'll be on board. Or can we do low dose?" So the doctors will do low dose just to start the thing.

Like many other providers, Sophia shared that she does not consider suicidality a contraindication to transition-related care. She elaborated by sharing a hypothetical situation in which she may want to consult other mental health care providers:

> For me, no. I don't think that it is. And I make that very clear with my clients [pause]. This being said, I have not had somebody who is attempting suicide on a regular basis, who's trying to access transition-related care. So I would definitely want to consult with other mental—I would want this person to be being seen by other mental health professionals. I would not want to be alone, but I would become advocate-therapist in that sense of like, this person does need to be on this path of trans-related care, and is taking a bottle of pills every two weeks and ending up in the hospital. I would be wanting to consult with other mental health professionals about that kind of a case, but I haven't had that kind of a case.

4.3.1.2 Subtheme 3.1.2: Transition-Related Care is Often Part of the Treatment for Suicidality. Not only did the majority of provider participants share that they did not consider suicidality to be a contraindication to transition-related care (as seen above), but they also shared that they consider suicidality to be the opposite of a contraindication. More specifically, they shared that they understand suicidality to be an indication of a person’s suffering and that if that suffering is related to dysphoria (and the person is seeking transition-related care), then transition-related care is part of the treatment for suicidality. Simone stated the following: “Transitioning—if someone wants to transition and is feeling suicidal—then transition is one of the best things that you can do to treat suicidality.” Michelle shared similar thoughts: “Transition-related care is what gets people away from the brink, it’s what gets them hopeful that things will change. If the suicidal feelings are largely caused by the dysphoria, then transition is the solution.”

When asked what informed their understanding of transition-related care as being part of the treatment for suicidality, provider participants shared that in addition to being aware of the literature that shows this to be the case, they had consistently seen transition-related care alleviate suicidality in their clinical work. For example, Sophia shared:

> I’ve got the longer-term clients that I would see weekly, who were suicidal [pause]. And without exception, in all of those cases, the closer they moved in the direction of being able to present in their gender identity, the less suicidal they were, and generally the better their lives were becoming. So supporting them on that was addressing the suicidality.
>
> When asked to elaborate, Sophia stated:
>
> I’ve just seen people’s lives get good. They’re suddenly, you know—someone who thought for sure they wouldn’t live past [a certain age], is getting married and is becoming a parent and having a fabulous career. That’s one of my first regular suicidal

> ideation clients who's a trans guy, who's now living as a [profession omitted] and is a dad and is happy. And he wasn't going to live past [a certain age] according to him.… He's just a close-to-my-heart early example, but there've been so many examples of people whose lives I've just seen get better. Their depression symptoms lessen, their anxiety symptoms lessen, their suicidal ideation goes away, in most cases. Their relationships become more fulfilling, and their educational and professional lives open up. I've seen that many, many times too. Where I've seen somebody working from one dishwashing job to another, just getting by, just surviving, finally starts to have dreams about what they want to do with their lives.

Simone shared her understanding of transitioning/transition-related care being part of the treatment for suicidality by expressing the following:

> I think that's what the literature says for one thing, that suicidality decreases quite substantially as people both begin to be mirrored and accepted for who they are—whether that's socially transitioning or medically transitioning, the experience of some congruence between yourself and how you're treated—suicidality significantly decreases. I think it's about that mirroring a little bit as well. Also, being able to be in your body, to be in yourself [pause], it's important and necessary for well-being. And so when you can't be those things, then it's going to have a really negative effect on everything, including your desire to be in the world.

Gwen shared a similar observation:

> So there's nothing that specifically comes to mind that would suggest that if you are trans and seeking transition-related care and you have suicidal thoughts or have made an attempt, then you cannot move forward. And I think that's a good thing because there are

> a lot of trans individuals who are struggling with suicidal ideation and it would be a shame to say, “no, you need to get rid of that before transitioning.” Because as I mentioned before, suicidal ideation, at least among my clients, tends to decrease the farther along they are in their transition. So if anything, the transition appears to help their mood or anxiety struggles.

When queried directly whether she considers suicidality to be a contraindication to transition-related care, Mickey replied that she does not and in fact, she considers it to be part of the treatment for suicidality:

> Moi je pense que c’est le contraire. Souvent c’est la dysphorie qui est très, très haute, très, très forte dans différents aspects de la vie de la personne, que ça soit au niveau physique, justement un homme trans qui a des seins toute sa vie et il ne peut plus, il ne peut pas sortir, ne peut pas avoir de relation interpersonnelle, il y a de la misère de trouver un travail parce qui pense que “tout le monde va voir mes seins, même si je mets un binder.” Donc c’est sûr que quand la personne a une dysphorie très forte, les soins vont emporter un certain soulagement. Ça va diminuer et ça va arrêter un peu les idées suicidaires, justement les “je me sens enfermer dans ce corps que je n’aime pas, je me sens enfermer dans un rôle sexuel que je ne veux plus.” Le fait de passer vers la transition, souvent ça va aider la personne beaucoup et ça va lui donner espoir, comme je disais tantôt. Donc, je vois que c’est le contraire. Ce n’est pas une contre-indication parce que d’habitude, la personne trans [pause], sa détresse n’est pas à d’autre niveau qu’au niveau de la dysphorie. Oui, c’est sûr qu’on peut trouver d’autres choses concomitantes, des diagnostics qu’on peut donner, mais la plupart c’est relié à la dysphorie, à la souffrance

> [pause], ce manque de congruence à ce qui ressent et ce qu'il est physiquement ou au niveau social. Donc je dirais que ça va aider plutôt que nuire.

Julie reflected on how she has experienced transitioning having a positive effect on her clients' well-being, and how that is a meaningful part of the work for her. She stated: "C'est le fun de voir que le traitement c'est la transition. C'est vraiment ça. Pour plusieurs personnes, la transition va vraiment opérer beaucoup, beaucoup dans la guérison. Fait que c'est fun de participer à ça aussi."

Several providers explained that while they understood suicidality to be in part due to dysphoria, and that they viewed access to transition-related care and/or transitioning as part of the treatment for suicidality, they were careful not to overemphasize the "curing" powers of transition-related care. For example, Simone shared the following:

> Also I feel like it's really important to be able to be like, "okay so there's some relief coming but to also be very, very mindful of the fact that things like depression and anxiety and feeling suicidal are things that you've been experiencing for so long, since you were just a mini, that it's not going to disappear in a second.…" So to not be "oh miracle cure! And then you're going to be better, great." I think that's really dangerous because people don't feel great immediately, or they do and then they don't, and that's [pause] dangerous I think, to have that expectation for people. And scary. It's so scary to come to the other side of it and be like "why don't I feel better? Why hasn't anything changed?"

Indeed, several providers reflected on the fact that in their clinical experience, once clients had transitioned to the level that the client desired (e.g., social, medical, legal), then they often wanted to address other issues such as childhood abuse or current challenges. Simone shared that she sometimes explains this phenomenon to clients in the following way: “The thing that has prevented you from being able to address those things that are so hard, that’s going to change. So now you’re going to have a whole different energy to work on the things that are hard…”

4.3.1.3 Subtheme 3.1.3: Sometimes Stabilization is Needed. Some providers shared that while they did not consider suicidality to be an absolute contraindication to all transition-related care, they believe that some situations may require stabilization before moving forward with certain aspects of care. For example, Julie shared that she does not believe suicidality is a contraindication to hormone therapy, but in certain hypothetical situations, stabilization may be needed if suicidality were present and destabilizing to a client while they were seeking gender-affirming surgery. Julie shared:

> Jusqu’un certain point il faut quand même avoir une certaine stabilité. Quand tu vas te faire faire un vaginoplastie, tu dois être capable de te faire les soins quand tu vas revenir chez vous. T’sait c’est quatre fois par jour, une heure, une heure, une heure chaque. Y’a un niveau, je dirais. Si on met une échelle d’un à dix, je dirai que quand on arrive à cinq, ce n’est peut-être pas nécessairement une bonne idée d’aller trop vite. Mais, moi je n’e les vois pas les gens rendus la, parce que quand je fais ma lettre, ils vont à la clinique—quand je fais ma première lettre ou ma deuxième lettre, ils s’en vont a—Au niveau de l’hormonothérapie, non. Je ne dis pas que c’est une contrindication, au contraire. Surtout si c’est quelque chose qui fait partie de leurs sentiments dépressifs de ne pas être en bon genre et de ne pas s’exprimer et de ne pas être vues comme ils voudraient l’être. Si ça fait partie de leurs symptômes de dépression et d’idéation suicidaires, faux qu’ils prennent des hormones. Puis les hormones, je vois ça comme juste un début. Ce que je vois comme

> plus important chez une personne qui demande une certaine présence d'esprit, c'est tous qui s'appellent les chirurgies, qui vont être permanents. Faux que tu restes tranquille pendant un mois après une mastectomie, par exemple. Tu restes tranquille, tu ne pas jouer au basket, tu ne peux pas élever des sacs d'épicerie, tu ne peux pas faire rien de forçant parce que tu pourrais te blesser énormément. Vaginoplastie, pendant plusieurs mois tu vas être obligé de te faire des dilatations quatre fois par jour. Faut que tu aies quand même assez d'amour pour toi, pour bien prendre soin de toi. Puis c'est sûr que quand tu es suicidaire, que tu veux tuer, tu manques un petit peu d'amour de soi. Donc, jusqu'un certain point. Jusqu'un certain point. Puis ça dépend aussi de ton réseau autour de toi. Dans mon travail, je m'arrange pour essayer de faire grossir le réseau autour de la personne. M'assurer que la personne n'est pas toute seule quand elle arrive chez elle, m'assurer qu'elle est bien préparée. Ça je trouve ça très important. Donc j'évalue sa santé mentale, sa capacité de prendre soin d'elle et tout ça. Fait qu'à un certain niveau, des fois ça peut-être questionnant, et à d'autres niveaux ce n'est pas un problème.… Dans la mesure où ils sont stables au niveau de la santé mentale. Mais pas quelqu'un qui fait des idées suicidaires, qui veut passer à l'acte, qui fait de la grosse automutilation. C'est évident qu'elle n'est pas prête. Ce n'est pas une contrindication à tous, mais a la chirurgie peut être que ça serait mieux d'attendre d'être plus stable.

Julie later shared that she was not completely comfortable working with clients who are experiencing suicidal ideation, and that she was not aware whether suicidality was a contraindication to transition-related care according to the WPATH standards of care and other protocols. These two things, taken together, can help contextualize her answer above.

Sarah explained that suicidality is not considered a contraindication in most cases when it is related to dysphoria; however, she might consider it a temporary contraindication if it is assessed to be acute/active and/or an unhelpful coping strategy, particularly in the context of a surgery assessment. Specifically, she explained that part of what she assesses during gender-affirming surgery assessments is the person's capacity to experience and cope with a stressful life event (such as surgery). Sarah said:

> Nope [pause], no [pause], it's not a contraindication. No, not at all. But it would be a matter of determining how acute that is or whether or not that was in the past. That in itself is not a contraindication, it would have to take into consideration someone's overall mental health and their coping. It basically comes down to a coping thing, because you're trying to assess somebody on whether or not they can consent and take on a stressful life experience, and if somebody's coping is already kind of low, then that's what we worry about. It's not a matter of, are they in the right frame of mind to make a decision that they're trans, it's not related to the gender identity piece. It's related to safety around *at this period* in someone's life, in *these* following months, does this make sense given this person's ability to cope right now? And if it's something related to "I am so isolated because I have this chest that genders me, and I need for it to come off because if it doesn't, I don't see any way of continuing," that's a different narrative than … a coping strategy around disappointment or anger. We have a lot of understanding and empathy for folks for whom presenting the body to the world or to one's self just feels so dysphoric and the isolation that comes with that, therefore makes someone feel "this needs to change or else I can't continue on," in comparison to somebody who maybe is otherwise well but goes to suicidality to us in a way of saying, "do this or else," almost like a bargaining piece? … We have had at times people say, "give me my surgery or I'll kill

> myself." But in a way of a manipulative piece.

Sarah went on to further explain why suicidality in the context above might be considered a temporary contraindication to surgery:

> Because once you're done dealing with us, you have to deal with the surgeon. And the surgeon might say "I need this, this, this, and this." The surgeon *will* say that. You just have to be able to cope and deal with healthcare providers to get there. Basically, passed us, you're going to have to deal with the surgeon and we have to be able to say that somebody's mental health is stable or relatively stable. So if that's the way they're coping, then we have to investigate that further. It's actually not clear cut. It's really situational with people. Like, we have had somebody in the past who had a pretty chronic relationship with suicidality, and would just kind of go to that place often, but he was seeing a therapist weekly, and he had a lot of social anxiety but he was doing a bit better, and going to school. And that just became part of his history, and it didn't *necessarily* change but we said okay. So it really is person-specific. Somebody having a long history of engaging in suicidality doesn't stop us from saying yes. It's really going to be individualized. And I think that we'll be more concerned about it if that's the only way somebody copes, compared to somebody who we are like "wow, this is really intense dysphoria for you. Let's see how we can get this changed."

Sarah also shared the following:

> There are folks who really aren't doing well, and will share how they're doing, and that can sometimes mean that we'll continue to work with somebody who is, let's say, suicidal, or has substance-use issues. We wouldn't say yes or no to surgery, we would say "let's work together to hopefully make you well and then surgery would make sense." I

> said that in a blanket statement kind of way, but that’s not always how it always works. But let’s say if somebody was suicidal, it wouldn’t be the right time for surgery at that time.

Sarah clarified her earlier statement of “But let’s say if somebody was suicidal, it wouldn’t be the right time for surgery at that time” with the following:

> For example, if someone’s acutely suicidal and they don’t have any supports or any treatment and they’re not open to treatment, like they’re not open to working on feeling better—the whole thing about surgery is that we want to make sure that somebody is going to have the best outcome and making sure that they’re safe afterwards, and *oftentimes*, this is kind of a bit of an assumption, but oftentimes if someone’s suicidal and they’ve isolated themselves and they don’t have any supports, those are the folks we worry about. They’re on their own, living on [income support], maybe in an apartment on their own, and they’re like “I need to have surgery or else I don’t think that I can continue.” We just hope to help that person in broadening their options and choices around like, who’s going to take care of that person if they’ve been so unwell that they’ve isolated themselves? We worry about things like that, like how are you actually going to live after surgery, when you’re recovering at home by yourself and you’re feeling like there’s no options? We try to kind of broaden for somebody then, “okay, you need supports, you need a GP or a psychiatrist, you need to broaden your support networks. We can get you connected to the infirmary, maybe.” And then we do have people for whom they have a personality disorder for example, and they have a relationship with suicidality as being one of the coping strategies. So folks for whom suicidality is always kind of an option in the corner, and sometimes that feels safe. Because some people who

have a recurrent experience of suicidality, it’s one of the choices or options. And that’s fine for it to be there, but if somebody continues to engage with that as the coping, then we would work with them to determine—going to surgery, talking with all the surgeons, talking with the care providers, having surgery in and of itself, all of these things are stressful in themselves, so if your coping is to just go to that when things get stressful, we need to help you to manage what your options are when you’re feeling stressed, because that’s not an effective coping strategy. Suicidality can present in a bunch of different ways as an option for people for different reasons, so for people who have an ongoing relationship with suicidality as coping we would be trying to work with them to increase their coping strategies. For example, we have had people who we’ve said, “you know, at this point, you are using way too many drugs to have this surgery right now, because the surgeon won’t take you, because you have to be off this, this, and this drug,” and like drugs, not medication, but drugs, “and if you aren’t, they won’t see you. So we’re feeling a bit stuck. Can you work on that?” And they’re like, “Ok, now I’m suicidal because you’ve said no.” And we go back and say “no, we haven’t said no, we said how can we support you in working on these things, because the surgeon won’t medically see you if you’re smoking this much weed. The anesthesiologist will say no. So you’re up against this wall, we want to help you with that.” But then they attempt suicide and then we’re kind of like, “let’s increase the coping so that when you do run up against difficulties moving forward—first of all, you’ve got to work on all the stuff around substance use, so that you can actually get the access, so that the surgeon will say yes—and if you do come up against troubles in moving forward, how are you going to cope that’s not suicide?” So, that’s just an example of someone who presented after we said “not right now, but please

> access this, this, and this program, here’s some options of somewhere you could go” and that was their reaction.

As seen above, sometimes when providers seek to help trans clients stabilize different aspects in their lives in order to access surgery it can be experienced as gatekeeping. The ways stabilization and gatekeeping overlap will be explored further in the next chapter.

4.3.2 Subordinate Theme 3.2: Gatekeeping

Many provider participants spontaneously explored their relationships with the concept of gatekeeping. Of those who explored this topic, the majority reported being somewhat to very uncomfortable with the fact that their role put them in a gatekeeper position. Abby explored how she negotiates her role as both a gatekeeper and advocate-activist:

> When it’s easy, it’s easy, and I can just write an awesome letter and everything’s great! And then I don’t have to feel like I’m the gatekeeper. Ultimately, I kind of am. They need a letter from me if they want to get a [provincially]-covered surgery, for particular surgeries. I don’t try to hide any of that, it’s just a matter of fact at this point. It’s an uncomfortable fact.… You know, there’s a part of me, sort of the activist-advocate part of me that is like “these are the facts, if you tell me this, then it’s going to become an issue. If you don’t tell me, then I won’t know.” … It’s being completely transparent, ultimately… just being transparent. And I always am with suicidality. Sometimes I’ll have conversations with clients at the beginning of starting to work with them, where they will really want to know “what happens if I tell you this?” And I’ll say, “here are the things. If you say this, then yeah, I’m going to be very concerned. If you’re going to talk about this and this, then we will talk and we will have a conversation, and I’ll ask you some questions, and ultimately, the goal is never to go behind your back right. That’s

> never ever the goal, is to, you know, get you attacked by the police so they can bring you to the hospital. That's *absolutely* never the goal. That would be the worst case scenario so what are the steps before that happens, ideally?" And just to be as transparent as possible at every point along the way.

Abby shared an instance where she was asked by a client to write a letter of support for gender-affirming surgery and she broached the subject of the client's suicidality and expectations post-surgery, which was experienced as gatekeeping by both the client and Abby herself. Abby said:

> I was recently working with a person who initially came for high anxiety related to something that had just a little bit to do with their transition, but not much. And their anxiety was so high that they disclosed to me that they often had thought about suicide. I wasn't expecting that they would need or want anything from me in terms of a letter. But then several months later, they mentioned "Now that [name of clinic omitted] isn't—now that I don't have to wait 4 years or whatever and you can write the letter for me, I want you to." And I said "okay, we're going to have to talk more about the suicidality because like I said to you earlier about the risks of—we need to have a conversation about it to find out how much are you banking on your life being a hundred percent more perfect when you get this particular surgery? Because if it doesn't go well, and you've already been thinking about suicide, how is this going to fly? It's a conversation we need to have." And if I'm writing the letter then I'm supposed to refer to any mental health issues, and ideally you can write "client had been suicidal or had some suicidal ideation and is well-supported now and doesn't seem to display any." Something like that. When I think of [name of surgeon omitted]'s clinic, that's what they would want to see. But even

> in these clinics, I haven't heard of people being turned away because you've mentioned suicidality. But that particular client I mentioned was actually understandably angry with me. And I understand, I really understand. Because it felt to them like gatekeeping, which it felt like that to me too, it felt similar. It was challenging. We worked through it, and in the end it was fine, but it's challenging.

George explained that one way he negotiates his role as assessor/gatekeeper and advocate-activist is by explicitly explaining to clients that he views his role as one of an ally that can help facilitate the process for them. He said:

> I'm acutely aware that when they're coming for a letter, they're not coming for therapy they're coming for an evaluation. So I'm put in this position where I'm this gatekeeper who's going to judge them and evaluate them, and that's a really scary place for a client to come in. It's important to clear that for them, that that's not the role that I see myself playing. I've never refused a letter or given a letter that was contrary to the goal of the individual.

George elaborated on the fact that when he explicitly states his position to his clients, he notices his clients' anxiety decrease. He explained:

> In the first 15 minutes, it kind of feels like a job interview, in some ways. They come in and sit down, straight and proper, making eye contact, giving very brief, direct answers. So as we talk about it a bit, they feel more comfortable talking about stuff with me. They're used to people judging them so they have a good, solid defensive wall and you can sort of see that wall slowly come down as the session goes on, more relaxation, more leaning back, put the coat next to you instead of on top of you, more smiling and laughing, and sort of more forthcoming, like telling a story as opposed to just giving very

> short answers. You can tell that there's a sense of, "okay, now I'm dealing with the person and not some administrator that's going to be an obstacle."

4.3.3 Subordinate Theme 3.3: Working with Suicidality

Collectively, provider participants had worked with hundreds of trans clients and patients, many of whom had experienced suicidal ideation and/or behaviour before or during the care provided by the provider participant. Thus, much can be learned from what provider participants shared regarding how they work clinically with trans clients who are experiencing suicidal ideation. The majority of providers reported suicidal ideation being a common experience for their clients. For example, Simone stated:

> It's a very common theme. I've had contexts in which that's been one of the central things that we have been addressing as the other things are happening, as the transition process is unfolding. It feels a bit like "how are we going to keep this person here to get to this stage?" where it's been a very activated part of the work that I'm doing. And for others, it's more of a background, historical thing. And for others, it's more at the ideation level: people who regularly wake up and wish they hadn't, and then that becomes more acute, depending on other factors that are going on in their lives.

4.3.3.1 Subtheme 3.3.1: Suicide Risk Assessments. Providers reported using a variety of approaches regarding screening for suicidal ideation and assessing it. Some providers systematically ask clients about past and current suicidal ideation and behaviour, via either a questionnaire at the outset of therapy or in person during the intake session. Some providers also systematically ask about non-suicidal self-injury or history of familial death by suicide. Others providers shared that they query suicidality when certain topics come up in session, such as depression or trauma. For example, Abby shared the following:

> As soon as anyone mentions depression, I screen for suicidality. If they mention any kind of trauma history, I usually screen. If they're saying "I've already come out to everyone in my life, I'm happy and I'm all set, and I just need you to help me move along" I don't usually [pause], it doesn't feel appropriate. If they're saying "I grew up in a family where I was beaten up because I like to wear girl's clothes," then I would say "okay, this must really be a challenging time for you to come to terms with this" and I'll ask "through the years, how have you coped? Has suicidality been something? Have you ever used any substances to help you cope? Have you self-harmed in any way?" Questions like that.

Mickey specified that when working with trans children and teens, often it is the parent(s) or guardian(s) who will report suicidal ideation experienced by the youth. Sometimes the ideation is the reason the parent(s) or guardian(s) sought Mickey's services in the first place. She explained that on occasion it is the youth's suicidal ideation that will signal to the parent(s) or guardian(s) how distressed the youth is and this will help move them to a place of taking the youth seriously regarding their gender identity. She stated:

> Avec les enfants et les adolescents: c'est le travail qu'on fait avec les parents, ou avec la famille, les tuteurs, la personne qui prend soins. L'évaluation, qui commence des la première rencontre, est absolument nécessaire de faire avec les parents. On fait deux ou trois rencontres avec les parents pour voir un peu l'idée de ce qu'il se passe. Souvent ils vont m'apporter pourquoi ils ont décidé de venir consulter et de s'impliquer et de croire leurs enfants dans le questionnement. C'est à cause des indices de "mon enfant va mal." Par exemple, j'avais un enfant de 10-11 ans, prépubère, donc il voyait que ça s'en venait la puberté et que tout allait se développer... Le beau-père a trouvé une corde et des choses dans son garde-robe. C'est pour ça le beau-père est venu me voir et "non, non, non il faut

> qu'on fasse quelque chose. Il y a quelque chose qui se passe. Donc, beaucoup les parents vont être très à l'écoute de ça et au niveau de l'évaluation. C'est là qu'ils vont me dire "ah oui, mon enfant a parlé de 'quand je vais disparaitre, vous allez être contents.'" Je vois aussi ça au niveau des parents, soit ils sont dans le déni ou soient ils m'amènent cette information-là.

Many providers spoke of reassessing suicide risk throughout their work with a client. For example, Sophia shared:

> First I would assess the degree of suicidal ideation, like how severe is this? You know, once a week while alone awake at night, but the days go quite well? Or many nights go quite well? Or is this a state that they're in all the time? But I'm going to regularly check in with them, with any person who has suicidal ideation. "How are you feeling about your life right now? And what's happening in it? Where are you headed? Are you still having thoughts about suicide this week? Are you thinking about dying? When does it come up, and what can you do?" I'll be checking in on a regular basis. Perhaps, depending on the client, it might even be most sessions I would check in about it.

4.3.3.2 Subtheme 3.3.2: Safety Planning. Provider participants also spoke of engaging in safety planning with clients if suicide risk was present. Maxime shared that they engage in safety planning when there is active suicidal ideation and impulsivity on the client's part:

> Évidemment, on fait toujours des plans d'action si jamais il y a de l'impulsivité puis il y a des idées suicidaires plus actives. Qui est-ce que la personne peut appeler? Où est-ce que la personne peut aller ? C'est quoi les ressources un, deux, trois?

Sammi shared that part of their safety planning with clients includes asking clients to agree to contact a trusted other, which can include Sammi, should they find themselves seriously considering acting on their ideation and moving towards putting their plan in place. Sammi said:

> Usually if the suicidality is quite immediate, like they have a plan, I will get them to agree verbally or written that they will contact either me or a close person before attempting, and that's worked, I've had that happen.… Just to break that isolation and being like "you don't have to carry that experience alone." So usually, when it jumps from ideation to a plan, then that's when the red flags go off, and it's like "okay, well let's make sure that we have some sort of protocol in place for when it becomes that you have a plan." Because then from a plan to attempt, it's usually not that far behind.

Sophia shared that she uses a similar approach to Sammi, regarding asking the client to contact her should trusted others not be available:

> I've had people talking about when they feel that way, and so I make room for them to talk about it, and then I make a plan with them. My policy with clients is if you ever feel that way, what is going to be the commitment? What are the steps that you're going to do? If steps 1, 2, and 3 don't work, you know, you can't reach this person or this person, will you tell me about it? Will you commit to telling me about it next session? Will you reach out to me, if you can't reach the other people on your list? So I do ask for that commitment. And also when people sign on with me for therapy, I also tell them that if I am concerned for their health or well-being and I've lost contact with them, that I will break confidentiality for that reason. I will contact their emergency person and let them know that I'm concerned about their safety.

Some providers shared that in addition to informing clients about the limits of confidentiality in the first session, they are often asked very specific questions about what would necessitate a provider breaking confidentiality. Providers reported answering these questions in full, in order for their clients to making informed decisions regarding what they would like to disclose to them, as well as creating therapeutic safety for clients to broach certain topics that may feel risky to the client. For example, George shared:

> I'll have clients call me and say, "okay, what exactly is the confidentiality about [pause], like where is the line?" Often they want to know if they tell me they are cutting or that kind of stuff, am I going to freak out? And I reassure them that no, it's just imminent and preventable, you'd have to tell me "today I'm going to kill myself at 9, this way." It becomes a way to open up space to talk about that.

4.3.3.3 Subtheme 3.3.3: Clinical Interventions Regarding Suicidal Ideation. Several providers shared some interventions they use when working with trans clients experiencing suicidal ideation. Sammi shared the following:

> One thing I say often is "are the tools in your toolbox outdated? Because if you were a child that lived a trans experience and you didn't have any power in how to transform that, it makes sense that suicidality was a coping strategy, to escape reality. But that's an outdated tool, basically. If it's not in service to the present version of you, then that can cause more pain." I joke with clients: "Windows 97 is running and it's 2017 and you need to reboot your system. You need to reboot the kinds of tools that you're using in the present day." If it's things like addiction, which is also a coping mechanism, or suicidality, or using sex as a coping mechanism, or using some kind of behaviour as a coping mechanism, it's like "well, is it still in service to you now? Or is it time to reboot that system, to the point of 2017 version?"

Mickey explained that she acts as a client's coach (when needed) and recommended other providers working with trans clients do the same. She shared that coaching has many positive psychological effects, such as helping to decrease clients' feelings of being overwhelmed as well as communicating to the client that the provider "has the client's back," which can be reassuring and empowering for the client. Mickey said:

> Je pense si on fait le lien avec les idées suicidaires, [le coaching] les sécurises beaucoup. Je pense que ça enlève beaucoup de stress et beaucoup d'anxiété. Donc ils [loud exhale] respirent.… Parce que des fois ils voient tellement tout compliquée comme on disait tantôt, "woah, woah, woah, la grosse montagne." Donc de juste pouvoir dire, "regarde, je vais t'accompagner quand tu vas être rendu à changer ton nom. Tu vas pouvoir venir me voir et on va tout regarder ensemble, puis qu'est-ce que ça veut dire, et ton choix de nom" et c'est comme si ils projettent dans le futur "Ah, je ne suis pas tout seul là-dedans. Je peux me référer si j'aimais j'ai des questions ou des problèmes. Il y a quelqu'un qui va être là pour me backer si j'ai des difficultés." Donc ça je sais que mes clients me dit que ça rassure beaucoup. Même s'ils sont très indépendants, très autonomes, ils font leurs choses tout seuls finalement, mais le fait d'avoir quelqu'un à côté, on dirait ça les faits "OK, je suis capable, je le fais".… Donc ça enlève des stress et ils peuvent se concentrer vraiment sûr qu'est-ce qui est important dans leur cheminement.

Sammi shared that they use an integrative therapeutic modality and often employ narrative therapy interventions when working with trans clients.

> I do a lot of narrative therapy, so getting trans clients to dream and vision what they want to be. And it seems like such a simple concept but it's often so emotional to permit oneself to have a vision about their future self. And that type of work goes a long way. I remember working with someone and asking them "if you could shift out to a totally different planet and start again, what would you look like if you didn't have to be

> restricted by any policies or be attached to any people that know the old you?" And I remember that exercise being really, really empowering for that client.… Suicidality and being entrenched in trauma often prevents people from thinking of the future so when they're living trauma day to day, it's very hard to actually connect with the future self. And so I do think that it can be really empowering in terms of actually countering suicidality and challenging the effect that trauma has, to say "I will be and can be a person in a year from now," versus trauma making people live day to day.

George explained that he speaks openly and without judgement with clients about their suicidal ideation, if present, and relates it to wanting to live differently. He said:

> Most people tell them "oh my god, it's so terrible, you shouldn't do it, blah blah blah." So I try to create an environment where it's okay to talk about death and the client's relationship to death. And clinically, if it's possible, if I see that it's relevant, I try to relate the desire to die with it also being about a desire to live differently.

Sammi also explained that they strive to allow space for clients to express and explore their suicidal ideation in session, in part to identify the function of the suicidal ideation. They said:

> My experience has been that suicidality is very common, it's very common, it's very um… normal. And the more that I have just allowed it to be a part of the trans experience and the less that it's pathologized, I find the more it can be investigated in a deeper way. So a lot of times in suicidality, it's like, "you shouldn't feel it or it's bad that you feel it." We want you to move away from feeling it. But I have found that a lot of times that it's just a normal reaction to feeling pain or it's a normal reaction to wanting the pain to go away, right? And wanting the pain of being isolated or the pain of being unseen or the

> pain of being rejected to go away. And so to take the kernel of truth behind that is you want to feel relief. So how can we cultivate a feeling of relief that doesn't result in you hurting yourself or ending your life? It's kind of like breaking the shell of suicidality apart and trying to find what that ideation is in service to. And oftentimes it is in service to a sense of empowerment or a sense of "I can at least be in charge of my own life, if I can't be in charge of who signs these papers and who gives me hormones and who gives me that and the other." I do a lot of investigating of what is the suicidality in service to and that really makes it less scary. Because it's not "I shouldn't feel this feeling," which is just basically repression and denial, which only exacerbates suicidality and it makes it more isolating.

4.3.4 Subordinate Theme 3.4: The Script/Expected Narrative and Protective Withholding

As seen in the literature review, there often exists a power imbalance between trans individuals and their care providers that can lead to a dynamic in which the provider expects to hear a certain narrative and/or the trans person engages in protective withholding of certain information out of fear of being denied care or services. Both trans and provider participants spoke to this phenomenon and their understanding of it.

4.3.4.1 Subtheme 3.4.1: Provider Participants' Accounts Regarding Protective Withholding. Many providers expressed the belief that their clients do not withhold information regarding their suicidal ideation or behaviour out of fear of negative consequences, such as being denied transition-related care. Many providers shared that they work hard to intentionally create a client-centred, affirmative relationships built on trust, with the hopes that this will help increase their clients' comfort with sharing such information. For example, Mickey explained that she uses a two-pronged approach where she spends time in the first session and subsequent sessions explaining that her role is to support the client and that suicidal ideation is not something that will affect her transition-related care assessment, and she will openly and without judgement conduct thorough suicide risk assessment with individuals. Mickey explained that the latter decreases the stigma around suicidality and often helps clients speak openly about their ideation, if present. Below is her answer to a query regarding whether she thinks clients withhold information from her regarding their ideation, which led to an explanation of the first prong of her approach:

> Uh non. Peut-être parce que je nomme d'emblée que toutes ces petites problématiques-là qui vont surgir et qu'on va travailler ensemble, et ce n'est pas dans le but de "oui, je recommande ou je ne recommande pas la personne pour la hormonothérapie ou la chirurgie," c'est plutôt pour bien les préparer à affronter tout ce qui s'en vient, pour être bien outillé. J'explique beaucoup ça dans mon bureau, dès l'évaluation. Je leur explique que oui, je suis là pour les éclaircir, les aider à prendre une bonne décision très claire et tout. Mais aussi en même temps pour les aider à être fort et avoir une base solide pour faire face à tout ce qui s'en vient. Donc souvent ils vont être très, très faciles à se confier, parce qu'ils savent déjà que ce n'est pas un des critères pour dire "je te donne la lettre."

A few mental health provider participants shared that some of their clients feared negative ramifications from other transition-related care providers should their suicidal ideation become known. Some providers shared that they held the belief that certain providers did view suicidality as a contraindication and that trans people likely engage in protective non-disclosure when interacting with those providers.

A minority of providers shared that not many of their trans clients disclose current suicidal ideation to them. Sarah hypothesized that this is the case in her work due to clients presenting their “best selves” during transition-related care assessments, particularly during surgery assessments. She noted that assessments often change the dynamic between herself as a provider and her trans clients seeking transition-related care, due to the fact that she is in a position where she will either approve a person for surgery or not. For example, she contrasted her current clinical experience to previous work experience, where her role was to provide psychotherapy rather than to conduct gender-affirming surgery assessments, and shared that she now hears about suicidality much less due to clients perhaps volunteering that information less readily. Sarah explained that this is understandable given that the reason clients are meeting with her is to access specialized services (in the case, gender-affirming surgery), and that the requirement of having “stable mental health” in order to access gender-affirming surgeries is typically known by clients before they begin the assessment with her. Sarah also spoke about being aware of informal information sharing that happens in trans communities and the likelihood that information regarding how to prepare for such appointments is known by clients before they meet with her.

> We don’t have people coming here and saying “I need help with my mental health.” We have people coming and saying “I’d like a surgery, how do we do that?” I’ll pause on that thought for a second and say people also are luckily connected to communities where they kind of … blog about “here’s how it went when I went to go see this organization to get my surgery approval. Here’s what I said, and here’s who I met with, and here are the questions that they asked me.” So there’s a context of people gathering together to say “here’s what happened in these appointments and here’s what they’re going to ask you. So here’s how to prep.” And I have no judgement on that. I think people are coming to access something and that’s totally fine. But in comparison to people coming because

> they really want help with their low mood or their substance use or whatever, and they're saying "please help me with this," that's not how people present here because our reason for meeting is, generally, to provide access to funding for them, and access to surgeries. So those pieces around how somebody is doing may get honestly shared in a session or in an assessment and there may be some holding back on the person's part in order for them to get access. And I'm not judging them in any way. That's just [pause], that just is. We take people on their face value of what they're presenting. People don't offer up how they're feeling as genuinely and don't clearly describe their struggles as freely as they would if we're not trying to approve them for something that needs them to have a good mental health.… I'm reflecting on my work in terms of when people come to you because they're in a space where they need help with their mental health, in comparison to somebody who's coming to you because they need help with getting a surgery. The narratives are a bit different. Like, I wonder what I might hear if I wasn't somebody who's going to say yes or no to surgery. I'm, I'm aware of that. It's also up to the person to share what they would like to share with me in the session, and I'm taking someone at face value. But you know, there are times where you can tell that someone's affect is so low, that you would have that frank conversation: "I'm worried about your safety." We'd have those conversations, but it doesn't happen at the same frequency or intensity as it used to in my other work where people are coming for different reasons.

Sarah went on to also say:

> But uh [pause] yeah, it's different because, in comparison to just going somewhere where you say "I need help" and there isn't a checklist of things [pause], they're not trying to access anything but help. Whereas folks here have the end goal of surgery, and we both

> know that we need to accomplish these things first. These things being stable mental health.

Sarah also shared the following regarding her understanding of the protective withholding that she thinks clients may be engaging in:

> But I haven't actually run into having to do any safety planning with somebody face-to-face in this role. It's quite different. Four years here, three years there where I would've done it pretty frequently in a different program, so that's what I mean. It's not that people don't have it, it's just that we're getting a presentation to meet what someone's needs are.

4.3.4.2 Subtheme 3.4.2: Trans Participants' Accounts Regarding Protective Withholding.

Trans participants shared a varied approach to disclosing suicidal ideation to providers: some had disclosed to their providers and others had not, while some participants had disclosed to some providers and not to others for fear of negative ramifications to their ability to access transition-related care. Disclosure or non-disclosure was often provider-specific as well as dependent on whether they had been asked directly about suicidality by the provider.

Oliver shared that he did not disclose his suicidal ideation, which developed in the days following surgery, to his surgeon or the post-surgery recovery team. He didn't disclose out of fear of possible negative ramifications on his access to care, as well as suicidality not being queried or assessed by his providers. He stated:

> They don't ask, so it doesn't come up unless you bring it up. Which is something actually in the trans community, we've said that they should be monitoring that, because it's very, very, very common after surgery. *So* many trans guys—and I have to say trans guys because they're who I talk to, I haven't talked to a lot of trans women immediately post-surgery, so that I don't know about—but as far as trans guys go, *most* of us, or a good

> chunk of us at least, experience post-op depression. And they never ask about it ever, so it doesn’t come up in that sense.

It should be noted that Oliver’s primary care team, whom he had access to after he returned home following a period of post-surgery recovery, were likely aware of his suicidal ideation. At the time of the interview, Oliver shared that his family doctor was aware of his symptoms of depression and had prescribed him anti-depressants. Oliver shared that he felt well supported by his primary care team.

Nomi shared that her family doctor queried suicidal ideation directly, and her psychologist was also aware of her suicidal ideation at the time. Nomi said:

> Ils ont souvent fait allusion. Comme quand mon médecin dit “penses-tu que ça ne va pas bien au point de te suicider?”, je dis “oui, mais il faut m’aider.” Fait qu’elle m’a donné des antidépresseurs, mais elle ne pouvait pas faire grand-chose de plus.… Et c’est pourquoi ma psychologue voulait me voir aussi.

Devon shared that they had disclosed their suicidal ideation to their therapist, with whom they rarely discussed their gender identity and related concerns and who was not affiliated with the clinic from which Devon was receiving their transition-related care. However, they had not disclosed their suicidal ideation to their transition-related care providers. When asked to expand on that and whether that approach was meeting their needs, they said:

> That’s a hard question. Because on the one hand yeah, it’s working for me in the sense of I’m getting what I need, I’m just getting it from a lot of different places. But in terms of like, from a clinical perspective, I don’t know maybe they should know about that. That’s something I never really thought about talking to them about because that’s not in my head when I’m there. And maybe there’s also just a bit of fear of, like you know, am I

> going to be allowed to access care if they think I'm crazy? Which is a thing that existed in the past, I don't know if it still exists, but it's kind of just like a thing in the back of your mind [sigh]. I don't know. It almost seems like it's working from my perspective but it seems like maybe it's something that would be good for them to know and … maybe they should ask about? But I feel also if they asked about it, would people tell them the truth or would they hold back because they are scared of not getting the gender affirming care that they want?

Presenting an expected narrative and/or engaging in protective withholding was reported in other areas, besides suicidality. For instance, in the Disempowerment subtheme, we saw how Oliver did not feel comfortable disclosing his frustration to his surgeon regarding the surgeon's disregard for his bodily autonomy for fear of then receiving sub-standard care. Betty shared that she had not disclosed the fact that she started smoking cigarettes to her provider, out of fear of her provider would discontinue her hormone therapy. She also had questions regarding what effect, if any, hormone therapy can have on one's sexual orientation, but had not asked her provider out of fear of negative appraisal and denial of further hormone therapy. She summarized her relationship with this provider by saying: "I feel like I don't trust him and he doesn't trust me." Devon, a non-binary individual, spoke of their worry of being denied hormone therapy (in this case, testosterone) if their provider did not perceive them to be masculine. This worry persisted despite reassurance to the contrary from their partner, who also receives transition-related care from the same provider. Devon said:

> I know that there has been a history in the community where it's "you have to tell the doctors what they want to hear or you don't get the care that you need." That was something that was in my mind when I first started accessing care, like "what do I have

> to do or say or wear, or what do I have to be to convince them that I should get care?" And my partner is saying "it's fine, they are not gatekeeping, that's the entire point of this service." But there's still this sense that I'm going to choose what I wear to really emphasize masculinity even though that's not how I really dress, because if they don't see me trying to be masculine, then why would they let me have T [testosterone]?

***4.3.4.3* Subtheme 3.4.3: Therapeutic Interventions Aimed at Countering The Script/Expected Narrative/Protective Withholding.** Some provider participants shared how they will try to create trust with clients to counter protective withholding of information. Sophia explained that when she senses that clients are engaging in protective withholding, she will sometimes explicitly state that suicidality, if present, will not be a barrier to transition-related care. She said:

> I usually get a sense if someone's very fearful about me and my role, as an authority. And often they are, which is understandable because I'm seen as a gatekeeper, and in a way I am. I have been in a position on more than one occasion where I said to a client that if they do experience suicidal thoughts, feelings, moments, that is not a reason to deny them care with respect to transitioning. But it is important to talk about and to care for and to deal with that. I will say "often there's a very strong relationship between needing transition-related care and feeling suicidal. So I'm certainly not going to be somebody who's going to, in any way, block your access to those things if you feel suicidal." I don't say that as a matter of course, and maybe I should…. [And] they will open up. And you can feel [pause], they kind of melt a bit. Like, they start to open up about a lot of things. And of course, I can imagine they're feeling like they are walking this line because they've heard stories of people having terrible, negative experiences with health care

> providers. And they both have to emphasize the severity of their situation while not saying something that would disqualify them, or that they imagine might disqualify them, from getting the treatment. And it's terribly uncomfortable. So I really put a lot of energy in trying to make people feel comfortable.

Simone shared that she will say:

> I often try to say "everybody has a different kind of story, and I know that there's been an expected story that the system imposed on trans folks about how they come to understand their transness, but that's created a situation where we don't get to hear that many other kinds of stories, but we know that there are many, many stories." So I try to throw those kinds of things out there as soon it makes sense to do it, as soon as there's an opening, so that there's some space.

George noted the following regarding how he counters the expected narrative and helps clients through potential protective withholding:

> Yeah, it's a catch 22 and I think clients kind of feel like when they come in for the evaluation, they're kind of like "uh, like how much can I say?" Like, if they're on hormones and I'm like "how are the hormones going," they're like "fine!" and I'm like "come on [chuckles], fine? Tell me a little more." They're afraid of making it look like things aren't going exactly according to plan. I try to use a bit of humour and say "hey, come on. Fine on hormones? I've never heard of anyone say fine. All kinds of things but fine is [chuckles]—you know, people experience it different ways, usually there's a certain degree of [pause] sort of confusion or ambivalence, or emotional volatility or some changes that are like 'oh my god, what's going on?'" The point is, there's this fear of being very explicit about what's going on in my life and how am I feeling when

> someone's being evaluated. Like, I want to make everything seem like everything's great, you know. But I think that that kind of attitude also puts people at risk because we're not really getting the real information…. If people are afraid of sounding suicidal, and they know if sounding suicidal will be a no, like, it'll be like an impeding factor, then they'll avoid saying anything that makes them sound suicidal. But then they're not going to talk about what they need to talk about, and get the support and feedback. And so they're all alone with that then. So that puts them much more at risk. They need to be able to feel like they can say exactly what's going on, and not have that used against them to slow down or stop or block the procedure.

Simone later reflected on the positive psychological effect she believes actively countering the expected narrative creates for her clients:

> I think people are relieved to have an opportunity to explore [pause], I think what happens often is that people get put into a position of presenting, like to their families, medical people, and to lots of people, a wall of sureness of total unquestioning certainty about who they are and why this is the right decision for them. Because they're fighting against people's "what the fuck" and "that's crazy," right? So there's no space for lots of people in lots of contexts to be actually grappling with something that's normal in any new change, which is to be like "is this what I want?" "Does this make sense?" "Is this actually going to make me happy?" "Is this who I am?" "What will it mean?" "What will it look like?" "What if I really want this part but not that part?" You know, all of the questions that are just very, very regular questions to have. So I think that when people do feel comfortable that they're not going to have their access to resources threatened or someone's acceptance of them threatened, then they can actually explore that stuff, which

> can be a little bit of a relief.

4.4 Superordinate Theme 4: Recommendations from Participants Regarding Suicidality and Transition-Related Care

All participants were asked to share recommendations regarding suicidality and transition-related care. These recommendations were intended for providers, trans individuals, or both groups of people. Together, provider participants had been working with trans clients for several decades, and had worked with several hundred trans clients. They had gained valuable insight and clinical wisdom from this rich experience and had several pertinent recommendations to share. Together, trans participants had several decades of lived experience of surviving and thriving as members of sexual and gender minority populations and they drew on their own rich experiences while making the following recommendations. In addition, the majority of trans participants were also connected to various trans communities, often in volunteer positions that placed them in support or leadership roles, and the knowledge gained via these roles also helped inform their suggestions.

4.4.1 Subordinate Theme 4.1: Capacity Building

One of the most common suggestions from both trans and provider participants was a recommendation regarding capacity building. More specifically, participants recommended capacity building among providers regarding the provision or approval of transition-related care, as well as increased capacity for trans individuals to access transition-related care.

4.4.1.1 Subtheme 4.1.1: Providers Should Stay up to Date with the Most Current Evidence, Best Practices, and Standards of Care. Several providers underlined the importance of staying informed regarding several different subjects in order to offer the best possible care to trans clients/patients. Simone succinctly stated that she recommended that “As therapists, we should be as informed as possible about the processes and the benefits of transition for mental health." Staying abreast of research pertaining to suicidality and transition-related care was underlined as particularly important by several providers, and the Tran PULSE research project and its subsequent publications were named as a good example of clinically-applicable research. For example, Abby stated "I would hope that anyone working with trans clients would have some understanding of the research. The Trans PULSE research has helped me. It's something to hang on to in terms of some kind of a guideline." Michelle also spoke of the utility of the Trans PULSE results to clinical work, and the importance of staying up to date with pertinent research overall. Michelle said:

> And all these studies that are coming out, are there. Trans PULSE is available in completely comprehensible little bulletins that are even translated to French. Even if the clinician does nothing else but to keep up with the Trans PULSE data, they are already prepared, they are already preparing their clients well. So I think one of the things that therapists working with trans clients have to do is they have got to be informed and they have got to know what's going on in the research world. The research is very clinically based, and is very useful for clinicians. And it is in such a fast, fast moving field. It's true for any of us, as clinicians, that we are obligated to keep up in our field. But in this case, the stakes are so high that it's just inexcusable not to. I'll be that adamant about it.

Michelle also recommended that providers stay informed in order to collaboratively identify potential challenges that may come up after the person transitions, in order to help clients prepare for these possibilities. Michelle said:

> So it's a collaborative work to identify what the potential hurdles might be or the challenges, and to look at some of the ways to address them before they become

> challenges. And in order for us to do that, we have to stay informed.

Mickey also recommended that providers stay up to date. She nuanced her recommendation by explaining that part of providers' roles is to be a coach or guide to trans clients when needed, in order to decrease client's distress and feelings of being overwhelmed regarding legal and procedural steps. She therefore recommended that providers seek to be knowledgeable and up to date regarding pertinent laws, processes, procedures, and more.

> C'est toujours d'être à l'affut de ce qu'il se fait et d'être au courant. Parce que c'est ça aussi, les lois qui changent, comme ici il y a eu la loi pour le changement de nom, le changement de sexe. Donc il faut que je sois bien informée pour pouvoir bien informer mes clients…. Autant au niveau plus thérapeutique, mais aussi au niveau logistique, où je les guide, qu'est-ce que tu peux faire…. Déjà d'avoir quelqu'un qui dit "OK, tu as besoin de trois lettres, tu as besoin d'écrire au registre de nom, tu dois aller devant le notaire". Des choses comme ça. Juste le pré- et post-opératoire aussi. Les gens sont beaucoup dans l'idée d'avoir la chirurgie, mais ce qui se passe avant, qu'est-ce que tu vas avoir besoin après aussi, au niveau monétaire, au niveau de arrêt de travail? Donc c'est toutes ces choses-là qu'on va les guider aussi. Beaucoup plus comme coach à ce niveau-là, moins comme thérapeute, mais quand même. C'est nécessaire.

Michelle pointed out that in addition to being aware of clinically relevant research, mental health providers need to be aware of wait times and the processes for medical transition. She explained that having this knowledge helps her create treatment plans in which delays are minimized, therefore potentially minimizing the distress trans clients may feel during transition.

> Some of the challenges are medical. So being aware of wait times, and things like that. So that we aren't saying to a client "well, let's do this first, and that first" when you know

> they have six months wait after that to see a doctor. Like, let's move this thing on. Because dysphoria is not a diagnostic challenge, it's everything else around it. Not in terms of diagnosis only or identifying the potential hurdles, but it's also knowing how accessible trans-health care is. If you know that it is going to take steps 1, 2, 3, 4, 5, 6 for your client to see somebody for hormones, then when the dysphoria has been identified, you start the person on that path, you don't wait.

George recommended that providers become familiar with resources in the community that could be beneficial to their trans clients.

> Get to know some of the resources. As a rule, I'll always try to hook clients up, if they aren't already, with peer support groups, advocacy groups, and that kind of thing. Because that can really help break isolation and help them normalize and help them fantasize about their future in different ways by being exposed to people at different stages. So that's important.

George also recommended that providers engage in self-reflection and gain trans-specific knowledge:

> Check your prejudices. I mean, that's the first thing. And if you're going to work with trans clients, you have to know the politics and understand the language, and understand what they confront in their experience, not only from dominant culture and ideology, but also from mental health and health care professionals. So it's important that if you're going to work with the trans population, that there's a significant political component to it that you need to understand in order to really be an ally for them. Particularly when they're consulting primarily for trans-related issues, it's less of a clinical issue than a political issue. There are all kinds of clinical issues existing in their lives and we can

> process transition as a clinical issue too, but it's not primarily a clinical issue. It's not something that people need to be treated for.

In the recommendation above, George not only suggests that providers engage in self-reflection and gain trans-specific knowledge, but also that providers don't view trans identities or transitioning as a mental health issue. He elaborated further on this latter point by saying:

> It used to be that the person had to qualify for a GID [gender identity disorder] diagnosis, even before they'd be considered [for transition-related care]. And politically it's still an issue; politically to get [public health care] coverage [for medical transition-related care], you need a diagnosis. So it still has a powerful place. But I don't approach transition as a mental health issue, it's a social problem that requires laws to be changed, so that people can do what they need to do sooner. So clinicians need to know the politics; they need to understand the difference between someone who's transgender and someone who has a mental health problem. They're not the same.

Elaborating on the above recommendation, George went on to say:

> You have to know your gender politics. That's important primarily in order to be a good ally, but also be able to differentiate what's political and what's sort of more personal. They're so intertwined that you have to navigate the two. Otherwise, the risk of pathologizing a client for being trans, of seeing trans being something of a pathology, is very high. So we're not treating sick people to fit them in a healthy society, we're treating healthy people to fit them in a sick society.

As seen in the quotes above, provider participants believe that trans-competent care can and should include several components that are beyond traditional knowledge areas when working with a specific population. In other words, provider participants indicated that trans-competent care is more than being knowledgeable regarding trans-affirmative interventions, but also requires providers to be knowledgeable regarding current research, best practices, medical and legal processes involved with transition-related care, and being willing to take on a coach role when needed.

4.4.1.2 Subtheme 4.1.2: Increasing Access to Medical Transition-Related Care and Trans-Competent Mental Health Care. Several provider participants made recommendations regarding increasing access to trans-competent care. First, several providers recommended that there be increased funding and training for medical health care providers in the public system, in order to increase their capacity to provide affirmative and competent medical transition-related care. Second, several participants suggested that there be an increase in trans-affirmative mental health professionals in the public health care system. All providers, with the exception of Maxime and Sarah, worked in private settings, and provider participants in both public and private health care systems identified the lack of trans-affirmative care in the public sector as an important problem. Maxime made the following recommendation regarding this situation:

> Je pense qu’il faut former les gens à donner des soins qui sont “trans-sensitive,” essentiellement respectueux de l’identité de genre et compréhensif. Puis en particulier, il faut former les gens qui font partie du système de santé publique. C’est la priorité.

In addition to the training Maxime recommended above, they recommended that money be injected in the public sector specifically for trans-competent care. They explained that while they felt comfortable referring their trans clients to their trans-competent mental health care colleagues, these professionals were all in private practice and Maxime’s clients often could not afford the associated costs of seeking these services. Maxime further explained that when they had referred clients to mental health care providers in the public sector (e.g., public health care clinics in catchment areas throughout the city), the referrals had been declined with the explanation that there were no therapists with the necessary knowledge to work with the referred clients. In addition, Maxime shared that their trans clients often told them that they would rather go without services than seek services and risk experiencing marginalization, transphobia, and other forms of oppression from providers/the system. Maxime therefore recommended that funds be allocated in the public system specifically for trans-competent physical and mental health. Maxime explained that that is currently not happening, and they had therefore built a small team by hiring a mental health care provider to work with their trans clients:

> Puis l'autre chose c'est d'injecter de l'argent dans le système. Par exemple, depuis le début janvier, j'ai commencé à engager un travailleur social de ma poche parce que j'ai un tel manque de ressource puis un manque de confiance envers les ressources publiques que j'ai préféré monter ma propre équipe. Est-ce que c'est normal qu'un médecin de famille qui est payé par le système de santé doit engager lui-même ses propres professionnels ? Non. Je ne pense pas que c'est la solution, mais temporairement c'est plus viable pour moi. Puis c'est vraiment parce qu'il n'y a pas de travailleurs sociaux de disponibles et pas de travailleurs sociaux qui sont trans-sensitive de disponibles pour moi. C'est vraiment les deux choses, c'est vraiment l'éducation puis l'argent.

Mickey also recommended increased education and training for providers in the public system, in order to increase the number of providers in the public system who are trans-competent. In addition, she elaborated on how she tries to work within the constraints of a lack of public system providers as a private practitioner:

> Ici au Québec, les gens doivent payer dans le privé. Puis je vois des gens très fragiles au niveau psychologique, à cause de la dysphorie, qui n'ont pas les moyens de venir

> consulter. Fait que moi ce que je fais, mettons je dis, “regarde, viens me voir une fois par mois,” ou on essaie de mettre ça pour qu’il puisse sortir leurs sous et venir me consulter. Mais je trouve ça triste parce que c’est des personnes qui auraient plus besoin d’un suivi plus, plus, plus, qui n’ont pas les moyens. Et moi je ne peux rien faire, je suis un peu mal prise dedans, parce que c’est mon travail en même temps, je ne peux pas donner des crédits. Donc c’est ça la partie que je trouve injuste pour les gens qui n’ont pas les moyens. Je trouve des organismes où ils peuvent aller. Mais suivi comme tel, par un spécialiste, on n’en a pas beaucoup qui travaille au niveau public. Puis souvent ils vont aller dans le côté public, ça va être des gens qui ne sont pas nécessairement spécialistes et formés dans la réalité trans.… On pourrait avoir plus de spécialistes dans le réseau de la santé [public].

Collin shared the recommendation that increasing trans-competent training for generalists would be helpful for trans individuals accessing mental health care. He said:

> I do feel like there needs to be more training. Therapists and psychiatrists that are not necessarily specifically for trans people still see trans people, which is fine. I just feel like they should have more training which is specific to being able to care for trans people. I feel like it’s almost expected of trans people to see professionals that are specifically made for trans people, which is more difficult to do. Like, it’s harder to access…. It would just be nice to have the provider just better understand me and to not have me be forced to explain myself over and over to different people. And even after I explained myself, a lot of the times I feel like I am not understood. Which is difficult. Because how am I supposed to get the care I need if the professional I’m getting the care from doesn’t understand my needs?

Simone strongly recommended that mental health care providers in private practice consider the financial barriers some trans clients may experience, and suggested providers consider using a sliding scale model to determine their fee structures. This recommendation can be understood to be connected to the lack of mental health care in the public health care system, as well as needing to consider intersectional aspects of trans clients' lives, such as the interaction between transphobia and income. Simone said:

> For providers, I think it's really, really, really important to think about having financially accessible services. I think it's an ethical responsibility for care providers. And however you structure that, like whether you have your wealthy clients paying like a million dollars or whatever, like however you do it. I think that anybody who genuinely wants to provide services to the trans community needs to be thinking about money.

Michelle recommended that family physicians become the first line of care for the majority of trans clients:

> I think that physicians, who should be taking over the first line and should be doing the triage of trans clients to find out if anybody needs more than just their GP. They should be doing that job too, and not just doing medication via informed consent, but also doing, "okay, so how are you doing with your coming out? And how is this going?" And is the 17 year old client two seconds away from being kicked out of the house? You know, etcetera.

Michelle also suggested that therapists should be willing to be available and involved outside of the therapeutic hour:

> In terms of suicidal ideations and suicidal gestures, in general, not and just for trans folks, therapists have got to be willing to do everything they can and go outside of some kind of

> rigid framework. A few years ago the APA issued a [pause], not a warning, but it was a stern letter, to psychologists saying you need to be more available to your clients. You can't just be available that one hour, not with some of the clients you're seeing, and so you need to expand that. You need to phone check-ins, for example.

Devon (a trans participant) shared that they were currently accessing mental health care via the public health care system. Similar to several of the recommendations made by providers earlier in this section, Devon recommended that trans-competent mental health care providers be available in the public system:

> There's that overlap between transness and mental health problems—and not all the mental health problems are going to be strictly related to being trans, but being trans touches every aspect of your life in some way—so I think it would be really helpful to have specifically trans-competent mental health professionals. So that you can go in and you can get help with your self-worth or your childhood trauma or your anxiety, whatever it is that you are dealing with mental health-wise, without having this experience of having to be trans-101 for the person who is supposed to be helping you…. In terms of [name of community clinic omitted], I'm getting a lot out of it, but I get 12 sessions there. I get 12 hours and what percentage of those hours am I spending trying to get my therapist to understand that I'm neither a man nor a woman and that that's a thing? Or trying to get the therapist to understand what I'm saying about this or that experience touches on my transness? And I think it would just be really helpful to have somebody who has already done that background work.

Devon clarified that they were recommending trans-competent therapists be available in the public health care system:

> Trans people are more likely to be in poverty and they are more likely to be unemployed, so [private therapy] is well and good if you have access to it. But that'll leave a lot of people between the cracks. It's this sense that accessibility would be really important. So it doesn't necessarily have to be through trans-specific care, but just in the community, through [name of community clinic omitted], or through [name omitted] hospital, or through [name of community clinic omitted], wherever it is, to just to have them [trails off].
>
> Interviewer: Through the public system?
>
> Devon: Yeah. And like and really genuinely trans competent. Not like, "oh I did a sensitivity training on trans people, I'm trans competent."

Mickey recommended that mental health care providers who offer care to trans individuals seek to be trans-competent via completing specialized training and seeking clinical supervision. She believes that if that is not the case, then providers should refer trans clients to more knowledgeable providers due to the potential for causing harm to trans clients. Mickey said:

> Mon avis est que les personnes qui travaillent avec la réalité trans sont formés puis qui aillent un suivi de supervision selon les Ordres. Des fois je reçois des clients qui ont été voir d'autres collègues, mais ils ne connaissent pas la situation, la problématique comme telle. Puis ce n'est pas évident. Avec qu'est-ce qui ils ont dit, des fois on ramasse les morceaux. Donc je me dis, je ne suis pas spécialisée dans [un certain sujet, par exemple], je ne traite pas [les gens qui vivent cela]. J'ai des collègues qui se spécialisent là-dedans. Toi tu connais cette réalité bien, tu as été cherché des formations et tout. Moi je dirais que pour la réalité trans ça devrait être la même chose. Chez les psychologues, chez les

> sexologues, même chez psychiatres.

In the quote above, Mickey explained that in her experience, harm can and has come from trans people seeing professionals who do not have adequate training or competency to work with this population. This harm can happen on one or more levels, according to Mickey. There is the harm of therapists acting in a prejudiced or unintentionally ignorant way (as seen in the quote above when Mickey said “Avec qu’est-ce qu’ils ont dit, des fois on ramasse les morceaux.”) There is also the harm of the client spending time and money trying to access transition-related care only to find out that the therapist is not qualified to deliver or facilitate it. For example, Mickey said:

> Ça coûte très cher venir au privé et en fin de ligne la personne dit “mais regarde, moi je te donne la lettre, mais je ne sais pas si je suis reconnu à le médecin en question.” C’est dommage parce que la personne a déboursé beaucoup de sous.

Michelle also spoke to the harm that can come from a trans client working with a provider who is not adhering to the latest and best practices, and she put forth the recommendation that providers should stay up-to-date and informed. She said:

> I think ultimately, it’s worse to see somebody inadequately than to not see them at all. I think that can cause more harm because the person’s hopeful and needing things and the therapist is not providing what the person needs. And maybe they’re in private practice, and by the time the client realizes this isn’t the right therapist, they’ve blown half their budget that was allotted to get their assessment or to get the support they were looking for. So I think we have a responsibility to work according to the latest practices, the best practices, the latest research, and the standards of care.

Betty made a recommendation that was a call to providers to increase access to transition-related care by supporting their patients' transitions. Betty suggested that medical providers adopt an expert patient model to their care and to trust their trans clients. Betty said:

> For the providers: believe us and do it. Give us hormone therapy if we ask for it, even if you've never done it before. You can look it up. I understand the WPATH Standards of Care suggest that you work with your existing doctor. So don't be afraid, go ahead and support the transition. Prescribe, monitor, trust us. Feeling like you won't get the care has the biggest negative impact, I feel. [Doctors] are afraid of something, but not giving the care is much worse.… So the doctor is afraid that if he prescribes, I'll get some kind of regret or something, maybe I'm secretly crazy, or maybe I'm misleading them about something just to get the meds, or something like that. Or they are afraid that they haven't done this kind of care before so they maybe are afraid they are going to make a mistake. But the consequence of not—I feel like they have my potential for happiness in their hands and not providing hormone therapy would be them taking the happiness away.

Betty went on to reflect on the ease with which primary care physicians can inform themselves regarding delivering hormone therapy, as well as how the risk of not prescribing hormone therapy was often greater than the perceived risk of prescribing hormone therapy:

> I don't know what's hard about it at all. I'm not a doctor, but it doesn't [pause], there are instructions. "This is what you watch out for and you should do it." And even in the Standards of Care, I feel like the risk of not prescribing it is—it can have very serious negative outcomes. Unless you are going to definitely kill them with the meds, you should prescribe them because you could be killing them by not prescribing it. You could be leading them to ideation, leading to suicide.

4.4.1.3 Subtheme 4.1.3: Creating Professional Networks. Maxime recommended the creation of a professional network of health care providers in order to facilitate the exchange of information and best practices, as well as offering a group of peers that providers could seek consultation from.

> Une autre recommandation que j'aimerais rajouter c'est vraiment, je pense, développer un réseau entre les professionnels de santé qui offrent des services de soins pour qu'on soit mieux connecter, qu'on harmonise nos pratiques, qu'on puisse se poser nos questions. Puis qu'on puisse un peu standardiser la qualité des soins vers le haut.… Comme je disais, je suis peu en contact avec les gens à Toronto ou de Vancouver par exemple, pour nommer les principales villes.… On serait moins isolés et ça serait très pertinent qu'on soit en contact tout le monde ensemble. On n'est pas nombreux à travailler dans le domaine.

Maxime went on to explain that a local mentoring network could be beneficial for providers. Specifically, a local professional mentoring network could help providers who do not have very much experience working with trans individuals connect with mentors who have more experience. Such a mentoring network could potentially increase the number of people who are willing to deliver transition-related care by making the work more accessible and less unknown. Maxime said:

> Je pense juste au niveau local par exemple, si un médecin de famille ou un autre professionnel voulait commencer à voir des personnes trans dans sa pratique, je pense que ça serait moins intimident si cette personne-là pouvait embarquer sur un listserv ou pouvait m'envoyer un courriel de temps en temps. Je fais un peu de mentorat, où je serais en contact avec des médecins qui ont juste quelques personnes trans dans leur clientèle et qui sont plus précautionneux puis moins à l'aise. C'est toujours vraiment pertinent

> d'avoir une personne ressource ou savoir à qui s'adresser, ça fait beaucoup moins peur…. Je pense qu'il faut qu'on soit en contacte tout le monde. Oui c'est ça, plus développer le réseau professionnel pour que les gens qui veulent commencer à voir des personnes trans se sentent encadrer et ne se sentent pas seuls.

4.4.2 Subordinate Theme 4.2: Reframe and Depathologize Suicidal Ideation

Several providers recommended viewing suicidal ideation as a client's way of coping with distress. Sammi shared several recommendations around her understanding of suicidality being a response to societal transphobia and cissexism. They suggested that providers normalize suicidal ideation, differentiate it conceptually from self-harm, and facilitate exploration regarding the function of the suicidal ideation before moving to safety planning. Sammi said:

> And then when a person with a trans experience feels suicidal and that's pathologized or that's seen as a big "oh no" or "you shouldn't feel that" or "how can we prevent that from happening?" No, it's just a normal part of feeling unseen, it's a normal part of not seeing yourself exist in the world. So I think that my advice is just really to let that sink in as a non-trans health care professional. Like, "of course you feel that and it doesn't mean that you're going to do it." And I think there's a huge difference also between self-harm and suicidality. Self-harm is often seen as on a continuum of when you're going to end up ending your life. And it's like no, a lot of times self-harm is so that people can feel like they exist, they can feel some experience and some sensation of themselves existing. So maybe it's strange advice, but just really normalizing it and actually staying with it rather than immediately jumping to like a protocol that's about how can we prevent it from happening. You're still going to have time to do that, I'm not saying don't do that, but it's the best to get a little bit further. Like, what is it this suicidal ideation in service to?

Abby also recommended conceptualizing suicidal ideation as a coping strategy, specifically, as a neurochemical-based coping strategy developed due to early life events. She explained her recommendation in the following way:

> And the other thing that I think is interesting and exciting is the more recent research around the neuroscience connected with attachment and with self-soothing, and with self-harm and how all of those things connect. I just had a conversation with a trans client this morning, who was talking about suicidality. This person had been hospitalized for suicidality [years ago], and I'd been working with them at that point. But it's been [several years] that they haven't been considering suicide. And so we were exploring "why now? Why is it this looping thought in your mind?" And we framed it in terms of the chemical reactions within the brain, and how perhaps it's your brain's way of looking for some relief, right? A little bit of an adrenaline rush and then the parasympathetic nervous system can kick in, and you feel better! And that's this loop. So that's a way of understanding it. And then there's some kind of prefrontal cortex activation that you can say, "oh, that thing is happening that Abby just described to me." Then maybe there's a moment that you take and say, "if that's what I'm trying to do, if I'm trying to make myself feel better then [pause] maybe there's something else?" Because it's become a habit for this person, right? And so we were talking about it this morning, and they were really kind of thinking "okay, actually that perspective really helped me in some ways to normalize it" and to not be so freaked out by their own suicidality.… And that to me feels hopeful, because it's just making it more accessible, in terms of a subject.… You can take the sting or potency out of it.

George offered two specific recommendations for providers regarding suicidality among trans individuals who are seeking transition-related care. Firstly, he concisely recommended that suicidality not be considered a contraindication to delivering and facilitating transition-related care. Secondly, he recommended that providers understand suicidality as a type of coping mechanism, one that gives clients a sense of agency when they may be feeling a lack of agency in many other parts of their lives.

> Don't use suicidality as an excuse to block the process, I think that's counterintuitive. Yes, we have to protect our clients, but we need to let them fight too, and sometimes, that's the only fight they've got in them. The idea that if this gets bad, I can just end it. And it gets bad. I think if any human being had to go through what some trans folks have to go through, you know, it's not even a question, it's inevitable, you need to negotiate that and you need to have a sense of control over that.

Sophia underlined the importance of providers understanding the link between suicidality and gender dysphoria, in part to avoid pathologizing trans clients with suicidal ideation or behaviour.

> [I would recommend] making explicit the connection between the distress related to gender dysphoria and suicidal ideation. That these are not two separate things. They're very related. Sometimes they are exactly the same thing. Sometimes they are *the exact same thing*. Like in other words, you fix the gender dysphoria and there is no more suicidal ideation. So, that's a thing that I think that a lot of people don't know, don't realize. I don't know if education or certain ways of talking about it are needed [pause]. I don't have specific suggestions, but just that I think that's a really important missing piece that makes the care, in some cases, miss the point, and discourages the clients unnecessarily, and potentially increase their suicidal ideation. Because there's this major

> point missing. In other words, they're being evaluated and pathologized for having suicidal ideation instead of understood and validated: "of course you have those thoughts because of gender dysphoria."

Sophia went on to make the following recommendation:

> I want people to pathologize the suicidal ideation a whole lot less. I mean of course it means the person is in more acute danger currently, but it's a symptom [pause], or it just follows from the distress related to dysphoria. So you have to treat the dysphoria.

4.4.3 Subordinate Theme 4.3: Providers Should be Advocates

Michelle shared her view that providers who work with trans clients have several main tasks or roles, with one of them being that of an advocate. The recommendation of being an advocate is linked to the recommendation of working outside of the therapeutic hour, as much consultation-advocacy work is done on the provider's own time. For example, Michelle explained that school administrators and other staff will often seek consultations with her when there is one or more trans student enrolled in that school. She views part of her role as a provider who works with trans individuals to also include being a pro-bono consultant for schools, in order to share information with them regarding how they can best meet their trans students' needs. She acknowledged that students can and do often advocate for themselves, but that it is a bigger systems-level issue and that as a provider, part of her role is to do that advocacy work. Michelle said:

> So yeah, I think it's being willing to go out of your way and being willing to look at the pressures that your clients are under. I'll give you an example, I was talking to a school psychologist yesterday at [a college], a [college] who refuses—you know, the answer to "can you internally adjust your forms, so the student who hasn't made a formal change of

> name or gender on their papers can still be called the way they want?" and the [colleges'] answers oftentimes are "oh no, that's too complicated." It's like, "well, have you checked with your tech people?" So this school psychologist says "but the student themself goes around to each professor at the beginning of each semester to tell the professor, this is my name, this is my pronoun, etc.", and I said "do you realize, do you *realize* what you're asking of this student, at the beginning of *every semester*? What you're putting on their shoulders?" and I said "where's the follow up from the [college] saying 'oh yes, you've got to respect this student, and listen to what they have to say, they're not just having a moment of folly here, this isn't some kind of little crazy idea that they've come across?'" …. I have some students that will just not go to school because of that. Because not everybody's [going to be able to] go to see a prof who they don't even know, who they haven't even started a semester with them, and they have to just hope that the prof is not going to freak out and decide to somehow reflect that in their grade, although of course they would never do that, but of course they would. So you've got your 16 year old or 17 year old, who's dealing with that in [college], with a mother who doesn't accept, with issues around their own dysphoria, and their body stuff, their girlfriend just left them, right? …. So the other task of the trans-sensitive therapist is to be an advocate.

Michelle further explained the importance of providers being advocates for their trans clients and trans individuals in general, and pointed out that often that is pro-bono work:

> You cannot just sit in your office, no way! You've got to advocate because there's nothing out there and as long as there's nothing out there, we have to go out there, and we have to advocate for our clients. We have to put our weight, add our voice to theirs, oftentimes, because they're just going to be dismissed. And so there's a lot of case

> management, you know, there's a lot of case management. You're my third of four meetings today and two of them have to do with schools that I have to work with to get them understanding what trans students need. And for free. So you have to be willing to do advocacy work and you have to be willing to do it pro bono. So if you're not interested in doing all that, be aware that what you're doing may not be enough.

Michelle added to her recommendation that providers be advocates, in part to decrease the risk factors that trans clients may experience:

> Work with whatever it is that the client is having trouble with. I've written to employers and I've facilitated clients writing letters to employers, employees, or supervisors who will refuse to use the proper name or pronoun. I've written to human resources and used words like "discrimination" and it's interesting how the problem gets fixed immediately. So it's using all of your resources to work with the client. Because people get suicidal because they lost their job, and they're going to lose their home, and it's concrete things! Most of it is really related to societal transphobia and transsexism, and transmisogyny, and everything else.

4.4.4 Subordinate Theme 4.4: Therapeutic Recommendations

In addition to the recommendations above, providers shared several other important recommendations regarding suicidality, transition-related care, and clinical best practices when working with trans clients and patients. Abby recommended that providers continuously integrate minority stress and other forms of oppression, such as racism, into their conceptualization and understanding of their trans clients' lived experiences. She said:

> [I would recommend that] people have a real sense of how damaging the long-term effect of living in a world that says your body, your experience of your body, and your

> expression of your body, and your sense of who you are is wrong in some way. Be you a Black body who doesn't feel like it fits in all the intersections that that involves. Just for that always to be present in the room, for that always to be something in your head.

Simone explained that she intentionally moves away from neutrality in order to take a therapeutic stance of a "desirably queer world" in her clinical work, and recommended that other providers do so as well:

> I often take a stance where I might not in other instances really take a position. When somebody I've been working with is like "I think I've decided that I want to transition" after like a long period of exploration, I want to be like "yay! Fuck that's wonderful, I'm so happy for you." I want to be able to give them the celebratory response that they should be receiving in the world. I think that that's important and therapeutic, and it's important not to be neutral sometimes. So I guess another recommendation would be to be a cheerleader or … [hold] that idea of a desirably queer world of why aren't we hoping that [people] are gay or queer? To sort of be a person who presents this possibility on some level. But to just be like, "of course it's a wonderful thing that you're coming out as trans, that you're a woman, yay!" And to be a person who can do that.

Simone made several recommendations around providers seeking to minimize the power imbalance between them and their clients. She began by concisely stating "I think informed consent is a vital component of transition care." She later expanded on this recommendation by saying:

> Ideas around harm reduction and informed consent are a really important part of conceptualizing the work. I would say all the work we do, but I think that it has particular importance in this context where it's a group of people who have been overly pushed into

> the psych world in order to have their needs met … they've been very pathologized.

Simone suggested that therapists try to empower clients and remove barriers to care whenever possible:

> Often it's a very disempowering experiencing—or there are aspects that are super disempowering—of moving through the system to get what you need and want. And as a provider, I think it's extremely important to be as counteracting to that disempowerment as possible, to work to empower people to make the choices that they want to make and to facilitate them doing that to the best of their abilities. To be removing barriers, not creating them.

At the time of the interview with Simone, trans individuals were required to participate in therapy/an assessment from a mental health care provider in order to access hormones or surgery from medical care providers. Simone conceptualized this as "mandated therapy" and made several recommendations regarding working within a "mandated therapy" framework. She recommended that providers view themselves as facilitators of a process, in order to help clients access the care they need. She also suggested that providers strive to understand that the client might feel a certain level of distrust as the therapist and client work to establish the therapeutic alliance. Simone said:

> I do think it's really useful to think of it as friendly mandated therapy in terms of like the range of ways people are going to engage with you. Because like I said, I feel like I've word-of-mouthed enough that often people trust me coming in. But earlier on … you're a tool. There are a lot of barriers to having an alliance if people think you're just there to evaluate them to get something, and then you could say no, right? To sort of understand that that's part of your position, and be able to respond to that in a meaningful way …

> with the client. To be understanding of their distrust, their suspicion.

Simone also suggested that, although it is mandated therapy, providers could convey that therapy could be a useful experience for the client:

> To also be like “maybe I’m going to have to sell the process.” As in, I’m going to sell the “we have six months to spend together, what do you want to do?” Like, “we have a chunk of time that we need to spend together in order to meet these requirements to the best of our abilities, so how do you want to use the time? Here are different ways people have used the time. Let’s actually make it a meaningful experience… in whatever way. And most people in the world have a useful thing they could do in therapy.” To sort of take away the “you’re not the boss of me, I don’t want to be here” feeling that comes with being forced into doing something you didn’t necessarily choose to do. And to be like “okay, totally, but also, here’s what we can do, right?”

Michelle recommended that providers utilize an age-inclusive conceptualization of trans individuals and consider the different developmental tasks that coming out entails at different ages and stages of life. She noted some of the differences providers may see when working trans clients who are coming out across the lifespan. Michelle said:

> So I think it’s also very important when we’re thinking about our trans clients to not just to think about the 18 year old or 20-something who has full parental support etcetera. I mean, their life isn’t constructed yet, they’re starting from scratch. They don’t have to deconstruct 30 years of a career, and a marriage, and kids who won’t talk to them, and the grandkids are kept away from them because they’re a quote-unquote “bad influence,” etcetera, etcetera.

Simone shared a recommendation for trans individuals regarding therapeutic fit and autonomy:

> For trans folks themselves, I would say the same things that I’ve said to anybody who’s seeking a therapist, while recognizing that there are fewer options available since money and trans-friendliness are requirements: but if it’s not a good fit, you don’t have to stay. And certainly if it’s not a good fit in terms of the providers not being trans-affirmative, that you don’t have to stay.

4.4.5 Subordinate Theme 4.5: Personalize Transition-Related Care

As seen earlier in the results section, Nomi shared that she was denied personalized care for several years and that it had a significant negative impact on her mental health. Nomi strongly recommended that medical providers approve or deliver personalized transition-related care, both with regards to hormone replacement therapy and gender-affirming surgeries. Nomi said:

> Du côté hormonal, c’est important d’écouter les patients sur comment ils se sentent. S’ils se sentent bien ou pas bien. Ce n’est pas juste dans la tête, des fois c’est vraiment du côté hormonal. Donc c’est important de ce côté-là de s’assurer que tout est correcte. Puis pas d’avoir peur de diminuer ou d’augmenter, ou de jouer un peu. Tout en respectant le corps aussi, parce que faut que tu restes en santé quand même.

Nomi went on the elaborate on why personalized transition-related care is important, and the benefits it can have:

> C’est important de respecter dans toutes ces procédures-là médicales et autres, les désirs des personnes trans quand c’est dans les choses raisonnables, de les respecter dans ce qu’ils désirent faire. Parce que ça peut les libérer pour aller plus loin après. Puis ça leur permet de pouvoir respirer puis pouvoir passer à autre chose. De tout le temps

> arriver, "ça te prend absolument ça, ça te prend absolument ça," non. C'est important de les laisser aller un peu plus parce que c'est ça qui va justement les libérer un peu plus. Surtout moi, c'était comme ça. Quand on me laissait tranquille avec quelque chose, je pouvais enfin respirer et prendre ma décision par moi-même. Ce n'est pas aux autres de décider quand t'es prêt pour quelque chose ou non. Que ce soit l'hormonothérapie ou autre besoins nécessaires, t'as bien beau être un professionnel de la santé puis dire "c'est ça que ça te prends", ce n'est pas nécessairement en ce moment-là que la personne a besoin. Fait que c'est important de respecter les désirs des gens dans cette transition-là. Je connais des trans qui ont leurs papiers pour avoir l'hormonothérapie mais ils ne les prennent pas encore parce qu'ils ne sont simplement pas prêts. Pas parce qu'ils ne veulent pas le faire, juste que ce n'est pas le temps. Fait que moi je les respecte là-dedans puis je leur dit "regarde, quand tu seras prêt ou prête, tu le feras, c'est tout", mais je ne fais pas de pression avec ça. Moi, je ne suis pas là pour leur dire quoi faire. Mais c'est la même chose pour le médecin pratiquant, ou le psychologue, ou autre. La saint graal de la transition, ce n'est pas la vaginoplastie ou n'importe quoi d'autre, c'est ce que la personne a besoin pour se sentir mieux avec elle-même. Fait que c'est important de respecter ça.

As seen at the end of Nomi's quote above, she recommended that providers support transition self-determination and self-autonomy. She specifically recommended providers move away from the assumptions that bottom surgery is the desired "holy grail" of transition-related care, and instead learn each individual patient's transition goals, and support them in achieving those goals. She went on to explain this recommendation in further detail, underlining the fact that a transition self-determination approach would render patients' decisions truly informed and consent-based.

> Essayer de sortir un peu des terrains battus. Je suis certaine que je ne suis pas la seule personne au Québec ou même, je ne sais pas comment ça se passe en Ontario, mais l'accès à l'orchiectomie … c'était nécessaire dans mon cas. J'en avais de besoin. Puis à une certaine époque, au Québec ou ailleurs, la vaginoplastie se faisait en plusieurs étapes où on faisait l'orchiectomie et plus tard on faisait la vaginoplastie. Ils ont arrêté ça, puis c'est une vaginoplastie tout d'un coup. Mais il y a des gens qui ont besoin de respirer entre les deux. Moi, le fait d'avoir subi l'orchiectomie avant la vaginoplastie, ça m'a permis d'avoir un certain [pause] une fois que j'ai subi mon orchiectomie, puis que j'ai eu plus tard mes papiers, j'ai décroché de cet espèce de peur de la vaginoplastie. L'espèce de côté irréversible de la chose. Et ça m'a permis d'avoir un détachement sur mes organes génitaux que j'avais à l'époque, avant d'arriver à la modification finale. Vu qu'on m'avait laissé tranquille, qu'on m'avait donné mes papiers, qu'on m'avait donné mes choses comme je les voulais, je ne prenais plus d'androcur parce que ça me faisait mal et je n'aimais pas ça, quand qu'on m'a laissé enfin respirer dans toute cette espèce de bureaucratie-là, ça m'a permis de pouvoir m'asseoir et penser à moi.

4.4.6 Subordinate Theme 4.6: Increased Provider Accountability

As seen throughout the results, participants often spoke of power imbalances between providers and trans clients/patients, with trans participants experiencing a sense of disempowerment when accessing or trying access transition-related care. Patricia, a trans participant who shared many instances of feeling disempowered throughout her transition-related care experiences, shared the following observation regarding a lack of accountability among providers:

> But also, the point is that there's no trans patients that are one voice. And you don't speak out when there's violence. And the only spaces where you can speak is to other trans people, and online groups, where people talk about their experience and they share that "this doctor is good," "this doctor has been fucked up," or "see this one." And then people end up on the same waiting list. But there's no way to hold providers who have ill-informed practices or are just plain fucked up accountable.

Patricia reflected on how one system of accountability, formal complaints to providers' licensing boards, exists but shared that she perceived several barriers to lodging a formal complaint. She explained that she was instead envisioning a feedback and accountability system that empowers trans individuals in a way that counters some of the disempowerment felt when navigating medical systems or accessing transition-related care.

> There are formal things like le Collège de médecin [the Québec licensing body for physicians]. But it takes so much energy and power and documentation to prove anything, that it's really hard. And someone's attitude towards trans people might not constitute a fault for them. So what exists is lists. [Name of organization removed] has a list that people update: "These are the recommendations. This therapist is great. Maybe don't see this one." But there needs to be some kind of way for trans people to talk back about their experiences in a way that's safe. And to give feedback in a way that's taken seriously. Because when you see a doctor, you give your power away to someone else, but there needs to be some kind of counterbalance to that. It's not about holding doctors and threatening them to give you the care that you want. It's about [pause] yeah. There needs to be something.

4.4.7 Subordinate Theme 4.7: Increased Preparedness Regarding Surgery Among both Trans

Individuals and the Providers who Support Them

Both Oliver and Patricia made several recommendations regarding increased preparedness among trans individuals seeking surgery and the providers who support them. Specifically, they shared that increased access to information regarding the surgery itself, as well as the after-effects of surgery, would be beneficial for both providers and trans people alike. Oliver recommended increased awareness and monitoring of post-surgery depression and suicidal ideation, particularly among providers involved in the post-surgical care. He said:

> I think they should take more care around the mental health aspects. When I checked into the hospital, they gave me a paper with patient rights and all of that, and it did have a suicide line on it. And my parents kind of chuckled at it. And when I said "oh, I just want to die," I said to my mom "I guess now we know why they put the suicide line there." So I think the hospitals maybe are aware, but not all the care providers *after* are aware, you know? That's something they should be monitoring. Even if you don't have complications, all that medication in your system, and the anesthesia and everything. Most of us, or a lot of us, suffer from depression and despair and all that, and nobody ever asks about it.

Oliver also suggested that surgical providers consider listing depression as a possible side effect of surgery in the consent form and/or patient information documents. He suggested a de-stigmatizing approach, underlining that anticipating the possibility of these difficulties could help trans individuals prepare to cope with them, should they arise. Oliver said:

> It should probably be part of the post-operative care and it should also be part of the listed risks. You know, when you go in surgery, it says the risks: fistula, strictures, death, allergic reactions, whatever. It should maybe even list depression or something like that.

> Because it’s so common and you’re never prepared. I’m prepared for it because I’ve had so many surgeries, but if it’s your first surgery, a lot of people are not prepared for that.… I see so many guys post in our groups, like “oh, I’m so depressed and I feel suicidal and I don’t want to talk about it.” Because people are embarrassed to talk about it, for one thing, because there’s still so much stigma around mental illness. So now you have the stigma of being trans *and* the stigma of mental illness. And then people don’t know—they’re not prepared, they don’t have anything set up. I had appointments set up with my doctors, I know because I’ve already had mental illness. I know that I can go to the Canadian Mental Health Association or the [name of the mental health hospital omitted] or I can call the crisis line. But if you weren’t expecting this, I think it hits you harder and you don’t have anything in place. And then once you’re feeling like that, how do you find those resources? You don’t want to, you just want things to be over.

In addition to the potential benefit of being able to prepare for potential post-surgery depression and/or suicidal ideation, Oliver proposed that increased knowledge and awareness of this phenomenon would normalize people’s experiences, therefore helping them reach out to others for help if they needed it. He said:

> Then we would know it’s normal and maybe feel less alone. I see so many people post about their embarrassment and not wanting to talk about it. If they knew they weren’t the only ones—because then people are usually good about chiming in, “I suffer from depression” or “I always get depression after surgery” or “it’s normal.” But, if you already knew going into it that it’s normal, then in case it does happen to you, you’re like “okay, I’m not alone. I can talk about it at least with other trans guys. Because it’s so common, maybe they have good resources, maybe they live in my city and they know a

> good counsellor."

Oliver also recommended that post-surgical complications be reconsidered from the patient's point of view and that there be increased transparency regarding complication rates. He said:

> It would be nice if it was more highly regulated in a way. Because we as trans guys experience complications and stuff. There are surgeons who are quoting "oh, we have a 20% complication rate or a 30% complication rate." But really, if you look at what we as trans guys consider as complications, it's essentially 100%. And even my doctor said to me, "these surgeries have 100% complication rate." If you have a fistula and it heals on its own or something, they don't necessarily consider that as a complication, but for us, it's a complication. It's our body, there's something that's not working right. So I feel like sometimes we're being misled when they quote these very low complication rates.

Patricia made several systems-level recommendation regarding increasing preparedness for surgery. The following recommendation centered around the need for peer support and the importance that such a role be recognized and compensated:

> And I think so much of the experience for the patient going through surgery, going through this process with medical professionals, is based on a relationship between one trans patient and a group of cisgender medical professionals. But I think there's something in pair-aidant [peer support person], like, another trans person that has had some experience that can help you navigate things way better than any social worker or any therapist can ever do that.… And I think that that should be recognized. And that should be, yeah, a path. And therapists should suggest other trans people that have lived through the experience. "If you have questions, you should talk to this person that I know

> that is willing to do that work." And maybe this should be a path for a pair-aidant [peer support person], or like accompagnateur [support person].… But the thing is also that that's real labour and it should be recognized as such. And trans labour is never recognized in the world, and especially in this context, it's not. It's a very informal thing but it's really real. So yeah, there should be a way to recognize that. Trans people have this experience and they have this very specific knowledge that no medical provider has.

In an additional systems-levels recommendation regarding increasing preparedness for surgery among trans individuals, Patricia suggested that trans women's experiential knowledge be recognized as valid and important and be incorporated into the Standards of Care.

> The experiential knowledge only comes from trans women, but you don't talk to any other trans women that have lived that experience through the pathways through [name of clinic omitted], so that knowledge is not shared. And people have no access to it, unless they know people that have had surgery. It becomes this informal [pause], and that's real and that's important. I think it should exist, this informal trans women pool of information. I think it's great. And that's why people survive, and that's why people have survived for so long, and still do and will in the future. And it's not that it should be taken away, but it should inform the procedures or the standards of care. It should be recognized, right? … You can make a recommendation that trans women have experiential knowledge of surgeries, and it should be recognized by medical professionals and practitioners.

As seen in the recommendations above, provider and trans participants alike shared a variety of important recommendations based on their lived experience, clinical experience, and/or connection to trans communities. In the next chapter (Chapter 5: Discussion), the results will be summarized and linked to the existing literature, limitations to the current project will be outlined, and future research directions will be explored.

5.0 Discussion

The current research project aimed to answer the following research question: How do trans people and care providers experience and understand the interaction between transition-related care and suicidality? Interpretive phenomenological analysis (IPA), a qualitative methodology that focuses on exploring individuals' understandings of major life events, was used to answer this question. The results from the current study both support the existing literature regarding suicidality and transition-related care, as well as offer a unique contribution by presenting participants' own understandings and lived experiences regarding the interaction between suicidality and transition-related care.

A brief summary of the results will be presented first. This summary will include a general introduction, followed by brief overviews of each superordinate and subordinate theme. Following the summary of results, the findings from the current study will be placed in the context of the existing literature on the subject of transition-related care and suicidality, and the novel contributions of the results will be outlined. Next will come an exploration of the limitations of the current study and this writer's reflections regarding designing and completing this research project. Implications of the findings both for clinical work and future research will then be discussed. Finally, a statement of contribution, followed by a final summary, will be presented.

5.1 Summary of Results

In-depth interviews were conducted with 11 care providers and 7 trans individuals in order to explore the research question. Participants either worked or lived in Montréal, QC, Toronto, ON, or London, ON, and surrounding areas. Fourteen participants identified as White and four identified as people of colour. Provider participants were medical (*n* = 1) or mental health (*n* = 10) care providers who reported having 2 to 20 years of experience in their professional fields. They were between the ages of 25 and 60 years old. All provider participants had worked with at least one trans client who had expressed suicidal ideation. Trans participants were between 18 and 40 years old. Four participants were in the work force, one was unemployed, and two were university students. Trans participants' experiences with transition-related care ranged from having recently accessed care to having completed their desired level of transition a few years prior to the interview. All participants had experienced suicidal ideation at some point in the five year period prior to the interview.

Results showed that participants had rich and varied ways of understanding the interaction between suicidality and transition-related care. Four superordinate themes were identified via data analysis: *Factors that contribute to suicidal ideation and behaviour*, *Factors that decrease suicidal ideation and behaviour*, *Clinical work with trans individuals experiencing suicidal ideation and behaviour*, and *Recommendations regarding suicidality and transition-related care.*

5.1.1 Factors that Contribute to Suicidal Ideation and Behaviour

The majority of participants spoke about many different factors that contributed to suicidal ideation and behaviour among trans individuals. These factors mainly, but not exclusively, centered around transition-related care, as this was the focus of the current study. Data analysis showed that participants spontaneously identified contributing factors that impact suicidality before, during, and after transition-related care is received. In addition, contributing factors were identified at three separate levels and one combined level: individual factors, interpersonal factors, systemic factors, and combined interpersonal and systems factors.

Individual factors that were understood to contribute to suicidal ideation and behaviour by the current study's participants included shame (feeling shame, being shamed, and shame due to internalizing societal-level anti-trans bias); dysphoria (gender dysphoria and post-surgery bodily dysphoria); and postoperative aspects including depression, surgical complications, and chronic pain. Interpersonal factors included family-related factors (e.g., rejection, non-support). Systemic factors included barriers to accessing transition-related care and existential erasure. Factors that were both interpersonal and systemic included transphobia; feeling disempowered (including feeling dehumanized, feeling violated, and/or experiencing a loss of bodily autonomy); being gatekept; and intersectional aspects (e.g., class/socio-economic status, race and ethnicity, having a disability).

5.1.2 Factors that Decrease Suicidal Ideation and Behaviour

Participants spoke of a variety of factors that decreased suicidal ideation and behaviour, which were broadly categorized as transition-related care and non-transition-related care factors. Trans participants shared their experiences of having gender identity-related realizations and developing identity clarity, which helped alleviate their suicidal ideation. In addition, many individuals, provider and trans participants alike, spoke about the positive effect that access to information regarding transition-related care had on well-being and mental health, including suicidality. More specifically, the positive psychological effect of transparency and access to information was experienced or understood as a factor that helped decrease trans people's uncertainty regarding expectations and likely next steps; decreased uncertainty, in turn, was related to increased well-being and decreased suicidal ideation. Furthermore, the vast majority of participants spoke about how having access to transition-related care itself helps alleviate suicidal ideation and behaviour. Relatedly, woven throughout the majority of participants' interviews was the idea that bodily autonomy and gender self-determination, in the context of transition-related care, both greatly helped decrease suicidal ideation and behaviour. Lastly, provider participants spoke of observing hopefulness develop among their clients and noted that this hopefulness was often fostered through the delivery of timely, affirmative, consent-based transition-related care.

Participants also shared their experiences of non-transition-related care factors that had positive impacts on their well-being and mental health, including suicidality. These factors included a helpful volunteer on the Tran Lifeline, a health centre that used participants' correct names and pronouns, a psychiatrist who helped a participant access academic accommodations, switching from a non-affirmative environments to an affirmative one, ID and name changes, hope and perseverance, and, lastly, one participant shared that the relationship with his mother was a suicide protective factor. Provider participants spoke of how they intentionally help trans clients to broaden social networks and social support in order to help alleviate isolation, distress, and suicidal ideation.

5.1.3 Clinical Work with Trans Individuals

While speaking about their experience as clinicians working with trans clients who experience suicidality, providers provided rich narratives and examples of how they strive to best support their clients. This superordinate theme contained four subordinate themes (*Is suicidality a contraindication to transition-related care?; Gatekeeping; Working with suicidality; and "The script"/expected narratives/protective withholding)*, described below.

Providers were asked directly whether they considered suicidality to be a contraindication to transition-related care. The majority of providers shared that they do not consider suicidality to be a contraindication to transition-related care, and went on to explain that transition-related care often helps decrease suicidality among trans individuals. A minority of providers explained that when conducting surgery assessments they will seek to help a client stabilize their mental health (e.g., active suicidality, substance use that may interfere with their ability to receive surgery), which is sometimes perceived or experienced as gatekeeping by the trans client or patient. Indeed, provider participants often explicitly or implicitly spoke about their roles as gatekeepers. The majority of providers explained that the role of gatekeeper was an unwanted role due to the nature of the system around approval or delivery of transition-related care. Some providers spoke about how they reject that role entirely and strive to act as facilitators to a consent-based process.

Provider participants also spoke about how they support trans individuals experiencing suicidal ideation. They spoke of conducting suicide risk assessments and engaging in safety planning when needed. They also spoke about therapeutic interventions that they use with trans clients who are experiencing suicidal ideation.

In addition, participants spoke of their understanding or experiences of protective withholding of information. Providers spoke of the ways they aim to create relational safety with their clients in order to allow for all clients' narratives to emerge, as opposed to an expected narrative or script. Trans participants' shared their experiences regarding protective withholding of some information, due in large part to the power imbalance in trans health care and providers' discretionary power over approving or delivering transition-related care. Lastly, providers shared being aware of the power imbalance and shared some clinical interventions they employ that are aimed at countering "the script"/expected narrative/protective withholding.

5.1.4 Recommendations from Participants Regarding Suicidality and Transition-Related Care

Finally, all participants shared recommendations regarding the interaction between transition-related care and suicidality. Six subordinate themes were included in this superordinate theme. First, participants spoke at length about how capacity building around affirmative, evidence-based transition-related care would help decrease trans individuals' suicidal ideation and behaviour. Specifically, they spoke about increasing access to medical transition-related care and trans-competent mental health care; ensuring that providers stay up to date with the most current evidence, best practices, and standards of care; and of creating professional provider networks. Second, participants recommended reframing and depathologizing suicidal ideation. Third, it was recommended that providers act as advocates for individual clients (when needed) and for systemic change in general. Fourth, therapeutic recommendations were made (e.g., integrating minority stress and other forms of oppression, such as racism, into one's understanding of trans clients' lived experiences), Fifth, it was recommended that providers offer personalized transition-related care. Sixth, increased provider accountability was recommended. Seventh, it was recommended that providers increase their awareness and knowledge regarding gender-affirming surgery, as well as helping to increase preparedness for surgery among their clients.

5.2 Links to Existing Literature and Novel Contributions

The results of the current study map onto the existing literature in a number of ways, as well as offer novel findings. To start, many of the subordinate themes found in the *Contributing factors to suicidal ideation* superordinate theme support and expand on the extant literature regarding suicide risk factors among trans individuals. Results showed that participants understood suicidal ideation and behaviour among trans individuals to be due at least in part to gender dysphoria, as well as in large part due to interpersonal and systemic factors such as anti-trans prejudice and stigma. As seen in the literature review, it is well documented that minority stress, transphobia and other forms of oppression, and social determinants of health negatively impact trans individuals' mental health, well-being, and suicidality. In addition, in a first study to examine gender minority stress and factors from the interpersonal theory of suicide (IPTS) among trans adults, Testa and colleagues (2017) found that external/distal minority stress variables (rejection, non-affirmation, and victimization) were related to suicidal ideation via internal/proximal minority stress variables (internalized transphobia and negative expectations). They also found that two internal/proximal minority stress variables (internalized transphobia and negative expectations) were related to suicidal ideation through two interpersonal theory of suicide factors (thwarted belonging and perceived burdensomeness). Relatedly, in a USA-based study that examined the relationship between minority stressors, depression, and suicide among trans individuals, Tebbe and Moradi (2016) found that minority stress (specifically internalized anti-trans attitudes, discrimination, and fear of anti-trans stigma) was related to suicide risk via a mediated relationship with depression. Taken together, these results indicate that it is important to consider minority stress as well as social exclusion when considering risk factors for suicide among trans individuals, which is reflected in the results of the current study as well.

The findings from the current study showed that factors that contribute to suicidal ideation and behaviour include family-related factors such as rejection, non-acceptance, and non-support. In the literature, family rejection has been shown to be a predictor of suicidal attempts among trans individuals (e.g., Klein & Golub, 2016). Specifically, Klein and Golub found that among their trans participants, "moderate levels of family rejection were associated with almost twice the odds of attempted suicide, and high levels of family rejection were associated with almost three and a half the odds of attempted suicide" when compared to trans participants who had reported low levels of family rejection (p. 3). The results of the current project expand on the existing literature by offering a nuanced understanding of how family-related factors interact with transition-related care and suicidality. For example, we saw in Collin's experience that his parents accepted trans people in general, but they did not believe Collin when he disclosed being trans to them, nor did they support his medical transition. This non-acceptance and lack of support caused Collin high levels of distress and contributed to his suicide attempt. Mickey, a provider, shared that she often sees adult clients become distressed and sometimes suicidal when their partner threatens divorce and alienation from their children if the trans person goes forward with transition-related care. Thus, the results of this study showed that family-related factors such as rejection, non-acceptance, and non-support can be perpetrated in a variety of ways by family members holding a variety of beliefs about trans people in general and about the trans person in their own family.

The current study found that factors that contribute to suicidal ideation varied across individual (e.g., shame, gender dysphoria), interpersonal (e.g., disempowerment), and systemic spheres (e.g., societal transphobia). Relatedly, Perez-Brumer and colleagues (2015) identified individual- and structural-level risk factors for suicide attempts among transgender adults. They found that higher rates of internalized transphobia (an individual factor) increased the odds of lifetime suicide attempts among their sample of transgender adults, as did being on the female-to-male spectrum, being a person of colour, and having less than a complete college degree. They also found that lower levels of structural stigma significantly negatively predicted lifetime suicide attempts even when controlling for gender identity, age, race, income, urbanity, and internalized transphobia.

A novel contribution of the current study lies in the analysis and subsequent mapping of contributing factors across individual, interpersonal, and systemic levels, while also mapping them across time periods (before, during, and after care). These results are the first such attempt at consolidating the two (levels and time frames) through trans individuals' and providers' understanding of the interaction between suicidality and transition-related care. As a novel, qualitative contribution to the literature, these results can be used to develop and test hypotheses that can be tested quantitatively. They can also be used by care provider readers to help deepen their understanding of factors that contribute towards or decrease suicidal ideation among trans individuals.

Many of the subordinate themes found in the *Factors that decrease suicidal ideation* superordinate theme support and expand on the resilience and suicide protective factors among trans individuals identified in the extant literature. Tebbe and Moradi (2016) demonstrated that social support from friends is a suicide protective factors for trans individuals, as it was significantly negatively related to suicide risk via the mediated relationship of depression. Similar to the results seen in the *Factors that decrease suicidality* superordinate theme in the current study, Tebbe and Moradi (2016) underlined the importance of trans individuals building and having support systems. They propose that "such social systems may act to attenuate feelings of isolation and loneliness, or thwarted belongingness (see Joiner, 2005)" (p. 530). They also proposed that socializing with other trans individuals may offer trans people the psychological experience of being mirrored and seen in their gender identity. This interpretation of the benefits of social support by Tebbe and Moradi is supported by the results of the current study, as several providers spoke at length about the benefits of social support as a suicide protective factor among their trans clients, due to the validation, mirroring, and gender affirmation their client received via those social relationships. Moody and Smith (2013) and Moody, Fuks, Peláez, and Smith (2015) also found that social support was a suicide protective factor for trans individuals. The former study was a quantitative study that showed that social support from family was significantly negative associated with suicidality among trans Canadian adult. The later study was a qualitative study that elucidated how both formal and social support is protective against suicidal ideation for trans Canadian adult. Specifically, participants reported the experience of being accepted and valued as the protective element of social support.

Continuing with the *Factors that decrease suicidal ideation* superordinate theme, findings from the current study showed that participants found self-determination and autonomy in the context of transition-related care to be a factor that helped decrease suicidal ideation and behaviour, whereas disempowerment (e.g., a lack of self-determination and autonomy) in the context of transition-related care was a factor that contributed to suicidal ideation and behaviour. In addition, provider participants spoke of the gatekeeping dynamic and how they navigated this role, as well as making recommendations regarding mental health professionals taking an advocacy stance in their work and within systems. These factors and recommendations can be understood as supporting the existing psychological literature on these topics. For example, Toivonen and Dobson (2017) map the Canadian Psychological Association's Code of Ethics' four higher-order guiding principles onto the WPATH's Standards of Care Version 6 in order to outline potential ethical issues in psychosocial assessments for gender affirming surgery. Specifically, they underlined the power imbalance between clients and mental health professionals and named the gatekeeping dynamic that is present due to mental health professionals being in a position of assessor. They also outlined the importance of mental health professionals recognizing clients' self-determination and autonomy. They recommend that mental health professionals involved in trans health care "advocate for individuals with gender dysphoria, to reduce the stigma and the discrimination transgender individuals face regarding education, health care, housing, and employment (Grant et al., 2011)" (p. 184). They also recommend that mental health care professionals "advocate for increased resources to promote timely access to care, given the distress that may result from extensive wait times for psychosocial assessments and SRS" (p. 184). Toivonen and Dobson's recommendations as outlined above are supported by the findings of the current study. Lastly, like Toivonen and Dobson posit, the results of the current study also outline the importance of recognizing and respecting trans individuals' right to self-determination and autonomy.

Developing identity clarity regarding one's gender identity was identified as a factor that decreased suicidal ideation and behaviour in the current study. For example, Devon spoke of participating in a community-based group aimed at helping individuals explore their gender identities, where they reported learning that non-binary identities exist and are valid identities. Devon shared that previous to having access to this knowledge they felt like they had been trying to solve a puzzle with some pieces missing, and now having the missing puzzle pieces helped decrease their distress and suicidal ideation. Developing identity clarity is closely related to the gender identity-related realizations theme that was identified to be a suicide protective factor identified by Moody, Fuks, Peláez, and Smith (2015).

While trans participants were not directly asked whether they considered their transition-related care to have been delivered in a culturally-competent/trans-affirmative way, participants often spoke of this subject spontaneously. For example, participants shared that negative, disappointing, non-affirmative, or trans-antagonistic experiences with transition-related care providers affected their well-being, and sometimes caused an increase in their suicidal ideation, even if that provider was in fact approving or delivering transition-related care. These results both support and expand on previous literature on the subject. For example, Katarri and colleagues (2016) investigated the relationship between trans culturally-competent primary health care and mental health outcomes. They found that current depression and suicidal ideation in the last year were associated with self-reported experiences with non-trans-affirmative primary care providers. Of note, Katarri and colleagues found that trans participants who reported currently having trans-affirmative primary care providers were half as likely to report experiencing suicidal ideation in the past year as trans participants who reported having non-affirmative health providers. While Katarri's results speak to primary health care, the results of the current study speak to a variety of care experiences including primary care, mental health care, and specialized care (e.g., endocrinology, psychiatry) in the context of transition-related care. Results of the current study showed that provider and trans participants alike viewed gender affirming practices during transition-related care as being helpful, whereas non-gender affirming practices were found to be unhelpful with regards to mental health and suicidality.

These findings suggest that helpful transition-related care is not simply the provision of transition-related care and services, but must also include gender affirmative aspects within the care itself via providers and systems involved in transition-related care. Sevelius (2013) defined gender affirmation as "the process by which individuals are affirmed in their gender identity through social interactions" (p. 675). Transition-related care is both a process that supports gender affirmation, and in which gender affirmation is likely a key aspect of helpful care. While medical and mental health care providers hold a great deal of power over, and therefore responsibility towards, all of their clients, this is certainly true of trans clients due to the marginalization trans individuals face overall, the inherent power imbalance in the client-provider dynamic in trans health care, and the negative mental health outcomes associated with non-affirmative care. Therefore, providers are tasked with providing culturally-competent, trans-affirmative transition-related care.

Even the most well-meaning providers hold power, which can be experienced by trans clients as discretional power. In a legal context, where this term is most used, discretionary power is defined as “a power that a person can use if that person thinks that it is suitable given the situation and circumstances” (Translegal, n.d.). The psychological impact of providers holding discretionary power can be seen across several themes, most notably the *Disempowerment* subordinate theme of the *Factors that contribute to suicidal ideation* superordinate theme. For example, some trans participants spoke of the detrimental impact of being denied transition-related care due to perceived arbitrary reasons and subjective decisions made by providers, and how this increased their suicidal ideation. Other participants spoke of expecting to have to justify their need for transition-related care and subsequently experiencing a decrease in their suicidal ideation when that was not the case. The aforementioned experiences can be linked back to providers being perceived as holding discretionary power, which may create a sense of uncertainty and acute or constant precarity for the trans person seeking care.

The subjective psychological experience of precarity, as seen in the reported experiences of disempowerment, is closely tied to the power imbalance between providers and trans individuals, and the very real possibility that providers will be uncertain or lacking in knowledge regarding transition-related care. For example, several trans participants reported experiencing their care providers as uncertain regarding aspects of transition-related care, as well as sometimes experiencing stigmatization and discrimination while seeking transition-related care, with both situations (provider uncertainty and stigmatization/discrimination) negatively impacting their overall well-being and sometimes increasing their suicidal ideation. As seen earlier in the literature review, Poteat et al. (2013) documented and explored the above-mentioned dynamic between trans individuals and health care providers and developed a model that incorporated power as a key factor influencing interactions between providers and trans individuals. Specifically, Poteat and colleagues' findings showed that both trans patients and care providers report experiencing uncertainty during interactions with each other: trans patients are uncertain whether their care providers will be competent and have the knowledge needed to care for them, and care providers are uncertain how to best care for trans patients. Uncertain providers who held discriminatory views towards trans individuals acted in ways that reinforced medical power and authority, which in turn maintained the stigmatizing and discriminatory practices found in some health care settings. Poteat and colleagues posited that this interaction between provider uncertainty, discriminatory views, and power, which results in continued discriminatory views in health care settings, functions to maintain "systems of inequity that contribute to health disparities" (p. 24) for transgender individuals.

Readers will recall that the WPATH standards of care suggest that a criteria for hormone therapy and upper/chest surgery is the following: "If significant medical or mental health concerns are present, they must be reasonably well controlled" (Coleman et al., 2011, pp. 34 and 69) and that the criteria for gender-affirming lower/genital surgery includes the following: "If significant medical or mental health concerns are present, they must be well controlled" (Coleman et al., 2011, p. 60). It is unclear what "reasonably well controlled" and "well controlled" mean exactly, leaving the interpretation to each clinician's subjective clinical judgment. As seen in the results, a few provider participants explained that they seek to help their clients stabilize different aspects of their mental health or substance use habits in order for the client to be able to access surgery, which can be experienced as gatekeeping by the client.

Specifically, a “not yet” from a provider conducting an assessment for surgery can sometimes be experienced as a “no” or as an additional barrier by a trans client/patient. When understood in the context of the numerous other barriers that many trans individuals already face when trying to access gender-affirming surgery (e.g., wait times, lack of services or resources), it is understandable that a “not yet” from a provider conducting an assessment is a distressing and demoralizing experience for a trans person seeking transition-related care. In addition, mental health stabilization is often non-operationalizable. In comparison to physical health stabilization, where objective bio-medical markers are often used as measures, mental health status (via self-report and/or assessment) is often subjective. Thus, mental health improvement (e.g., decreased active suicidal ideation, decreased substance use) is also difficult to operationalize and subjective, which adds uncertainty to a trans person’s path to accessing gender-affirming surgery.

5.3 Limitations and Reflections

Although this study has several strengths, it is not without limitations. The research question, and therefore the interview protocol, focused on participants’ understandings of the interaction between suicidality and transition-related care. Transition-related care was understood broadly by the researcher as any and all care related to one’s transition, including but not limited to psychological and medical care. However, it is possible that participants understood transition-related care in a different way, perhaps a more medical way, and limited their responses to their experiences of medical transition-related care. Indeed, results showed a focus on gender-affirming hormone therapy and surgery in many participants’ responses. This focus was noticed by the research team after interviews had been completed and preliminary data analysis had occurred. As a result, we believe that a limitation of the current project is the unfortunate and unintentional potential reinforcement of the gender binary via the medical focus of transition-related care that emerged.

An additional limitation revolves around the fact that the interview protocol did not initially include explicit questions about how participants understood complex intersecting identities to interact with suicidality and transition-related care. This omission was not an oversight due to the research team not thinking about this subject (e.g., the project was designed with an intersectional paradigm), rather it was not asked about because it was assumed that participants would spontaneously address it when asked broadly about their understanding of the interaction between suicidality and transition-related care. As is a common best practice in qualitative research, the data from the first few interviews were reviewed and the interview protocol was adjusted to include an explicit question on the topic.

A further interview protocol-related limitation was identified in the finals stages of analysis and manuscript writing. This writer realized the lack of clarity in the following question, which was posed only to providers: “Do you consider suicidality to be a contraindication to transition-related care?” Both “suicidality” and “transition-related care” are vague terms in the context of this specific question, which likely affected the data collected. This writer now realizes that a clearer question (e.g., “Do you consider past or present suicidal ideation and/or behaviour to be a contraindication to hormone therapy and/or gender affirming surgery?”) may have resulted in clearer answers. In addition, data are limited as the above question was only asked of providers.

Another limitation of the current project is regarding the social identities of the participants, including racial/ethnic identity, age, and providers’ professions. Firstly, only a minority of participants were BIPOC (Black, Indigenous, and other People of Colour). During the course of recruitment, BIPOC-specific recruitment material was used in order to invite BIPOC trans individuals to participate in the project, with the hope of including and amplifying their voices. Although an intersectional lens was employed throughout the project and participants spoke of intersectional ways transition-related care interacts with suicidality, the effects of racism and colonization on the interaction between transition-related care and suicidality was spoken about by a minority of participants. In addition, all trans participants were under the age of 40 years old, with the majority of trans participants being between 30-39 years old. Thus, perspectives were not heard from trans individuals over the age of 40, which may represent a cohort effect and a lack of multigenerational experiences. Lastly, although the current study was open to all health care providers who provide transition-related care, the majority of provider participants were mental health care providers, with only one medical care provider. As such, perspectives were not heard from a variety of health care providers.

An additional limitation is with regards to the limited recruitment strategies used, for ethical reasons, which likely limited the visibility and awareness of the project. More specifically, a low-key recruitment strategy was intentionally used (e.g., physical posters in community centres and health centres, recruitment emails sent out to professional networks and community organizations). No recruitment was attempted via social media or other large-scale means. This low-key recruitment approach was intentionally employed as a way for the research team to prioritize the well-being of trans individuals via the research team’s ethical considerations of suicide research in a marginalized community. As such, the recruitment strategies employed likely resulted in the material reaching a limited audience as opposed to a broader audience.

The ability for the results to be generalized outside of the study sample is often something that is considered when reviewing a project’s strengths and limitations. Although present, lack of generalizability is not a limitation in the current study. More specifically, as is the case with all qualitative research, IPA is not a methodology that produces generalizable results. Rather, IPA seeks to come to a deep and rich understanding of a phenomenon via the researcher making sense of participants’ understandings of their own lived experiences. As such, the results of the study are not generalizable, as they were never intended to be. However, the results of the current study, like all results of qualitative studies, can have some level of transferability regarding the readers’ understanding of the phenomenon in question. Readers can then take their understanding of the phenomenon and integrate it in their next interactions with trans individual or care providers, in their clinical or research work, and/or in their personal and professional lives.

While considering the above-mentioned limitations, this writer reflected on the implications of the research question itself. For example, at the beginning of the results chapter we saw that Patricia expressed some understandable difficulty with and frustration towards being asked to speak mainly about the interaction between transition-related care and suicidality, as she reported the factors contributing to her suicidality were complex and intertwined. She further explained that by exploring the interaction between transition-related care and suicidality only, she was experiencing the research topic to perhaps perpetuate the narrative that once trans individuals access affirmative gender affirming care, they are expected to be completely free of distress and no longer experience contributing factors to suicidality. This narrative is often presented in a simplified way to convey the importance of access to transition-related care. However, it is a narrative that can lead to any account of distress, depression, or suicidality after accessing care being susceptible to being used as “proof” that transition-related care is not helpful or effective. In addition, it is a narrative that again essentializes trans individuals to their bodies only, and strips them of their humanity. For example, why is it understandable for cis individuals (who presumably have never accessed transition-related care) to experience distress, depression, and suicidal ideation, but not for trans individuals to experience the same post transition-related care, particularly when we consider the intersectional minority stress that trans individuals experience and the ongoing transphobia they may experience? All of this led this writer to continuously reflect on and consider the following: How can one advocate for access to timely, affirmative, competent transition-related care without (a) reducing or essentializing trans individuals to their bodies only, (b) simplifying trans individuals’ lived experiences and narratives and subsequently sacrificing a true understanding of their experiences, (c) perpetrating the narrative that transition-related care is a “miracle cure,” and (d) causing any harm? Or, in strength-based, positive terms: What does it look like to advocate for access to timely, affirmative, competent transition-related care while (a) honouring trans individuals’ lived experiences holistically, (b) presenting nuanced understandings of trans individuals’ lived experiences and narratives, (c) underlining the fact that transition-related care is often necessary (for those who seek, desire, and/or need transition-related care) but not necessarily sufficient on its own to help alleviate suicidal ideation and behaviour, and (d) be as helpful as possible while doing this work?

5.4 Clinical Implications

Results of the current study showed that participants often understood intrapersonal and systemic disempowerment to play a role in the interaction between increased suicidality and transition-related care. Furthermore, disempowerment was experienced in several nuanced ways, including lack of bodily autonomy and integrity, loss of bodily privacy, and feeling violated by providers. Results also showed that the participants reported experiences of empowerment to have had a positive effect on the interaction between suicidality and transition-related care. For example, affirmative consent-based care, personalized transition-related care, and providers and clinics using proper names and pronouns emerged as factors that decreased participants' suicidal ideation.

Mental health and medical care providers are often in the position of assessing trans individuals' capacity to provide informed consent to transition-related care. In addition, some providers also view their role as assessing the person for gender dysphoria; assessing the person's overall mental health and if mental health concerns are present, assessing the degree these concerns impact the person's functioning; and assessing the person's ability to cope with a major life change, such as starting hormones or having gender-affirming surgery. Results from the current study showed that depending on the outcome of their assessments, some providers will want to work with clients to help them stabilize certain aspects of their lives (e.g., suicidality, substance use) before approving or starting transition-related care. While provider participants often approached these assessments with the best of intentions (e.g., wanting the best possible outcomes for their trans clients), the need for stabilization before approval or delivery of transition-related care was often experienced as gatekeeping and distressing by trans individuals. The current results support the existing literature, which document the gatekeeper-advocate role that providers often negotiate (e.g., Budge, 2015; dickey and Budge, 2017). In addition, results expand the current literature on the topic. Specifically, results showed that even experienced, well-meaning providers can and will intentionally and unintentionally act as gatekeepers, in large part due to their beliefs and professional and ethical responsibilities, as well as current guidelines and standards of care that require providers to be assessors. Providers thus will sometimes be in the position to help alleviate suicidal ideation and behaviour by helping to facilitate access to transition-related care, and will sometimes be one of the sources of distress that contributes to their clients' suicidal ideation. As seen in the recommendations of the current study, as well as the extant literature, providers are encouraged to increase access to transition-related care for trans clients who are seeking that care.

The above results have important clinical implications. It is clear that having access to transition-related care is of utmost importance; however, having access to empowering transition-related care may be just as important. Providers who approve or deliver transition-related care are encouraged to work from a client-centered, informed consent, transparent, trauma-informed, affirmative, and culturally-competent care model, in which they work to provide care in an empowering way to trans clients. This includes personalizing care as much as possible (within current medical, psychological, and ethical parameters) in order to centre trans clients and their needs in their own care, as well as providing accepting, affirmative, and celebratory messages to trans clients. It also includes employing a transparent clinical/therapeutic approach, which is a "critical practice to subvert processes of oppression in gender health care" (Rider et al. 2019, p.279) and constitutes explicit information sharing between provider and client. Primary care providers are often among the first people to whom trans people disclose their gender identities, and as such, providers are encouraged to provide an affirmative response during this critical coming out stage, where the response of others is paramount to well-being (Bockting & Coleman, 2016).

There is much that can be done that is proactive and precedes (and hopefully precludes) suicidal ideation and behaviour among trans individuals. Because suicidality among trans individuals is in large part due to disempowerment, oppression, stigma, social determinants of health, and minority stress, then it follows that addressing those factors would create positive changes for trans individuals and improve their physical and mental health. Such changes include systemic changes, such as decreasing societal transphobia and genderism via advocacy, education, and activism. These changes also include interpersonal interventions, such as interventions at the family-level aimed at increasing acceptance and support of trans people (Moody & Smith, 2013); interventions aimed at increasing affirmative social support networks (American Psychological Association, 2015); and interventions aimed at facilitating peer support from and by trans people (Bockting et al., 2013). It is important to note that cultural and intersectional considerations should be taken into account throughout all levels of intervention (individuals, interpersonal, and systemic). For example, there exist guidelines for suicide prevention among Two-Spirit people that underline the fact that a Two-Spirit person's "risk can be decreased if he/she is connected to his/her culture and traditions in a way that recognizes the impacts of colonization" (First Nations Centre, 2012, p. i). This is but one example of how an intersectional lens can be used in culturally-competent pre-crisis suicide prevention.

Pre-crisis suicide prevention among trans individuals should also include intrapersonal interventions. For instance, interventions aimed at increasing suicide resilience in trans individuals (Moody & Smith, 2013) and coping with minority stress and its correlates (Hendricks & Testa, 2012; Istar-Lev, 2004) would likely prove to be beneficial. It is important to note that interpersonal and intrapersonal interventions are necessary but not sufficient on their own. More specifically, wide-scale societal changes (e.g., decreases in transphobia and violence against trans people; decreases in anti-trans rhetoric from individuals in positions of power that influences public opinion; increases in human rights policies and protections; increases in societal acceptance and celebration of trans people; increases in access to education, safe housing, employment, and healthcare) are absolutely necessary. If the emphasis is placed solely on person- and family-level interventions, we risk placing the onus on oppressed and marginalized individuals for their own healing in a society that actively discourages mental health and well-being in this population.

The results of the current study showed that the study's participants understood suicidality to be present before, during, and after access to transition-related care for a variety of reasons. Providers are therefore encouraged to strive to understand clients holistically; specifically, to understand that mental health concerns, including suicidality, can continue after a person transitions. Indeed, extant scholarship demonstrates that distal and proximal stressors such as unemployment, non-affirmation of gender identity by others, and internalized transphobia are predictive of depressive symptoms in "post-transition" trans adults (Jäggi et al. 2018). Just as we understand cis individuals to have a full range of mental health experiences, from health to illness, we must understand that trans individuals also have that same full range, including after one receives transition-related care. For example, results of the current study showed that participants understood suicidality to be in part due to dysphoria, and identified transition-related care to be an important antidote to suicidality via decreasing dysphoria. However, results also showed that participants had a rich and varied understanding of suicidality as well as its interaction with transition-related care, and that dysphoria and access to care was but one piece of a large, multi-faceted understanding of suicidality and transition-related care. Providers are therefore encouraged to strive to see trans clients holistically, and query past and current experiences of dysphoria, disempowerment, difficulty accessing transition-related care, and minority stress such as transphobia, as well as protective and resilience factors such as experiences of bodily autonomy and social support.

It is important to note the already existing resilience, strength, and coping within trans individuals and communities. The author would be remiss to paint a picture of trans individuals as powerless victims of oppression with no voice or coping strategies. In fact, resilience, coping, and thriving among trans individuals manifest themselves in a variety of remarkable ways, such as seeking and making use of social support, developing suicide resilience, using facilitative coping cognitions, embracing self-worth, cultivating hope for the future, advocating for one's self and one's community, and fighting for system-level changes (Budge, Katz-Wise, Tebbe, Howard, Schneider, & Rodriguez, 2013; Budge, Rossman, & Howard, 2014; Moody et al., 2013; Singh, Hays, & Watson, 2011). Community activism and advocacy by and for trans people are also outstanding examples of strength and resilience in this population, both of which have contributed significantly to the important trans-related societal changes seen in the last several decades.

5.5 Future Research

Qualitative research aims to further readers' understanding regarding a specific topic, and IPA in particular aims to deepen and nuance readers' understanding regarding a particularly salient or important life event for participants. The current study used IPA to document and interpret trans people's and care providers' understandings of the interactions between transition-related care and suicidality. While the current studies has it strengths, it is of course not without limitations. There are several ways that future research can address the limitations of the current study, as well as further advance readers' understanding of the interaction between transition-related care and suicidality.

Future counselling psychology-related trans health research may benefit from additional qualitative inquiries aimed at exploring trans individuals' lived experiences regarding what affirmative trans-competent care looks and feels like for trans individuals, beyond approval and/or delivery of transition-related care.

Next, asking questions in a general, non-leading manner is a common practice in qualitative research in order to allow participants to interpret the question and organically share their lived experiences, opinions, and beliefs. That being said, future research may benefit from greater language precision and clarity during the research process, such as asking specifically about suicidal ideation and behaviour rather than suicidality broadly, and asking about psychotherapy, assessments, hormone replacement therapy, and surgery rather than transition-related care broadly. Greater precision in the research process and interview protocol may allow for greater precision in the data, and thus results.

Future research would benefit from including more racialized participants and trans participants over the age of 40 years old, in order to explore their lived experiences and their understandings regarding the interactions between transition-related care and suicidality.

Lastly, the current project was completed in Canada, which is a country with socialized medicine (although, as we saw in earlier sections, the mental health and assessment portions of transition-related care are most often not covered by socialized medicine). As such, future research would benefit from similar research endeavours in other contexts, such as countries without socialized medicine, to account for the additional financial barriers likely experienced in these countries by trans individuals trying to access transition-related care (such as gender-affirming surgeries).

5.6 Statement of Contribution

The current study is the first qualitative study to seek to understand the lived experiences of trans individuals regarding the interaction between suicidality and transition-related care, and it is the first qualitative study to query care providers' understanding of this interaction. Results both support the existing literature and offer novel contributions. In addition, many trans participants spontaneously shared that they felt empowered during the interview process by being able to name and make sense of their experiences and make recommendations. It is my humble hope that the results of the current study can and will be used to help improve the delivery of transition-related care and best practices in the fields of trans health and trans-affirmative psychotherapy, and it is my hope that it is a (small) contribution towards helping to decrease the rates of suicidal ideation and behaviour in trans communities.

5.7 Final Summary

The current research study aimed to develop a deep understanding of how trans individuals and care providers who work with trans individuals comprehend and make sense of the interaction between suicidality and transition-related care. The study summarized participants' understanding of the factors that contribute to or decrease suicidal ideation and behaviour among trans individuals at the individual, interpersonal, and systemic levels, as well as temporally across care (before, during, and after transition-related care). In addition, the study outlined some of the ways provider participants work with trans individuals experiencing suicidal ideation or behaviour. Furthermore, the study outlined participants' recommendations for both trans individuals and care providers on the topic of understanding the interaction between suicidality and transition-related care. Lastly, suggestions were made regarding integrating the results and extant literature into clinical practice as well as regarding next steps for future research. The results from the current research study can be used to inform best practices regarding understanding and addressing the interaction between transition-related care and suicidal ideation and behaviour.

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Appendix A: Recruitment Poster – All Trans Participants

We are a small team of researchers and care providers specializing in LGBTQ health and suicidality. Chérie Moody is currently completing her dissertation. Her Master's research projects explored suicide protective factors among trans adults.

Do you identify as trans?

Are you 18 years old or older?

Do you live in or near Toronto, London (ON) or Montreal?

Have you accessed/tried to access transition-related care in the last 5 years?

Have you experienced suicidality (suicidal thoughts or actions) in the last 5 years?

If so, we would like to hear about your experience.

- **We are currently speaking with trans-identified adults who live in or around Toronto, Montreal, or London (ON)** about their experiences of accessing/trying to access transition-related care as well as having experienced suicidality (suicidal thoughts or actions) in the last 5 years.
- **BIPOC (Black, Indigenous, People of Colour) trans and Two-Spirit individuals are particularly encouraged to participate**, as are other trans individuals with multiple intersecting identities. The study is open to individuals who identify under the larger trans umbrella, including but not limited to binary and non-binary, Two-Spirit, agender, bigender, and genderqueer individuals, and individuals of trans experience.
- Interviews are **confidential, in-person, and last 45-90 minute**
- As a small thank you, **people who participate are compensated $30**
- Interviews can be conducted in **English or French**, and best efforts will be made to access trans-positive interpretation for other languages, including ASL, as necessary
- We are hoping the results will be used to **improve care providers' delivery of transition-related care**
- This study has been reviewed by the Research Ethics Board of McGill University (REB #280-1015)

If you are interested or would like more information, please contact Chérie at Cherie.moody@mail.mcgill.ca

This project is being conducted under the supervision of Dr. Pierre-Paul Tellier, who can be contacted at 514-398-6017 or pierre-paul.tellier@mcgill.ca

If you are currently in crisis or having serious thoughts of suicide, please call:
Trans Life Line at 1-877-330-6366
Hope for Wellness (For Indigenous people across Canada) at 1-855-242-3310
Suicide Action Montreal at 514-723-4000
The Toronto Distress Centre at 416 408-HELP (4357)
or ReachOut (London, ON) at 519-433-2023

Appendix B: Recruitment Poster – BIPOC Trans Participants

Are you a BIPOC Trans, Non-Binary, or Two-Spirit young adult or adult?

Do you live in Toronto, London (ON) or Montréal?

Have you accessed/tried to access transition-related care in the last 5 years?

Have you experienced suicidality (suicidal thoughts or actions) in the last 5 years?

If so, we would like to hear about your experience for a research projects that aims to improve health care providers' delivery of transition-related care.

- **We are currently speaking with BIPOC (Black, Indigenous & People of Colour) trans, non-binary, and Two-Spirit young adults and adults who live in or around Toronto, Montréal, or London (ON)** about their experiences of accessing/trying to access transition-related care as well as having experienced suicidality (suicidal thoughts or actions) in the last 5 years.
- This study had previously been open to all young adults and adults who identified as trans, non-binary, and Two-Spirit, and we are now inviting only BIPOC trans, non-binary, and Two-Spirit individuals to participate in order to ensure inclusion and amplification of BIPOC voices and lived experiences.
- Interviews are **confidential, in-person, and last 45-90 minute**
- As a small thank you, **people who participate are compensated $30**
- Interviews can be conducted in **English or French**, and best efforts will be made to access trans-positive interpretation for other languages, including ASL, as necessary
- We are hoping the results will be used to **improve care providers' delivery of transition-related care**
- We are a small team of researchers and care providers specializing in LGBTQ health and suicidality. Chérie Moody (she/her) is conducting these interviews as part of her research for her PhD. Her Master's research projects explored factors that help protect trans adults from suicide. Chérie is a White queer person who strives to do helpful research and clinical work using an integrative trans-affirmative, anti-racist and anti-oppressive, and intersectional feminist approach.
- This study has been reviewed by the Research Ethics Board of McGill University (REB #280-1015).

If you are interested or would like more information, please contact Chérie at Cherie.moody@mail.mcgill.ca

This study is being conducted under the supervision of Dr. Pierre-Paul Tellier, who can be contacted at 514-398-6017 or pierre-paul.tellier@mcgill.ca

If you are currently in crisis or having serious thoughts of suicide, please call:
Trans Life Line at 1-877-330-6366
Hope for Wellness (For Indigenous people across Canada) at 1-855-242-3310
Suicide Action Montreal at 514-723-4000
The Toronto Distress Centre at 416 408-HELP (4357)
or ReachOut (London, ON) at 519-433-2023

Appendix C: Screener Questionnaire - Trans Participants

Date: ___________________

Name: ___________________

Phone number: ___________________

Email address: ___________________

Intro:

Hello, may I speak with ____________. Hi my name is Chérie Moody. I'm returning your call/following up on your email regarding the research project about accessing transition-related care. Is now a good time to chat for a few minutes so I can explain the project to you? It will take approximately 5-10 minutes.

If no: When would be a better time to call you back? ________________________________

If yes: Great, thanks!

This project focuses on understanding trans adults' experiences of accessing transition-related care while also experiencing suicidal ideation. We know that there are high rates of suicidal ideation in trans communities but as of now we do not know how those thoughts interact with accessing transition-related care.

By transition-related care I mean going to see any medical or mental health professional during the transition process. By suicidal ideation or behaviour I mean any thoughts about suicide or any suicide attempts.

The goal of the research project is to understand people's lived experiences with suicidality (suicidal thoughts or actions) and transition-related care. One on one interviews are being used in order to hear trans people's stories. The goal is to honour trans people's voices and to position trans people as experts in their own experiences. So do to this I am conducting interviews with people who are interested in participating and who meet the criteria. The interviews take anywhere from 45-90 minutes each and participants will be given a $30 honorarium.

Do you have any questions at this point?

Would you be interested in participating in this study?

If yes:

So, now I am going to be asking you some questions to determine whether you are eligible to participate in our study.

1) How old are you? _______________
   (Must be over 18 in Québec and 19 in Ontario. If not, refer to Ineligibility section, #1)

2) Do you live in either Montréal, Toronto, or London (or surrounding areas)?
   (Must live in Montréal, Toronto, or London or surrounding areas. If not, refer to Ineligibility section, #2)

3) Do you identify as trans (e.g., trans, transgender, transsexual, Two-spirit, genderqueer, gender fluid, non-binary) or someone who has transitioned?
   (Must identify as trans or someone who has transitioned. If not, refer to Ineligibility section, #3)

4) Have you accessed or tried to access transition-related care within the last 5 years? This includes seeing any doctor, nurse, therapist, endocrinologist, or surgeon during your transition.
   (Must have accessed or tried to access transition-related care in last 5 years. If not, refer to Ineligibility section, #4)

5) Were you experiencing suicidal ideation or behaviour around the time you accessed or tried to access transition-related care?
   (Must answer yes. If not, refer to Ineligibility section, #5)

6) Would you be comfortable participating in a face-to-face interview to talk about your experience of accessing/trying to access transition-related care and your experiences of suicidality (suicidal thoughts or actions) that occurred around the same time?
   (Must answer yes. If not, refer to Ineligibility section, #6)

7) Would you be comfortable with the interview being recorded? Your name will never be spoken on tape and the recording will be kept completely confidential.
   (Must answer yes. If not, refer to Ineligibility section, #7)

8) Are you available to meet for 45-90 minutes in the next month or two?
   ____
   (Must be available. If not, refer to Ineligibility section, #7)

If a participant is eligible:

Thank you for your interest in this research project. You are eligible to participate and we would be delighted to invite you to do so.

9) I'd like to meet with you for the interview in the next few weeks, would that be possible?
   Schedule first interview: ____

10) What's the best way to reach you in order to send you a friendly reminder a few days before the interview?

Circle one: email or phone
If phone: Can we leave a message? YES NO

If you need to reach us before we reach you, please feel free to email me at Cherie.moody@mail.mcgill.ca. I will send you a confirmation email with this information.

Thank you for your interest in this research project, I am very much looking forward to meeting you!

If a participant is ineligible:

Thank you for your interest in our study. Unfortunately, you are not eligible to participate in this study at this time because ____________.

Possible reasons for ineligibility:

1) Age → We are seeking participants over the age of majority (18 in Québec and 19 in Ontario).
2) Location → Because the interviews will be face to face we are looking for people who live in either Montréal, Toronto, or London (or surrounding areas), since that is where the interviews are taking place.
3) Identity → We are looking for participants who either identify as trans (e.g., trans, transgender, transsexual, Two-spirit, genderqueer, gender fluid, non-binary) or who have transitioned.
4) Transition-related care → We are seeking participants who have accessed or tried to access transition-related care in the last 5 years. This is due to the fact that the interviews are based on what people remember, and if someone transitioned over 5 years ago it is possible that they will not remember exactly what that experience was like or how they felt.
5) Suicidality → We are seeking participants who experienced suicidal thoughts or actions around the same time they accessed or tried to access transition-related care**.** This piece is important because it is the focus of the research project.
6) Comfort with interview → We are seeking participants who would be comfortable being interviewed for a few hours. These interviews are face to face, and are the only way we are collecting data for this project.
7) Comfort with recording → As interviews will be recorded and later transcribed, we are seeking participants who would be comfortable being recorded.
8) Not available → I am hoping to meet with all participants in the next few months, but perhaps if I am still conducting interviews beyond that time I can re-contact you to see if you are still interested and perhaps available then.

Their answer/comments: ____

Appendix D: Screener Questionnaire - Provider Participants

Date: ___________________
Name: ___________________
Phone number: ___________________
Email address: ___________________

Intro:
Hello, may I speak with ____________. Hi my name is Chérie Moody. I'm returning your call/following up on your email regarding the research project about accessing transition-related care. Is now I good time to chat for a few minutes so I can explain the project to you? It will take approximately 5-10 minutes.

If no: When would be a better time to call you back? ________________________________

If yes: Great, thanks!

If yes:
This project is a qualitative research project focused on understanding the experiences of care providers who deliver transition-related care and who may or may not have worked with suicidal trans clients. We know that there are high rates of suicidal ideation in trans communities but as of now we do not know how those thoughts interact with accessing transition-related care.

By transition-related care I mean any care or intervention aimed at helping a client transition, such as a mental health or readiness assessment, a consultation, a medical intervention such as prescribing or administering hormones or referring someone for surgery or performing surgery.

The goal of the research project is to understand providers' experiences delivering transition-related care to suicidal clients, as well soliciting providers' feedback and suggestions for how to address the phenomena. Qualitative methodology is being used to explore this phenomena, thus I am conducting interviews with people who are interested in participating and who meet the criteria. The interviews take approximately one 1 hour and can be done in person or over skype.

Do you have any questions at this point? Would you be interested in participating in this study?

If yes:
So, now I am going to be asking you some questions to determine whether you are eligible to participate in our study.

1) Have you seen at least one trans client or patient (e.g., trans, transgender, transsexual, Two-spirit, genderqueer, gender fluid, non-binary) in the last 5 years?______________________
   (Must answer yes. If not, refer to Ineligibility section, #1)

2) Have had contact with the/these trans client(s)/patient(s) in the context of initiating or delivering transition-related care?____
   (Must answer yes. If not, refer to Ineligibility section, #2)

3) Would you be able and willing to participate in a one hour interview, either in person or over skype? This interview would be audio recorded so that I can later transcribe it. Audio files and transcripts are identified with participant pseudonyms in order to protect participants' confidentiality.___________________________________
   (Must answer yes. If not, refer to Ineligibility section, #3)

4) Are you available to meet for this interview in the next month or two? ________________
   (Must be available. If not, refer to Ineligibility section, #4)

If a participant is eligible:
Thank you for your interest in this research project. You are eligible to participate and we would be delighted to invite you to do so.

5) I'd like to meet with you in the next week or two, would that be possible?
   Schedule first interview: ____
6) What's the best way to reach you in order to send you a friendly reminder a few days before the interview?
   Circle one: email or phone
   If phone: Can we leave a message? YES NO

If you need to reach us before we reach you, please feel free to email me at Cherie.moody@mail.mcgill.ca. I will send you a confirmation email with this information. Thank you for your interest in this research project, I am very much looking forward to meeting you!

If a participant is ineligible:
Thank you for your interest in our study. Unfortunately, you are not eligible to participate in this study at this time because ____________.

Possible reasons for ineligibility:

9) Trans client/patient → We are seeking participants who have worked with at least one trans client/patient in the last 5 years. This is due to the fact that the interviews are based on what people remember, and if someone worked with a trans client over 5 years ago it is possible that they will not remember exactly what that experience entailed.

10) Transition-related care → We are seeking providers who have been involved in the initiation or delivery of transition-related care.

11) Interview: → We are seeking participants who would be able and willing to participate in an interview as interviews are the only way we are collecting data for this project.

12) Not available → I am hoping to meet with all participants in the next few months, but perhaps if I am still conducting interviews beyond that time I can re-contact you to see if you are still interested and perhaps available then?

Their answer/comments: ____

Appendix E: Informed Consent Form - Trans Participants

INFORMED CONSENT TO PARTICIPATE IN RESEARCH

Suicidality and access to transition-related care

REB # 280-1015

Principal Investigator:
Chérie Moody, MA, PhD candidate, McGill University, Montreal, QC, Canada
514-398-2904, Cherie.moody@mail.mcgill.ca
Supervisors:
Pierre-Paul Tellier, MD, McGill University, Montreal, QC, Canada, 514-398-6017, pierre-paul.tellier@mcgill.ca
Nathan Smith, PhD, University of Houston, Houston, TX, USA
ngsmith@central.uh.edu, (713) 743-7648

Purpose of the Study

This research project is being carried out by the above researcher. As a self-identified trans person, you are being asked to participate in a study to better understand your experiences of accessing or trying to access transition-related care while also experiencing suicidality (suicidal thoughts or actions). Previous studies have shown that there is a high suicide attempt rate among trans individuals. You will be asked about suicidal thoughts and behaviours you may or may not have experienced as well as being asked about your experiences of accessing or trying to access transition-related care.

Procedure of the Study

If you agree to participate in this study you will be asked to provide some general demographic information. In addition, you will be asked to participate in an interview, which will last 45-90 minutes. The questions asked during the interview will be regarding your experiences of accessing or trying to access transition-related care, any suicidal ideation or behaviour you experienced, and how those events impacted you. You will also be asked to participate in a short post-interview phone conversation, known as a follow-up contact.

In order to thank you for your time, you will be given an honorarium of $30.

You will also have the option to indicate your interest in participating in future research conducted by the above researcher. Should you wish to participate, you will be asked to indicate your email address and phone number. Please note that indicating your interest is not binding and you are not obliged to participate in future research should you be invited to do so.

Risks and Benefits

There are limited risks associated with this study. There is a chance that you might become uneasy or upset while answering the interview questions. In the event that the topic stirs up negative emotions, you may discontinue and withdraw from participation at any time without penalty (e.g., you will not be financially penalized and your access to services will in no way be penalized). Should you experience any emotional discomfort as a result of your participation in this study and feel as though you need to discuss this discomfort with a professional, the Canadian Register of Health Service Providers in Psychology provides a psychologist locator service that you may access by visiting http://www.crhspp.ca/findlist.php. **Furthermore, contacting your personal general physician or a local hospital is also a way of getting in touch** with a professional who can help you. Should you need to speak to someone immediately regarding **your experience with suicidal thoughts or behaviours please call the Trans Lifeline at** (877-330-6366) (http://www.translifeline.org). The Trans Lifeline is staffed a minimum of 12 hours a day and a maximum of 18 hours a day. In the case that you need assistance outside of the Trans Lifeline's hours, contact Suicide Action Montreal (866-277-3553) or the Toronto Distress Centre (416-408-4357). **Furthermore, if you are currently experiencing serious thoughts of ending your life you should immediately go to the emergency room of your local hospital to seek help.**

A potential benefit of answering the questions will be to help raise awareness of these important issues in the public forum. While there may be no direct benefit to you, participation may provide you with the opportunity to better understand your own experiences.

Participant Rights

You do not have to answer any questions you would rather not answer. You are free to withdraw from this study at any time without any penalty or prejudice. You may withdraw in one of two ways:

1) You may end the interview at any point and request withdrawal from the study. Your interview will not be used in the research project.

2) If you decide to withdraw after the completion of the interview, you may contact Cherie Moody (Cherie.moody@mail.mcgill.ca) and request withdrawal from the study. It is possible to withdraw your data from any unpublished reports for up to 7 years after participation: after 7 years, all identifiable data will be destroyed and it will no longer be possible to trace your data in order to withdraw it.

Confidentiality

All data obtained during this study will be kept strictly confidential and will be identified only by an assigned code number. The interview will be audio taped to ensure accuracy of the content of the interview; however, your name will not be spoken on the tape. Instead, you will select a pseudonym to be used during the interview. Audio recordings will never be disseminated. Audio recordings will only be transcribed by the principal investigator (Chérie Moody), or a research assistant or professional transcriber who has signed a confidentiality agreement; no other person will have access to any identifying information. Only the principal investigator (Chérie Moody), her research supervisors (Drs. Nathan Smith and Pierre-Paul Tellier), and some student research assistants at McGill University will have access to de-identified data. Data will be kept in secure digital data storage devices by all those who have access to it. The researchers will at all times comply with the Tri-Council ethical guidelines for research with human subjects. Things that you say may be presented without specific reference to you, referenced only by pseudonym and demographic information, or combined anonymously in aggregate form with the actions and words of other participants.

We will keep all the facts about you private. We would have to breach your confidentiality only:
a) If you intend to harm yourself,
b) If you intend on harming someone else,
c) If you inform us that a child is currently at risk for abuse or neglect,
d) If you report sexual abuse by a health care practitioner, or
e) If the records are subject to a subpoena by the courts (records can be opened by a specific court order but it is highly unlikely that this would ever happen).

Quotations from participants may be used during the presentation of results, either in manuscripts or at conferences/trainings/workshops. Care will be taken when presenting quotations in order to ensure your confidentiality.

Dissemination of results

Results will be disseminated to academic, mental health, medical, and community audiences. Specifically, research findings will be submitted to psychology journals, LGBT-focused journals, and suicide-focused journals, as well as at conferences and to community organizations.

Contacts

If you have any questions or desire further information with respect to this study you may contact Chérie Moody, the principal investigator, at cherie.moody@mail.mcgill.ca. You may also contact the principal investigator's academic supervisors; Dr. Pierre-Paul Tellier can be contacted at pierre-paul.tellier@mcgill.ca or 514-398-6017, and Dr. Nathan Smith can be contacted at ngsmith@central.uh.edu or 713-743-7648.

For information about your rights as a participant in a study, or concerns about risks, you may contact the Ethics Review Board of McGill University at 514-398-6831 or Lynda.mcneil@mcgill.ca.

Please note that the principal investigator and her academic supervisors are available to answer questions regarding the study or participation in the study but that this contact is not a suicide intervention technique nor an emergency/crisis service; they cannot respond immediately nor can they counsel participants regarding the thoughts or feelings the participants may be experiencing.

Participant's Consent

I have reached the legal age of majority in my province of residence. This research project has been explained to me. I have carefully read the above information and have had the opportunity to have my questions answered. I freely consent and voluntarily agree to participate in this research project. I also consent to being audio taped. I have been given a copy of this participant consent form for my records.

____
Name (Printed)

____
Signature

____
Date

I agree to participate in the follow-up interviews.

Yes ☐ No ☐ Initials: ________________

I agree to the follow-up contacts by phone following each interview.

Yes ☐ No ☐ Initials: ________________

I agree to my de-identified data being used for Cherie Moody's future research projects.

Yes ☐ No ☐ Initials: ________________

I agree to be contacted to be invited to participate in future research project conducted by the principal investigator. This agreement indicates my interest in being contacted only, and does not bind me to participate in any future research project.

Yes ☐ No ☐ Initials: ________________

Appendix F: Informed Consent Form - Provider Participants

INFORMED CONSENT TO PARTICIPATE IN RESEARCH
Suicidality and access to transition-related care
REB #280-1015
Principal Investigator:
Chérie Moody, MA, PhD candidate, McGill University, Montreal, QC, Canada
514-398-6908, Cherie.moody@mail.mcgill.ca
Supervisors:
Pierre-Paul Tellier, MD, McGill University, Montreal, QC, Canada,
514-398-6017, pierre-paul.tellier@mcgill.ca
Nathan Smith, PhD, University of Houston, Houston, TX, USA
(713) 743-7648, ngsmith@central.uh.edu

Purpose of the Study

This research project is being carried out by the above researcher. As a medical or mental health care provider, you are being asked to participate in a study to better understand your experiences of working with trans individuals who are accessing transition-related care. Furthermore, due to the fact that previous studies have shown that there is a high suicide ideation and attempt rate among trans individuals, you will also be asked about your experiences of working with trans clients who are suicidal. Lastly, you will be asked for recommendations and suggestions regarding suicidality and transition-related care.

Procedure of the Study

If you agree to participate in this study you will be asked to provide some general demographic information. In addition, you will be asked to participate in an interview, which will last approximately 1 hour. The questions asked during the interview will be regarding your experiences of initiating, delivering, or controlling transition-related care with trans clients/patients who may or not have been suicidal.

It may be necessary for the principal investigator to contact you post-interview in order to ask clarifying questions regarding the information you shared during the interview.

You will also have the option to indicate your interest in participating in future research conducted by the above researcher. Should you wish to participate, you will be asked to indicate your email address and phone number. Please note that indicating your interest is not binding and you are not obliged to participate in future research should you be invited to do so.

Risks and Benefits

There are limited risks associated with this study. There is a chance that you might become uneasy or upset while answering the interview questions. In the event that the topic stirs up negative emotions, you may discontinue and withdraw from participation at any time without penalty.

A potential benefit of answering the questions will be to help raise awareness of these important issues in the public forum. While there may be no direct benefit to you, participation may provide you with the opportunity to better understand your own experiences.

Participant Rights

You do not have to answer any questions you would rather not answer. You are free to withdraw from this study at any time without any penalty or prejudice. You may withdraw in one of two ways:
1) You may end the interview at any point and request withdrawal from the study. Your interview will not be used in the research project.
2) If you decide to withdraw after the completion of the interview, you may contact Cherie Moody (Cherie.moody@mail.mcgill.ca) and request withdrawal from the study. It is possible to withdraw your data from any unpublished reports for up to 7 years after participation: after 7 years, all identifiable data will be destroyed and it will no longer be possible to trace your data in order to withdraw it.

Confidentiality

All data obtained during this study will be kept strictly confidential and will be identified only by an assigned code number. The interview will be audio taped to ensure accuracy of the content of the interview; however, your name will not be spoken on the tape. Instead, you will select a pseudonym to be used during the interview. Audio recordings will never be disseminated. Audio recordings will only be transcribed by the principal investigator (Chérie Moody), a research assistant or professional transcriber who has signed a confidentiality agreement; no other person will have access to any identifying information. Only the principal investigator (Chérie Moody), her research supervisors (Drs. Nathan Smith and Pierre-Paul Tellier), and some student research assistants at McGill University will have access to de-identified data. Data will be kept in secure digital data storage devices by all those who have access to it. The researchers will at all times comply with the Tri-Council ethical guidelines for research with human subjects. Things that you say may be presented without specific reference to you, referenced only by pseudonym and demographic information, or combined anonymously in aggregate form with the actions and words of other participants.

We will keep all the facts about you private. We would have to breach your confidentiality only:

f) If you intend to harm yourself,
g) If you intend on harming someone else,
h) If you inform us that a child is currently at risk for abuse or neglect,
i) If you report sexual abuse by a health care practitioner, or
j) If the records are subject to a subpoena by the courts (records can be opened by a specific court order but it is highly unlikely that this would ever happen).

Quotations from participants may be used during the presentation of results, either in manuscripts or at conferences/trainings/workshops. Care will be taken when presenting quotations in order to ensure your confidentiality.

Dissemination of results

Results will be disseminated to academic, mental health, medical, and community audiences. Specifically, research findings will be submitted to psychology journals, LGBT-focused journals, and suicide-focused journals, as well as at conferences and to community organizations.

Contacts

If you have any questions or desire further information with respect to this study you may contact Chérie Moody, the principal investigator, at cherie.moody@mail.mcgill.ca. You may also contact the principal investigator's academic supervisors; Dr. Pierre-Paul Tellier can be contacted at pierre-paul.tellier@mcgill.ca or 514-398-6017, and Dr. Nathan Smith can be contacted at ngsmith@central.uh.edu or 713-743-7648.

For information about your rights as a participant in a study, or concerns about risks, you may contact the Ethics Review Board of McGill University at 514-398-6831 or Lynda.mcneil@mcgill.ca.

Please note that the principal investigator and her academic supervisors are available to answer questions regarding the study or participation in the study but that this contact is not a suicide intervention technique nor an emergency/crisis service; they cannot respond immediately nor can they counsel participants regarding the thoughts or feelings the participants may be experiencing.

Participant's Consent

This research project has been explained to me. I have carefully read the above information and have had the opportunity to have my questions answered. I freely consent and voluntarily agree to participate in this research project. I also consent to being audio taped. I have been given a copy of this participant consent form for my records.

____
Name (Printed)

____
Signature

____
Date

I agree to participate in the follow-up interviews.

Yes ☐ No ☐ Initials: ________________

I agree to my de-identified data being used for Cherie Moody's future research projects.

Yes ☐ No ☐ Initials: ________________

I agree to be contacted to be invited to participate in future research project conducted by the principal investigator. This agreement indicates my interest in being contacted only, and does not bind me to participate in any future research project.

Yes ☐ No ☐ Initials: ________________

Appendix G: Demographic Questionnaire - Trans Participants

Age: ____________

Current gender identity and/or spectrum (e.g., transfeminine spectrum, transmasculine spectrum): ______________________________

Current sexual orientation: ______________________________

Race and ethnicity: ______________________________

Citizenship: ______________________________

Occupation: ______________________________

Annual income: ___________________________

Years of education: ______________________________

Pronouns used: ______________________________

Please choose a pseudonym: ______________________________

Appendix H: Demographic Questionnaire - Provider Participants

Age: ______________

Current gender identity: ______________________________

Current sexual orientation: ______________________________

Race and ethnicity: ______________________________

Sex assigned at birth: ______________________________

Citizenship: ______________________________

Occupation/profession: ______________________________

Setting(s) that occupation is carried out in (e.g., private practice, health centre, community organization): ____

Degrees attained (list all): ______________________________

Education undertaken specific to trans health: ______________________________

Year started working with trans people/delivering transition-related care: ________

Pronouns used: ________________________

Please choose a pseudonym: _______________________

Appendix I: Interview Protocol - Trans Participants

Introduction

Thank you for agreeing to meet with me and participating in this research project. It is very much appreciated. As you know, I have a specific goal with this research project. I'm hoping to talk with people who have accessed transition-related care (TRC), and by transition-related care, I mean any appointments with doctors, social workers, psychologists, surgeons, endocrinologists, etc., as well as any procedures such as (but not limited to) surgery and/or taking hormones. I'm also specifically talking with people who have experienced suicidal thoughts around the same time as accessing transition-related care. I'm hoping to better understand what that experience was like for people and that's why I'm doing these interviews.

TRC and suicidality

1) Can you tell me what you've heard about TRC and suicidality (suicidal thoughts or actions) or what your opinion about it is?

2) Ok, we are going to discuss your personal experiences with past suicidality (suicidal thoughts or actions), which may or may not be hard for you to think about and talk about. We will go at your pace and can take breaks or stop at any point. Does this sound ok? Please tell me a little bit about the time(s) you thought of ending your life. For the purpose of this interview, I'd like us to focus on the time(s) you experienced suicidal ideation that was around the same time you tried to access/accessed TRC. Can you tell me about that?

    Probes, if needed:

    i. How would you describe yourself at that time (of accessing TRC and having thoughts of suicide)?
    ii. What are some of the thoughts, feelings and experiences you recall from that time?
    iii. In the course of your TRC, did your suicidal ideation change in any way?
    iv. Do you feel that any events that took place during your TRC impacted your suicidal ideation? Or vice versa (your suicidal ideation impacted your TRC)? In what way?
    v. Do you think there were any people involved in your TRC who impacted your suicidal ideation? This could be somebody who either positively or negatively impact your TRC.
    vi. How do you think your care provider(s) saw you?
        1. Do you think they were aware of your ideation or behaviour?
        2. If so, do you remember how they addressed it and how it made you feel?

vii. I'd like for us to take a moment for us to talk about your identity or identities, and how you experience these identities interacting with your transition-related care and suicidality.

Recommendations

3) Do you have any recommendations/suggestions about TRC and suicidality (suicidal thoughts or actions)? For example, for care providers or other trans people?

Wrap-up

4) Is there anything I haven't asked you about that you would like to tell me about?

5) How has this interview left you feeling? (check-in with person about their suicidal ideation, if they disclosed experiencing current ideation)

End on positive

6) End on a positive: ask about the person's strengths, what they are grateful for, where they get support, favourite positive memory about themselves or someone close to them.

End by giving the participant local resources, and schedule the follow-up phone contact for tomorrow to check-in with the person about how they are feeling

Additional questions for pilot interviews:

1) What did you think of the demographic questionnaire that you filled out at the beginning?
2) I'm interested in your opinion regarding the questions I asked you today about your experiences. Did you think the questions were respectful? Did you perhaps notice some ways they could be improved?

Appendix J: Interview Protocol - Provider Participants

Introduction

Thank you for agreeing to meet with me and participating in this research project. It is very much appreciated. As you know, I have a specific goal with this research project. I'm hoping to talk with people who work with trans individuals, specifically, who deliver or approve transition-related care (TRC). I'm also hoping to speak with providers who may or may not have worked with suicidal trans individuals. As I'm sure you know, the suicide ideation and attempt rate is high in the trans community. I'm hoping to better understand how transition-related care and suicidality interact, and I'm planning on sharing the results with care providers such as yourself and members of the trans community.

TRC and suicidality

1) What is your current role and place of practice?
2) Do you have a certain treatment model when working with trans individuals? Do you adhere to certain standards or guidelines?
3) Can you tell me a bit about your experience of working with trans people/delivering transition-related care?
4) Can you tell me about your experience of working with trans people experiencing suicidal ideation and behaviour?
    a. How do you understand trans suicidality?
    b. Have you worked with trans client who are experiencing suicidal ideation/behaviour?
    c. Do you do screen for suicidality?
5) Can you tell me about your experience of suicidal trans people accessing transition related care?
    a. Is suicidality a contraindication to transition-related care?
        i. In theory (standards of care, guidelines, etc.)?
            1. Can you tell me more about that?
        ii. In (your) practice?
            1. Can you tell me more about that?
    b. Do you have a typical treatment plan for people experiencing suicidality and accessing transition-related care? (e.g., Do you use a protocol, or do you create an individualized treatment plan?)
6) Trans people often have multiple intersecting identities. I'm interested in hearing your thoughts regarding these multiple intersecting identities and the relationship between transition-related care and suicidality.

Recommendations

7) I really appreciate you sharing your experiences with me regarding your work. You seem to have given the topic a lot of thought. Do you have any recommendations/suggestions about TRC and suicidality? For example, for other care providers or trans people?

Wrap-up

8) Is there anything I haven't asked you about that you would like to tell me about?
9) End on positive: ask about favourite part of the job, favourite positive memory about their work/their clients

Additional questions for pilot interviews

10) What did you think of the demographic questionnaire that you filled out at the beginning?
11) I'm interested in your opinion regarding the questions I asked you today about your experiences. Did you think the questions were respectful? Did you perhaps notice some ways they could be improved?

Appendix K: Post-Interview Follow-Up Questions

Hello, May I speak with ___________________?

Hi, it's Chérie. We met yesterday for the interview. I'm calling you as discussed, just to check-in with you. Is now a good time?

If no: when would be a better time to get in touch with you? Can I call you later today?

If yes:

1) Thank you again for meeting with me yesterday, it is extremely appreciated. We talked about a lot of things yesterday, and some of them were a bit lighter and some of them were a bit heavier in nature. How were you feeling yesterday after we parted ways and for the rest of the day?

Notes:____
____
____

2) And how are you feeling today, now that a little bit of time has passed?

Notes:____
____
____

3) Do you have any questions for me, perhaps that have come to you since yesterday?

Notes:____
____
____

4) Do you have any feedback about the interview or project overall? Or anything that you would like to share that has come to mind?

Notes:____
____
____

Those are the questions that I had for you today. As you'll recall, we discussed your preferences for reading over the transcript once it's transcribed or your quotes, and so I'll be back in touch via email when the material is ready. If you need to get in touch with me between now and when I email you please feel free to do so. You can reach me at Cherie.moody@mail.mcgill.ca.

I'd like to thank you again very much for your participation in this research project.