Suicide risk in the UK trans population and the role of gender transition in decreasing suicidal ideation and suicide attempt

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Abstract

Purpose – *The purpose of this paper is to present findings from the Trans Mental Health Study (McNeil et al., 2012) – the largest survey of the UK trans population to date and the first to explore trans mental health and well-being within a UK context. Findings around suicidal ideation and suicide attempt are presented and the impact of gender dysphoria, minority stress and medical delay, in particular, are highlighted.*

Design/methodology/approach – *This represents a narrative analysis of qualitative sections of a survey that utilised both open and closed questions. The study drew on a non-random sample (n = 889), obtained via a range of UK-based support organisations and services.*

Findings – *The study revealed high rates of suicidal ideation (84 per cent lifetime prevalence) and attempted suicide (48 per cent lifetime prevalence) within this sample. A supportive environment for social transition and timely access to gender reassignment, for those who required it, emerged as key protective factors. Subsequently, gender dysphoria, confusion/denial about gender, fears around transitioning, gender reassignment treatment delays and refusals, and social stigma increased suicide risk within this sample.*

Research limitations/implications – *Due to the limitations of undertaking research with this population, the research is not demographically representative.*

Practical implications – *The study found that trans people are most at risk prior to social and/or medical transition and that, in many cases, trans people who require access to hormones and surgery can be left unsupported for dangerously long periods of time. The paper highlights the devastating impact that delaying or denying gender reassignment treatment can have and urges commissioners and practitioners to prioritise timely intervention and support.*

Originality/value – *The first exploration of suicidal ideation and suicide attempt within the UK trans population revealing key findings pertaining to social and medical transition, crucial for policy makers, commissioners and practitioners working across gender identity services, mental health services and suicide prevention.*

Keywords *Gender dysphoria, Gender transition, Health inequalities, Suicidal ideation, Suicide attempt, Trans suicide risk*

Paper type *Research paper*

Introduction

In the UK, the umbrella term "trans" refers to a significant minority of people whose gender expression or identity differs from societal expectations of their assigned sex at birth. It encompasses a wide range of people and consequent experiences and needs. Some trans people have a binary gender identity and identify as either men or women, some may identify with both ("bigender"), neither ("genderqueer"), whilst others may not have a gender at all ("neutrois"). Those who are assigned "female" at birth but who come to identify as a man may refer to themselves as a trans man or a man with a trans history whilst those who are assigned "male" at birth but who come to identify as a woman may refer to themselves as a trans woman or a woman with a trans history. It is not uncommon for trans people to use more than one

identity label at any one time (such as trans woman and genderqueer) or a range of labels over time, thus highlighting the fluidity of gender and identity. Trans people may undergo medical intervention in order to align their physical bodies with their gender identity and this is known as gender reassignment. Others may socially transition (namely, change their name and gender presentation) but may not wish to undergo any medical intervention. Whilst the latter is particularly the case for those who cross-dress (either on a full-time or part-time basis) or who identify as genderqueer, it can also be the case for those with a binary gender identity. Transition, as it was employed within the study and as it is subsequently described in this paper, refers to any part of a personal, social, and sometimes medical process by which someone has changed the way that they express their gender.

To date, there is no official estimate of the UK trans population. However, we do know that, although relatively small, the trans population has increased significantly in recent years and continues to rise. Reed *et al.* (2009) estimate the number of people undergoing gender reassignment in the UK to be in the region of 10,000 and the wider UK transgender population (i.e. those who identify as a gender other than that assigned to them at birth – including those who do not undergo gender reassignment) to be in the region of 300,000. Reed *et al.* (2009) also demonstrate an exponential growth rate in the trans population, which, they claim, represents a doubling of the population every six and a half years.

The few studies that exist point to high suicide risk within the trans population and yet very little is known about the exact nature of suicidal behaviour and risk within this demographic. Whilst there has been some research into trans people and suicide risk, this has been undertaken in the context of the US (Clements-Nolle *et al.*, 2006; Grossman and D'Augelli, 2007; Kenagy, 2005; Kenagy and Bostwick, 2005; Lie and Mustankski, 2012; Mathy *et al.*, 2003; Risser *et al.*, 2005). UK studies have focused on the risks within lesbian, gay and bisexual communities (Chakraborty *et al.*, 2011; King *et al.*, 2008; McAndrew and Warne, 2004) but not within the trans population. Prior to the Trans Mental Health Study (McNeil *et al.*, 2012), the only UK-focused survey to touch on trans suicidality was conducted by Whittle *et al.* (2007). The survey found that 33 per cent of trans adults attempted suicide at least once ($n = 873$), however, the survey's central focus was on trans people's experiences of inequality and discrimination and this finding emerged as a by-product rather than the central focus. Elsewhere, studies purporting to examine suicidality within the wider LGBT acronym (namely, lesbian, gay, bisexual and trans) have tended to only focus on suicidality within lesbian and gay (and, to some extent, bisexual) populations (Mayock *et al.*, 2008; Scourfield *et al.*, 2008).

Within the context of the US, non-random surveys of trans people found extremely high rates of suicide attempt – ranging from 30.1 per cent (Kenagy, 2005; $n = 182$) to 32 per cent (Clements-Nolle *et al.*, 2006; $n = 515$) and 41 per cent (Grant *et al.*, 2011, $n = 6{,}450$). The following factors were identified as elevating risk: younger age (< 25 years), depression, a history of substance abuse treatment, a history of forced sex, gender-based discrimination, and gender-based victimization (Clements-Nolle *et al.*, 2006). Risser *et al.* (2005) found a lifetime suicidal ideation of 60 per cent with 16 per cent in the previous 30 days leading up to the survey ($n = 67$, "male to female persons" only). Elsewhere, Kenagy and Bostwick (2005) note that two-thirds of respondents to their study had thought about attempting suicide ($n = 111$). In a survey comparing suicidality among transgender respondents with other groups – namely, heterosexual females and males, psychosocially matched females and males, and "homosexual" females and males – significantly more ($p < 0.05$) transgender respondents reported suicidal ideation and attempts than any group except "homosexual females" (Mathy, 2003). The study also found that those who had attempted suicide were more likely to report receiving or having received psychotherapy and psychiatric medications as well as difficulties with alcohol and drugs. Another survey, comparing suicidal intent across bisexual and transgender identities found that, relative to bisexual males, bisexual females and transgender individuals had significantly higher prevalence rates of suicidal intent, leading the authors to predict that sexism and heterosexism increase suicide risk within these groups (Mathy *et al.*, 2003).

Existing research points to elevated suicidal ideation and high instances of suicide attempt within younger demographics of the trans population. Grossman and D'Augelli (2007) found that nearly half of their sample had seriously thought about taking their own lives and one-quarter

reported suicide attempts ($n = 55$). Factors significantly related to having made a suicide attempt included suicidal ideation related to transgender identity; experiences of past parental verbal and physical abuse; and poor body image.

There is little information about completed suicide within the trans population (Haas *et al.*, 2011). One clinical study reported a disproportionate number of suicide deaths among Dutch trans women and men receiving hormone therapy as compared to the general population. In total, 13 (1.6 per cent) out of 816 "male-to-female" trans people had died of suicide, roughly nine times higher than in the general population (Van Kesteren *et al.*, 1997). Elsewhere, Asscheman *et al.* (2011), found that the total mortality among the "male-to-female" population was 51 per cent higher than the general population and that this was mainly due to suicide, acquired immunodeficiency syndrome, cardiovascular disease and drug abuse. In total, 14 per cent of "male-to-female" follow-ups and 8 per cent of "female-to-male" follow-ups had committed suicide.

This paper presents findings from the Trans Mental Health Study (McNeil *et al.*, 2012) – to date, the largest survey of the UK trans population and the first survey to focus solely on trans mental health and well-being[1]. The study was significant in terms of initiating a UK evidence base around trans mental health as well as beginning to raise the profile of trans mental health among policy makers, service providers, practitioners and community members. The study's findings on suicidal ideation and suicide attempt are presented in full here.

Method

In 2012, a study was conducted (McNeil *et al.*, 2012) to explore the mental health and well-being of trans people in the UK. A total of 1,054 participants accessed the survey, however, those who did not consent to take part were omitted as were those who were under the age of 18, those living outside of the UK and Ireland, as well as those who completed very little of the survey. The final data set comprised 889 respondents.

The survey was reviewed by Sheffield Hallam University's ethics committee as well as an advisory group comprising community members, researchers and other professionals with expertise in trans health issues. Stakeholders provided feedback at each stage of the research design and assisted with the pilot testing phase of the survey's development. Where relevant, questions were devised in consultation with the researchers of the Trans PULSE project (Bauer *et al.*, 2009) in order to enable international comparisons to be drawn from the combined data. The Trans PULSE Project is an ongoing community-based research project exploring the impact of discrimination and social exclusion on the health of trans people living in Ontario, Canada.

The survey, hosted by SurveyMonkey, was disseminated to over seventy organisations and groups throughout the UK, including trans or LGBT (lesbian, gay, bisexual, trans) support organisations, health and equality groups, online forums and professional networks. Key groups and organisations – such as the Gender Identity Research and Education Society (GIRES), Scottish Transgender Alliance and National LGB&T Partnership – were given information about the study and were asked to share the survey with their members. The researchers also promoted the study via a workshop and keynote address facilitated by the Trans Resource and Empowerment Centre in Manchester.

The study relied on respondents self-selecting and therefore will not necessarily be demographically representative of the trans population as a whole. Trans people form a hard to reach population, with many deciding to keep their trans identity or status extremely private. No official monitoring of gender identity currently exists and, as a result, there are no accurate estimates of the size and demographical breakdown of the UK trans population. In addition, trans people may not necessarily go through official channels (such as obtaining a new passport or undergoing gender reassignment) and will therefore be "under the radar" with regards to research enquiries. At present, there is no definitive way of identifying the trans population in its entirety and therefore no identifiable population base from which to draw a representative sample.

Due to the pathologising frameworks surrounding gender variance and the high prevalence of societal transphobia, trans people can be reluctant to engage with research. Building trust and

rapport for the purposes of participation was therefore paramount. The researchers of the study had extensive contact with the trans community and have participated in various voluntary and community sector organisations and services. As such, the researchers were well placed to utilise their networks and engage participants via snowballing methods with key groups and organisations operating across local, regional and national levels. It is hoped that the innovative potential of the research – in establishing the first substantive data set on suicide risk – and richness of data gained justifies this approach and the findings there-in.

In keeping with existing research into the UK trans population (Whittle *et al.*, 2007), the survey found that respondents were over-represented in certain racial groups, with 86 per cent identifying as white British/Northern Irish/Scottish/Welsh or English ($n = 518$). However, the sample revealed a range of gender identities and stages of transition, unlike clinical samples which access only a subset of the total trans population[2].

The survey totalled 89 pages with an estimated completion time of one to two hours. The survey contained a total of 187 questions and examined rates of life and body satisfaction within the trans population as well as trans people's experiences of accessing a range of health and support services (including gender identity services and mental health services), current and past mental health issues, and experiences of daily life. Respondents were asked about their gender identity, transition status and other demographic markers – such as age, ethnicity, employment and sexual orientation.

The data discussed here contains statistics relating to rates of suicidal ideation and suicide attempt within this sample population, as well as quotations from the respondents themselves in answer to a range of questions covering their experiences of suicidal ideation and suicide attempt over the life course and the ways in which this may relate to their trans status and gender transition. Questions included the following:

- Have you ever thought about ending your life?
- How often have you thought about attempting suicide IN THE LAST WEEK? (options: never, once, a few times, daily).
- How often have you thought about attempting suicide IN THE LAST YEAR? (never, once or twice, monthly, weekly, daily).
- How many times have you attempted suicide?
- If you have attempted suicide, what method(s) did you use?
- Are you actively planning to attempt suicide soon or in the near future?
- Are there any trans related reasons that have made you think about or attempt to end your life?
- Are there any non-trans related reasons that have made you think about, or attempt to, end your life?
- Thinking about the amount of times you have thought about ending your life, has that changed as you have transitioned?
- Do you personally know of other people who have experienced the following because they're trans or because of their trans history? (options: Attempted suicide, Committed suicide).

Questions took the form of both tick box and open-ended dialogue boxes. The qualitative data is analysed through narrative analysis and emphasis placed on respondents' own experiences and their subsequent interpretation and framing of those experiences; how they make sense of their personal, social and embodied situation in relation to wider societal and institutional structures, dynamics and relationships of power (Dahlberg, 2006; Andrews *et al.*, 2008).

Results

Incidence and characteristics of suicidal ideation and suicide attempt

Of those that completed the section on suicidal ideation ($n = 581$), 84 per cent had thought about ending their lives at some point[3]. In total, 63 per cent of those had thought about suicide

in the last year, 27 per cent had thought about it in the last week and 4 per cent thought about it on a daily basis.

Of those who had thought about suicide, 48 per cent had made an actual suicide attempt, 33 per cent had tried more than once and 3 per cent had attempted suicide more than ten times ($n = 436$). In total, 11 per cent of respondents had attempted suicide within the past year ($n = 427$). Further, 11 per cent of the respondents were unsure as to whether they were planning to commit suicide in the near future, and 3.2 per cent were actively planning to do so ($n = 473$).

When those respondents who had never considered suicide were factored into the analysis, 35 per cent of the overall sample had attempted suicide at least once and 25 per cent had attempted suicide more than once ($n = 581$). According to global estimates, approximately 5 per cent of the general population attempt suicide at least once over the life course (International Association for Suicide Prevention, 2012). Trans people could therefore be up to seven times more likely to attempt suicide compared to the global average.

Of those who answered the question about which method(s) they used when attempting suicide ($n = 215$), most had attempted overdose/poisoning – including drugs, alcohol and other harmful substances (69 per cent), followed by asphyxiation – including hanging, strangulation, inhaling car fumes and drowning (30 per cent), use of a knife – including stabbing self and slitting of wrists (26 per cent), dangerous driving (7 per cent), jumping from an elevated position (5 per cent), jumping in front of a car or train (3 per cent) and electrocution (2 per cent). Other methods included self-starvation, setting fire to self, use of a firearm, exposure, and use of a needle to drain blood.

45 per cent of respondents personally knew of other people who had attempted suicide on account of being trans whilst 21 per cent of respondents personally knew of other people who had committed suicide on account of being trans ($n = 889$).

Trans-related and non-trans-related factors underpinning suicidal ideation and suicide attempt

Of those who had thought about or attempted suicide, 65 per cent felt that there were trans related reasons while 61 per cent identified non-trans reasons as relevant. Non-trans reasons for suicide risk included: relationship breakdown, work stress, dealing with other health conditions, family issues, abuse, rape, bullying, bereavement, poverty, addictions, homelessness, financial concerns and legal issues. Trans-related reasons included: gender dysphoria; confusion/denial about gender; fears around transitioning; gender reassignment treatment delays and refusals; and social stigma. The following sections explore the trans-related factors in more depth. Narratives are taken from those who answered "yes" to the following filter question: "Do you consider 'gender reassignment' or 'transition' to be relevant to you?" whereby transition was defined as "any part of a personal, social, and sometimes medical or surgical, process by which you have changed the way you express your gender". As a result, only respondents who felt that they were either "proposing to undergo", who are "currently undergoing" or who "have undergone" a process (or part of a process) of gender reassignment or transition are included here. The question was designed to be open-ended and as inclusive as possible, acknowledging personal and social experiences of transition rather than just emphasising the medical process of gender reassignment. The subsequent analysis includes accounts of both binary gender and non-binary gender identified individuals as well as those who use multiple categories to describe their gender identity ("trans man" and "genderqueer" for example).

1. Gender dysphoria. Gender dysphoria was seen as a key factor for suicide risk amongst a significant proportion of respondents. Gender dysphoria refers to both a medical diagnosis and set of symptoms describing the distress and disassociation experienced by an individual on account of the incongruence felt between their gender identity and assigned physical sex. It is important to note that not all trans people experience gender dysphoria[4]. For those who do experience it, gender dysphoria commonly (but not exclusively) begins during adolescence where it is is linked to the unwanted effects of puberty – when secondary sex characteristics appear, highlighting the unwanted social signifiers of a person's assigned sex. For many trans people, the effects of puberty are deeply troubling to their sense of self and often mark the

beginning of their disassociation from their physical bodies. Some participants described the discomfort or hatred that they felt towards their bodies prior to medical intervention: "When it felt like the hurt of 'being wrong' was going to get too big waiting for treatment" (man with a transsexual history); "Knowing I was stuck in the wrong body but not being aware of the help being out there" (constant and clear identity as a man). Other respondents described feeling disembodied on account of the mismatch that they felt between their physical body and their felt sense of gendered self, and the resulting sense of futility that this would not necessarily be relieved through medical intervention: "No one truly understands. There a (sic) physical things that cannot be changed with current medical technology" (trans man with a non-binary gender identity). Elsewhere, participants described feeling a sense of detachment on account of not feeling in their bodies and, linked to this, not being recognised for the gender that they felt themselves to be: "I felt I couldn't go on as I was, being treated like the wrong gender and living in a body that felt so utterly wrong and unnatural" (genderqueer-identified person).

A significant proportion of participants were so unhappy living in the role associated with their assigned sex that, as one participant put it, "I had to transition – it was that or die" (trans woman). This is expanded upon by another participant who describes contemplating suicide before they were aware of other options, such as gender reassignment: "I just wanted that Hell to end, and until I discovered transition was possible it seemed death was my only way out" (genderqueer-identified person). One participant describes how, prior to transitioning, they had reasoned that: "It was easier for me to consider suicide for a long time than to accept my gender issues" (woman on male-to-female spectrum). For them, suicide was preferable to continuing to live in the body and role of their assigned sex. This was not an uncommon narrative. Other participants felt that they should have been born a different gender and a handful of respondents discussed considering suicide as a means of enabling themselves to be reincarnated as their chosen gender: "I believe in re-incarnation (sic) and always thought that if I ended my life I would be re-born in to (sic) my true sex" (trans woman).

2. Confusion/denial about gender. Some participants felt suicidal because they were confused about their gender and did not have the information and support they needed to help them process their feelings: "Back in the early 70's there just wasn't the knowledge, resources and online help available like there is today and I felt so isolated feeling the way I did about myself" (trans man with non-binary gender identity). Others described the impact that suppressing their feelings and denying their gender identity has had on their mental health: "For years I thought I was the only person in the world who felt like this because I was told I couldn't exist. I tried to live as people expected, but it's exhausting and sometimes I'd just be so tired of struggling on" (trans man).

3. Fears around transitioning. Many respondents described feeling suicidal when they first considered transitioning because they were worried about the potential fallout and disruption that it would have on their lives: "Transitioning seemed too hard/like too drastic a step" (trans man). For others, suicide seemed a preferable alternative to the potential upheaval of transition or to any complications that they felt might arise. Participants also described feeling apprehensive about the end goal of transition: "Transitioning being too much, too slow, fearing that I will never feel complete" (trans woman) and that "surgery and hormones could only do so much" (woman on male-to-female spectrum). Participants reported feeling fearful and, as a result, trapped: "I got to the point where being a woman part time was not enough, and to be fulltime I had to totally come out and I also needed to seek medical assistance, I was scared and not sure if I was brave enough, I considered killing myself as an easy escape" (trans woman).

4. Gender reassignment treatment delays and refusals. Once they had made the decision to access medical intervention (such as hormones and surgery options), participants described external barriers – such as medical delays, cancellations and refusals – as significantly contributing to any suicidal thoughts that they experienced: "(Name removed) GIC (Gender Identity Clinic) delaying and eventually refusing treatment made me feel hopeless and that I have no control over my own body" (woman on male-to-female spectrum). Clinical decisions were shown to directly affect suicidal ideation: "(Name removed) refused me help at age 16 and forced me to wait until I was in my twenties before I could get help! At that point I became increasingly angry, depressed and suicidal – which was completely unnecessary if I had just

been allowed to access hormone replacement therapy at the age of 16 – I could have avoided several years of hell" (trans woman); "I feel I have only 2 choices; to change my body or to kill it. My lack of access to transitional services makes my (sic) feel like I should simply end the struggle" (trans woman). Elsewhere, one respondent said that they had thoughts about suicide after receiving prejudicial treatment from a healthcare professional:

> My doctor sent me to see a gynaecologist instead of the GIC. He said he didn't see trans people but he wanted to have a look at me. He then called in my husband and asked if he was ok with me transitioning – I felt abused. I felt I wanted to kill myself. When I went back to the doctor it turned out it was too late to go to the GIC as they weren't seeing any more patients at that point. If I'd gone there in the first place, I'd just have got in in time. C'est la vie – after this I gave up hope of transitioning due to my family's attitudes and worry that I might be exposing them to ridicule or injury (Trans man).

Here, the respondent describes being let-down in several instances. According to this account, the respondent was wrongly referred by his GP to a gynaecologist rather than a GIC, resulting in the respondent experiencing significant delay which, as claimed here, meant that he could not get onto the GIC waiting list. The respondent then subsequently received a negative response from the gynaecologist who asked to see his husband and, in so doing, appeared to give preference to the husband's own wishes over the needs of the patient. There is also an inferred undercurrent of unwanted curiosity and even voyeurism on the part of the gynaecologist. The non-supportive family environment here collides with the negative attitudes of healthcare professionals who, rather than supporting the wishes of the patient, became gatekeepers who ultimately prevented him from getting the treatment that he felt that he needed.

5. Social stigma. The stigma of being gender variant made some participants suicidal. Here, participants described experiencing prejudicial attitudes or treatment on account of their trans status or history. Incidents occurred at school, in the workplace, on the street, within the media, and even within trans community spaces:

> Being committed to a mental institution for being who I am destabilized me to the point that I had no where (sic) or anyone to turn to. I was left alone. I could not rationalize the problem of mind over body scenario. Always in fear of being beaten or worse (Man with transsexual history).

> Being outed in (name removed) newspaper in (date removed) & receiving insults and criticism from the trans community. This was the one & only time I felt like ending my life (Trans respondent).

Participants also felt suicidal when they experienced judgement and negative reactions from others: "I'm a freak and a tranny and sometimes name-calling coupled with my already low self esteem gets to me" (trans man). Others cited workplace bullying and discrimination as contributing factors for them wanting to end their own life: "The abandonment by my employer following the death threat at work and the abandonment by my employer following my GRS (gender reassignment surgery)" (trans woman). Elsewhere, it was the fear or experience of being rejected by others, including family members, which led to them having suicidal thoughts: "The feeling of not being accepted by society and family" (trans woman), "Bringing shame on my family" (trans woman), "I wanted to die because my best mates, the ones who were at my wedding … abused and rejected me" (trans man). For one participant it was the difficult ultimatum between "coming out" as trans and potentially risking social penalties, on one hand, or denying their trans status altogether, on the other, which led them to considering suicide as a third option: "doing the 'best thing' for wife and kids – rejected as I loved them too much to do that to them. Feeling there was no solution – death offered an easy way out. Fear of transition and of being unable to cope with the mockery and discrimination" (trans man).

Due to the high prevalence of transphobic hate crime, stigma and discrimination, trans people can feel particularly anxious about their trans history or status and may feel no choice but to conceal it from others and, in some cases, to opt for self-censure or denial: "I was very depressed […] am not really sure if this was triggered because I was denying that I was trans or through some other reason". For those considering transition or those in the early phase of exploring their gender, the fears of social marginalisation and exclusion can be so great that some may decide not to transition altogether and instead may live in their assigned gender, going to great lengths to suppress any intention to change their gender: "I had to grow up to (sic) fast, hide who I was and give up some of my dreams to do so" (trans person with non-binary gender identity). Linked to this, some respondents felt that by transitioning they would endure

considerable barriers and social fallout: “Prior to transition I thought of ending it all. The enormity of the problems seemed overwhelming! Needing to tell family, possibly losing family, scared if I would ever find a job, scared I would be an outcast etc. I once sat on the edge of a building for hours but just couldn’t do it” (woman with a transsexual history). At the root of this is a fear of rejection and, linked to this, loneliness and isolation – as expressed by another respondent: “I did not think anyone would want to be with me” (trans woman). Feeling unloved and unlovable on account of their trans status is a common narrative and may stem from the feedback loop between gender dysphoria and the internalising of transphobia, namely feeling somehow different or inferior on account of one’s status as trans and having those feelings confirmed by wider societal messages which stigmatise and discriminate against gendered “difference”.

The drip effects of social stigma were revealed in participants’ accounts of the sense of loss that they felt on account of their trans status and the daily hurdles and struggles that they faced: “Knowing that you will never be the one thing you want above anything else. Never being able to have children or experience the joys of motherhood. Spending nearly all your time to be an imperfect person in your own eyes. Life really is more difficult as a trans person, from shopping for new cloths (sic) to going out with friends and being scared to use the bathroom, so you risk waiting till (sic) you get home” (trans person with non-binary gender identity). Participants also discussed the ways in which being trans made them feel apprehensive about getting on with their lives: “Being trans adds to the factors that make me feel less hopeful about my future. I feel worried about how being trans may get in the way of my having a successful relationship, being a parent, having a successful career, receiving adequate social and health care etc” (man on female-to-male spectrum).

Impact of transition on suicidal ideation and suicide attempt

Transition was shown to greatly reduce rates of suicidal ideation and suicide attempt. In total, 67 per cent of respondents thought about suicide more before they transitioned and only 3 per cent thought about suicide more post-transition. In total, 7 per cent found that suicide attempts and ideation increased whilst they were going through transition. In total, 16 per cent reported no difference and 7 per cent were unsure ($n = 301$).

The following quotes highlight the experiences and feelings of those who thought about suicide less since transitioning and reveal the major part that transition plays in reducing suicidal ideation and suicide attempt in the majority of respondent narratives:

> Being able to transition made my life worth living and gave me hope for the future (Trans man).

> On balance I feel stronger in myself since transition. I also feel like I’ve let go of a big secret I was carrying around which takes some of the pressure off and makes me feel like I’m living life more genuinely (Man on the female-to-male spectrum).

For the minority of participants whose suicidal thoughts or behaviours increased after transitioning, possible reasons were cited but the exact nature of which were not clear such as this respondent who states that:

> The damage has become so severe with no recognition of the events or the resulting needs that post transition has become absolute hell with no hope of recovery (Trans woman).

Participants claimed that it was difficult to separate out trans-related factors from non-trans-related factors and that the two were linked. After they had transitioned, respondents said that they had experienced relationship breakdown, as well as trans-related discrimination and abuse. Elsewhere, participants claimed that non-trans factors contributed to increases in their suicidal urges after transition, and cited the following reasons: bereavement, work stress and financial concerns.

Participants who felt that their suicidal urges peaked during transition, as well as those who felt “unsure” or that there was “no difference” in their suicidal thoughts due to transition, cited the impact of undergoing transition – ranging from personal uncertainty to medical delays and the reactions of others – as significant trans-related factors:

> Mixed bag, happier with my appearance, unhappy at reactions (female on the male-to-female spectrum).

> Life has got harder over the last few years, from work and money to self confidence and social situation (trans person with non-binary gender identity).

Participant responses here suggest that the sheer stress of undergoing transition, which is exacerbated by a lack of support, as well as the knock-on effect of a lack of social acceptance and resulting social stigma can induce suicidal thoughts and behaviours.

Discussion

The findings reported here indicate that there are extremely high rates of suicidal ideation and suicide attempt within this non-random sample of the UK trans population. However, gender transition – for those that wanted it – was shown to drastically reduce instances of suicidal ideation and suicide attempt, highlighting the important role played by social transition and gender reassignment in improving quality of life and overall well-being amongst respondents.

The study found a strong correlation between a pre-transition state and suicide risk for those experiencing gender dysphoria. Many respondents reported increased feelings of gender dysphoria during adolescence; as they were enduring the unwanted physical effects of puberty and prior to accessing any hormonal treatment or surgical intervention which could go some way towards counteracting these effects. Linked to this, the study found that those who would like to transition but who were not able to (either for social or medical reasons) or who were struggling coming to terms with their identity and associated needs prior to transition may be at higher risk of suicidal thoughts or attempt. This included those who feared that they would be judged or rejected by others – including loved ones – if they disclosed their feelings and so instead opted to conceal their intentions and forego gender reassignment altogether.

A key finding to emerge from the study was the importance of timely access to gender reassignment treatment for those who required it. Transition was shown to have a positive impact on trans people's mental health and well-being; the processes of gender reassignment and social transition serving to significantly reduce rates of suicidal ideation and suicide attempt. The majority of participants cited the significant benefits of gender reassignment in terms of aligning their physical body with their internal sense of self, and the knock-on effects of being recognised as the gender that they felt themselves to be. In this way, the physical relief from gender reassignment served to dissipate feelings of gender dysphoria and, as a result, reduce destructive thoughts and behaviours, and suicidal ideation. As we've reported elsewhere (McNeil *et al.*, 2012), the use of hormonal therapy in countering some of the effects of an initial, often unwanted, puberty and inducing the secondary sex characteristics of a preferred gendered puberty, helped respondents to re-connect with their bodies and, as a result, report higher levels of body and life satisfaction, 85 per cent were more happy with their bodies since starting hormonal therapy ($n = 417$) and 83 per cent were more happy with their lives ($n = 398$) – McNeil *et al.*, 2012. Linked to this, hormonal therapy also made it easier for respondents to be seen and treated as their correct gender. Having their gender identity validated was greatly valued by the respondents who desired it and the vast majority of participants reported that recognising their gender identity or transitioning had improved their quality of life (78 per cent; $n = 520$) – McNeil *et al.* (2012). In addition, for those who accessed it, surgical intervention also helped to put respondents back into their bodies and, in the process, alleviated some of the effects of physical and, by turns, social dissonance, 88 per cent of respondents were more satisfied with their lives after having non-genital surgery ($n = 182$) and 83 per cent after genital surgery ($n = 131$) – McNeil *et al.* (2012). In addition, 74 per cent felt that their mental health had improved as a result of transitioning ($n = 520$; McNeil *et al.*, 2012).

Despite the clear advantages of gender reassignment, some respondents reported significant issues whilst trying to obtain treatment. As has been reported elsewhere, funding delays or refusals were common within this sample and respondents alluded to having gender reassignment treatment stopped or postponed altogether (Ellis *et al.*, 2014). These issues may, in some cases, contribute to suicide risk within this population and further investigation is needed.

As Ellis *et al.* (2014) have noted, waiting times far in excess of the eighteen week target were common with respondents often waiting months, and in some cases years, for a GP referral to

a Gender Identity Clinic. The waiting period is often a particularly fraught time and trans people can feel abandoned or left "in limbo" as they are left unsupported, leaving them prone to at-risk behaviour. Support here is critical and it is important that trans people are given relevant and up-to-date information about their transition as well as referrals to suitable social and support services. There is also a clear need here for targeted intervention and prevention work. It is crucial that NHS commissioning bodies and service providers (namely, Gender Identity Clinic specialists) are aware of the delays, impact that delays, interruptions and refusals have on the patients within their care, and that steps are made towards a flexible and patient-centred service.

It is crucial that those experiencing gender dysphoria have access to gender reassignment treatment with minimal delays or disruption and that they receive relevant information and support both from medical professionals as well as more informal sources – such as family, friends and support organisations – in order to build resilience and bolster health and well-being during this particularly difficult time. This highlights the need for a cultural shift towards recognising the importance of timely medical interventions (via hormones and surgery) in drastically improving quality of life for those with gender dysphoria. It therefore follows that undergoing gender reassignment within a supportive environment emerged as a protective measure against suicidal ideation.

Whilst respondents reported significant improvements to their mental health and well-being as a result of transitioning, the process of undergoing social transition and gender reassignment nevertheless emerged as a potentially stressful and fraught time. Transition represents a period of major personal upheaval during which a person experiences intense emotional, social and physical change. And although the physical changes which transition induces are in almost all cases greatly welcomed, the phenomenon of change and the momentum that it brings – for better or for worse – can nevertheless be unnerving, unpredictable and overwhelming. When a person discloses their trans status, they risk losing their loved ones, communities, jobs, homes. They also risk discrimination and violence. The high occurrence of the social "penalties" that trans people experience each time their trans status is revealed is well-documented (Whittle *et al.*, 2007) and these cut across families and relationships and into the everyday realms of education, employment, social life and healthcare. The changes can be subtle or life-changing as the person transitioning experiences a new way of being in and relating to their body and a new way of experiencing and being in the world. The body in transition experiences trauma then heals, perhaps over and over again, whilst new social scripts are learnt, amended or rejected. And yet, despite the challenges that transitioning brings, for many trans people the treatment is life-saving.

Whilst the study provided an important starting point for better understanding rates of suicidal ideation and suicide attempt within the UK trans population, it did not represent an in-depth exploration of the characteristics and correlates of suicide risk and behaviour. Instead, the findings on suicidal ideation and suicide attempt emerged as part of a wider survey of general rates of mental health and experience, which were examined mainly in relation to interaction with primary care, mental health and specialist health services. The study did explore some of the contributing factors for suicide risk – identified in terms of trans-related and non-trans-related factors – however, it did not present a substantive examination of all the factors which elevate trans suicide risk, particularly in relation to those for whom social and/or medical transition was not relevant or needed. Research exploring the nuances of trans suicide risk is therefore urgently required, in addition to research that seeks to understand the protective and preventative mechanisms surrounding suicide risk. There is also a need for research into completed suicide within the trans population.

Building a profile of suicide risk alongside a profile of suicide immunity is crucial in order to identify and disseminate key strategies for prevention work within this population, strengthening resilience within these communities as well as raising awareness and understanding within key support mechanisms and services. Only by fully understanding the factors involved can we begin to tailor approaches and interventions for suicide prevention within this high-risk and under-served population.

Notes

1. Larger surveys have been undertaken with the trans population – the "Transgender EuroStudy" (Whittle *et al.*, 2008) received 1,964 responses whilst the "National Transgender Discrimination Survey" (Grant *et al.*, 2011) received over 6,450 responses. The former was Europe-wide whilst the latter focused on the US Neither study explored trans mental health.
2. In total, 39.9 per cent of respondents identified as female, 24.8 per cent identified as male, 24.2 per cent either had no gender identity, a fluid gender identity or were unsure about their gender identity, and 7.9 per cent had a non-binary gender identity. In total, 12.5 per cent had not undergone and did not propose to undergo gender reassignment.
3. The lifetime prevalence of suicidal ideation in the general population is between 10 per cent and 14 per cent (International Association for Suicide Prevention, 2012).
4. Gender dysphoria is sometimes referred to as "Gender Identity Disorder" though the latter term is gradually falling out of use due to a growing acknowledgement of its stigmatising framing of the embodied identities of trans and gender variant individuals.

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