Looking At Barriers To UK Gender Services For Young People In Racialised Minority Groups

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ABSTRACT

Background

Young trans and gender diverse people of colour report negative experiences of healthcare systems (James et al., 2016) due to discrimination and lack of understanding. Studies have shown that accessing gender healthcare is difficult for this group (TransActual, 2021) which may be due to factors within healthcare as well as cultural barriers.

Aims

This study aimed to foreground young trans and gender diverse people of colour's experiences of the barriers to accessing gender healthcare and explore the resulting impact of these.

Methodology

Individual semi-structured interviews were conducted with six young trans and gender diverse people of colour aged 16-25 years old from within the general UK population. Results were analysed using reflexive thematic analysis (Braun & Clarke, 2018).

Results

Three main themes were generated: discrimination and difference, the development of self: from individual to community, and health.

Conclusions

The findings provide insight into how young trans and gender diverse people of colour experience and navigate barriers to gender healthcare. Difficulties arise due to a combination of healthcare discrimination, professional bias and cultural, social and internal barriers. Implications for this research are discussed, alongside recommendations for future research.

TABLE OF CONTENTS

INTRODUCTION

List of tables and figures

ACKNOWLEDGEMENTS

Firstly to my participants, you are absolutely incredible and I am so grateful to get to share your words. Thank you so much!

To Jordie (and Sid), for the love, the support, and the joy

To all of my friends for their support through my entire journey. Especially LLL for sharing this ordeal, and Katie for her ongoing love.

To my wonderful family, what would I be without you?

To Michael, thank you for all your thoughts and feedback, I can't wait to keep working with you!

Lastly to all the gorgeous queers who have been before and have come since: we're here, we're queer, get used to it!

To put this first, here are some resources for trans resilience: https://transhealthuk.noblogs.org/resources-for-trans-resilience/

And a book for professionals: Supporting Trans People of Colour: How to Make Your Practice Inclusive By Sabah Choudrey

INTRODUCTION

1.1. Chapter Overview

In recent years, there has been an increased focus on the experiences of trans and gender diverse people within UK healthcare, and concerns have been raised about the barriers faced by young people accessing services that support exploration or affirmation of their gender (referred to as ‘gender healthcare’ for the rest of this paper). While there is a growing body of literature on this topic, there remains a significant lack of understanding and awareness of barriers specific to young trans and gender diverse people of colour, who report high rates of negative experiences (James et al., 2016).

Trans and gender diverse people of colour exist within multiple systems of oppression, including misogyny, racism, homophobia and transphobia (Lockett et al., 2022; A. A. Singh, 2013a), making it difficult to navigate a systematically discriminatory healthcare system (Howard et al., 2019; Women and Equalities Committee, 2016) and lacks training for healthcare professionals providing care for trans and gender diverse patients (RCGP, 2019).

Despite aiming to do so, UK laws and policies, both generally and as relates to healthcare, are often ineffective at reducing discrimination against trans and gender diverse people and people of colour. Additional difficulties arise within families and communities due to a lack of understanding or acceptance of gender diversity.

This research will explore the context for trans people of colour in the UK, discussing some of the challenges created by diagnosis, dominant systems of oppression, and a changing social landscape. This chapter explores the complex interplay of factors that influence this group’s access to gender healthcare services.

An attempt was made to ensure that many of the papers included were either by trans or gender diverse and/or people of colour, or included someone with these identities in their research team, or that they consulted with these populations, or that trans or people of colour’s voices were clearly heard within qualitative research.

1.2. Terminology

Throughout this paper the term ‘trans and gender diverse’ will be used for people who are not cisgender (meaning you only identify with the gender you were assigned at birth; the shortened version cis will be used in this paper). Trans (short for transgender) and gender diverse people may describe themselves using one of many different terms, including (but not limited to) ‘binary’ trans (identifying as a man or a woman), non-binary, gender-fluid, genderqueer, agender, demiboy, demigirl. Trans is an umbrella term, however, not all gender diverse people identify as trans. Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and all identities not covered by those terms is shortened to the acronym LGBTQIA+. Queer is an umbrella term for those who hold any non-cis and/or non-straight identities.

Different terms may be used when referencing existing research where it is not clear that all non-cis identities have been included.

The term ‘people of colour’ will be used within the research to describe people who are Black, South Asian, East Asian, South-East Asian, Aboriginal, mixed heritage and all other racialised minority identities. Many terms referring to groups of people by race are contested, mainly due to the positioning of people being ‘other’ to the ‘norm’ of whiteness (this includes the term people of colour). Black and minority ethnic (BAME) is used in many contexts, however the use of the word minority is disputed by those who argue that white people are actually a global minority.

The phrase ‘young people’ will be used throughout the paper. In the literature review the term denotes people aged from thirteen to twenty-five as thirteen is a time where most people will have at least begun physical, cognitive and emotional changes linked to puberty. Twenty-five is the upper limit; while the UN defines youth as up to age 24 (United Nations, n.d.), many UK charities work with and define young people as up to age 25. The empirical study focuses on young people aged 16-25 due to restrictions with obtaining parental consent for those aged under 16.

Acronyms for gender and racial identities will not be used in this paper due to the feeling of irreverence it can provoke for readers about minoritised groups. The term minoritised groups denotes those that have been forcibly defined as minorities by more dominant groups.

1.3. Dominant Systems Of Oppression

Many people question gender for themselves and as a societal concept, yet dominant narratives such as whiteness, cissexism and heteronormativity hinder the opportunity of exploring positive representations of identity that sit outside these 'norms'. This section provides context for the systems in which all people, but specifically trans and gender diverse people of colour, are impacted and oppressed. These systems inform the development of gender healthcare services in the UK and so must be considered when attempting to understand barriers to access.

1.3.1. Models Of Gender

Sex, gender and sexuality are concepts that are conceived in different ways by different people, and the dominance of certain views shape the way systems are designed and structured, often in the favour of the ideas or preferences aligned with white cis-heteronormativity. This can mean the needs of gender diverse people and people of colour are not given prominence in discussions of service developments.

Essentialist views are based on identity being biologically or psychologically innate. They are often used to deny the existence or rights of people with sexual and gender diversity, insisting on a cis man/woman binary and heterosexuality as the norm. Essentialism posits that gender and sexuality are biologically determined and therefore largely unchangeable (Gülgöz et al., 2021).

Social constructionist approaches view identity as created by the social contexts that we are surrounded by. This does not mean that identity is a 'choice', but that people engage in 'performance' of identities developed and encouraged by society (Butler, 1999).

Essentialist beliefs are also used to support gender and sexual diversity by stating that people are 'born this way'. This view was developed through work by

Kinsey et al. (1948), who, while broadening knowledge of sexual experiences and preferences, encouraged an innate view of sexuality and the use of labels for different identities (Barker & Scheele, 2016).

The dichotomous debate of essentialism and social constructionism is not always useful for trans and gender diverse people in reality, especially when seeking gender-affirmative healthcare (Denton, 2019). Gender healthcare clinicians commonly work to a 'bio-psycho-social' model which recognises the relevance of biology alongside social and psychological factors (Polderman et al., 2018; Serano, 2017). This more nuanced perspective can be seen as beneficial for those seeking gender healthcare and should consider race as part of a holistic approach.

1.3.2. Hetero/Cisnormativity And Sexism/Misogyny

Young trans and gender diverse young people are subject to gendered expectations and stigma that they internalise, potentially causing shame. They may feel that they are not male/female enough, or that they look too male/female to be non-binary. This shame has been identified as a potential barrier to seeking gender-related healthcare support (White Hughto et al., 2015), which may be exacerbated by racialised gender discrimination.

Within the gender binary both trans and cis people are subject to unhelpful stereotypes (Gallagher & Bodenhausen, 2021), shown to negatively impact young people's mental health by contributing to negative body image, violence against women and high male suicide rates (Fawcett Society, 2020) and sexual violence against women, highlighted by the recent #metoo movement (Gill & Orgad, 2018). Non-binary, genderfluid and genderqueer people who stand outside of the gender binary are often ignored, misunderstood, or treated with derision (B. W. Vincent, 2016). Trans women and transfemmes, particularly people of colour and sex workers, are most at risk for sexual violence and murder, perpetuated by cis men due to conflated factors of sexism, homophobia, racism and transphobia (Raha, 2017) and being punished for "transgressing societal norms" (Wilson et al., 2016, p. 1).

Same-sex and gender diverse relationships are often viewed as 'other' or lesser when compared to cis, heterosexual relationships (Marzetti et al., 2022). Rubin

(2006) discusses a hierarchy of sexual practices that society places as “acceptable” and “unacceptable”, with same-sex experiences seen as unacceptable. Similarly, society also places ways of ‘doing’ gender in a hierarchy, with men and women performing gender in their stereotypical roles at the top, binary trans men and women further down, and non-binary people at the bottom, due to their lack of gender conformity.

Queer movements have fought to have same-sex marriage recognised and legalised and for queer people to be able to serve in the army (Auchmuty, 2004). Others have fought against assimilation and the heteronormative assumptions therein (Rubin, 2006). Trans and gender diverse people are not monolithic; some fight to be seen as the same as other men and women and some celebrate being in the separate category of ‘trans’.

1.3.3. Whiteness

Young people of colour are impacted by the dominance of whiteness, and this can have far-reaching consequences on sense of self and experiences with others. White supremacy (the belief that white people are superior to other racial and ethnic groups) is maintained to ensure that white people continue to benefit from white privilege, while minoritised groups are kept in inferior social, financial and education positions (Patel, 2022). Institutionalised racism presents in Western legal, educational, healthcare, employment, housing and incarceration systems (Elias & Paradies, 2021), including in the over-representation of white people in leadership roles (Patel, 2022), meaning that when faced with forms of authority, young trans and gender diverse people of colour will often be speaking to white professionals who may not have a good understanding of their needs. Stereotypes of racialised minorities are still regularly perpetuated in media and other forms of dissemination (B. Byrne et al., 2020). In some contexts, overt racism has been replaced by microaggressions, avoidance of racialised groups, and other subtle yet still dangerous forms of racism (Dovidio et al., 2018). Within mental and physical healthcare, racism and racist biases have been found to flourish (Fernando, 2017), impacting on the experience of services for young trans and gender diverse people of colour. These factors show that barriers to gender healthcare are likely to have a racial component.

1.3.4. Colonialism

Trans and gender diverse people of colour may be ‘othered’ based on historic values held by both white and people of colour in the UK, and can be part of the reason why acceptance from self and others is not always easy for this population. This is due in part to the effects of colonialism which are ingrained in the way gender and race are thought about by all races. The impact of being a person of colour in the UK (who may have connections to colonialised countries) means holding a tension between living in a country that is seen as more progressive about gender but ignores the damage wrought by that same country by colonialists (Akala, 2018).

Dominant systems of whiteness and cis-heteronormativity been imposed on other countries for hundreds of years via colonialisation and Christianity. White supremacy historically dictated the view of gender as binary, punishing those who did not conform, which included many societies and countries that now hold anti-LGBT beliefs (Buckle, 2020; Dutta & Roy, 2014; Karijo, 2021; Lugones, 2007). Within the binary standard men were viewed as superior, with far-reaching repercussions for women, particularly women of colour and their relationships with themselves and others (Mulholland, 2017; Nayak, 2007).

Trans and gender diverse people have always existed. Many cultures still do not hold a binary view of gender, and people who sit outside traditionally defined “male” and “female” identities include Two-spirits in indigenous North American communities, Waria of Indonesia, Fa’afafine of Samoa, Hijra in India, Muxe of Zapotec cultures in southern Mexico, Tom, Dee and Kathoey of Thailand, and Bissu, Calabai and Calalai of Indonesia (Young, 2019).

1.4 Theories Relating To Race And Identity

For context, Table 1 provides a breakdown of the current racial composition of England and Wales.

Table 1

Ethnic group categories, percentage of the population in England and Wales (Office for National Statistics, 2019)

Asian or Asian British	Bangladeshi	1.04
	Chinese	0.59
	Indian	2.80
	Pakistani	2.26
	Other Asian	1.29
Black, African, Caribbean or Black British	Black African	2.28
	Black Caribbean	1.02
	Other Black	0.22
Mixed or multiple ethnic groups	White & Asian	0.51
	White & Black African	0.27
	White & Black Caribbean	0.52
	Other Mixed	0.53
White	White	78.40
	White Gypsy/ Irish Traveller	0.03
	White Irish	0.59
	Other White	5.84
Other ethnic group	Arab	0.43
	Other	1.44

When referring to people of colour as a group it can seem that their views and experiences are monolithic. However due to widely-experienced racism and the limits of this paper, people of colour are discussed mainly as a group, albeit with diversity of experiences.

1.4.1. Relevant Identity Theories

It is useful to consider identity theory within the context of biological development. Among other physical changes, young people experience brain development that is linked to emotion and choice-making, and these changes cannot be separated from the social context within which the young person exists (Dahl, 2004). Children become aware of their gender at around age three (Goldhammer et al., 2022), meaning that their brain development will be based on a gendered experience.

The following identity theories, linked with the knowledge of brain development, demonstrate how identities are built in young people (including this papers focused age range of 16-25) in a way which links to multiple potential barriers to services. This includes identify within family, amongst peers, in society and as a trans or gender diverse person.

Erikson's identity theory (1968) suggests that there are various stages of identity formation. Identity formation is the creation of our own self, as perceived by both our self and by others, through interactions with other people and our environment. The stages that are relevant to both the literature being discussed and the participants in this study are 'identity vs role confusion' (ages 12 to 18) and 'intimacy vs isolation' (ages 18 to 40). Erikson's theory is based on the 'epigenetic principle' which suggests that people grow and develop in a way that is exponential and based on prior growth and experience, as well as in context to their environment and the people around them. Thus each identity stage is built on the one before. Each stage is marked by conflict, the management of which defines identity.

'Identity vs role confusion' is marked by a struggle to work out one's place in society, and this is often based around social relationships. Some of Erikson's early work noted how positive identity can enhance wellbeing within racialised minority groups (Vaughan & Rodriguez, 2014) For young trans and gender diverse people of colour, these social relationships may include discrimination, feeling different from peers, and a lack of representation of self, making the conflict implicit in this stage even more stark. Vaughan and Rodriguez (2014) suggest that the Erikson’s aim of ‘fidelity’ for this stage mirrors the concept of authenticity, a trait that is inherent to LBGTQIA+ youth in relation to owning their identity and potentially committing to wider causes relating to gender and sexuality. The ‘intimacy vs isolation’ stage covers a long period of life, and mainly relates to intimate relationships. For young trans and gender diverse people of colour, the difficulties that may have arisen from the previous stage could affect confidence in creating and maintaining relationships if they have internalised a message of not being good enough. However queer people often create their own community or ‘chosen family’, as well as having different relationship structures and placing higher value on friendships (Jackson Levin et al., 2020).

Social identity theories, such as that developed by Tajfel and Turner (2004), help to explain how people develop a sense of self based on their group membership. People feel more positive about those that they feel they share a group membership with (in-group) than those they do not (out-group). In this sense, trans and gender diverse people of colour are discriminated against as an out-group, for example as not male or female, not part of the LGBTQIA+ community and not British. This makes it hard for this population to develop a positive sense of identity and shows the importance of representation and community. It also shows how barriers are created by people with transphobic views who enforce a sense of otherness and perpetuate stereotypes of those that they have little contact with and much uncertainty about (McCullough et al., 2019).

Devor’s (2004) 14-stage theory of identity formation is specific to trans people. Many of the stages focus on the role of identity confusion and comparison, with many delays before moving to stages of acceptance and finally to a place of integration and pride. There are various stages in identity development relating to gender that access to support or information can be sought, and positive experiences of this are likely to promote healthy identity integration.

Finally, young people aged 16-25 are developing within a family context, meaning many adjustments for other family members to make space for their child’s emerging identities and preparations for the young person to potentially separate from the family, although this is under-studied in regards to trans and gender diverse youth (Carone et al., 2021) and can be different across cultures (Bulcroft et al., 1996).

The following section will discuss other relevant theories, including the minority stress theory within which experiences are framed that have a huge impact on identity development.

1.4.2. Minority Stress Model

The minority stress model posits that minority groups experience unique stressors which cause a negative impact on their wellbeing. Both the stressors themselves and the resulting difficulties are why some young people may not feel ready, willing or able to connect with gender healthcare services. This model was originally focused on Lesbian, Gay and Bisexual experiences but has since been expanded for use intersectionally, including a focus on race (Everett et al., 2019) and gender diversity (Tan et al., 2020; Testa et al., 2015). One definition of stress is a situation that causes an individual to struggle above their capacity to endure, which could then lead to physical or mental distress (Dohrenwend, 2000). Trans and gender diverse people of colour experience a multitude of stressors, including debates about their existence, systemic racism, exclusion from ‘safe’ spaces, racialised transphobia and violence (Lockett et al., 2022). Minority stressors are often rooted in whiteness and cis-heteronormativity and cause internal conflict due to existing outside of these dominant social narratives. Incongruent expectations (such as wishing for lighter skin or more feminine features) become stressors that induce feelings of self-dislike, guilt and shame (Meyer, 2003), and may mean that people do not seek help due to not feeling ‘trans enough’.

Many people assume that LGBTQIA+ people and people of colour have higher rates of mental illness that are inherent to their identities. The reality is that experiences of stigma and discrimination increase stress levels, leading to higher rates of psychological distress than white, cis and heterosexual groups. Linked to Meyer’s model, Rood describes how proximal stressors (thoughts and feelings created and maintained through discriminatory experiences) for trans and gender diverse people have been linked to “anticipated stigma, internalised transphobia, and gender identity concealment” (2016, p. 152). Trans people of colour also experience racism and transphobia from within the LGBTQIA+ community (Parmenter et al., 2021; Stonewall Scotland, 2019a).

It is important to recognise the minority stress process so that preventative measures can be taken at both interpersonal and systemic levels (Meyer, 2003), increasing the possibility of accessing support for trans and gender diverse people of colour.

1.4.3. Circles of Fear

Different racial groups may experience different barriers when seeking healthcare. An influential report showed that Black people are responded to differently than white people in health services (Keating et al., 2002), experiencing higher levels of discrimination (Benjamins & Whitman, 2014) which are communicated throughout families and communities (Keating & Robertson, 2004), resulting in Black people being less likely to seek out treatment. When help is needed it may be given too late, compounding negative beliefs about healthcare in the Black community and negative views of the Black community from healthcare professionals. This cycle is described by Keating and colleagues as a 'circle of fear' (Keating et al., 2002). Medicalisation and Westernised views of health have been argued to disproportionately affect racialised minorities (Keating, 2016).

Cultural ignorance of white professionals often means that people's beliefs about health and wellness (Szczepura, 2005) are overlooked. Racial biases in health result in, for example, Black men being perceived as aggressive and diseases on black and brown skin not being recognised (Kaundinya & Kundu, 2021). Descriptions of health experiences have also been shown to differ widely between Black service users and healthcare professionals, and there is a lack of engagement from professionals at community and primary care levels towards minoritised groups (Keating et al., 2002). This means that Black trans and gender diverse may be reluctant to approach professionals based on personal negative experiences as well as those of their community.

Historical trauma relating to healthcare may impact Black people's relationship to help. Well-known incidences include the non-consensual participation of Black men in the US in a study of the effects of untreated syphilis which resulted in over

100 preventable deaths (Manning, 2020), and the non-consensual use of Black woman Henrietta Lacks' cells to further medical research (Skloot, 2010).

Keating's report recommended a national programme focused on Black mental health and programmes to help reintegrate Black people into health services. The report's long list of recommendations are mainly specific to the Black community however models can be developed to think about how other groups may be treated by and respond to the healthcare system (A. Byrne et al., 2017; Fatimilehin & Dye, 2003), particularly those with intersecting identities.

1.4.4. Intersectionality

Intersectionality is the principle that one person can hold identities in several social categories, leading to multiple sources of discrimination (Warner & Shields, 2013). Crenshaw (1990) discussed the cumulative effect of intersecting identities. While being disabled denotes a lack of privileges in an able-bodied world, a disabled non-binary person of colour is likely to experience hostilities (Balsam et al., 2011) and barriers to healthcare (TransActual, 2021) that a white, middle-class cis disabled woman will not (Whitfield et al., 2014).

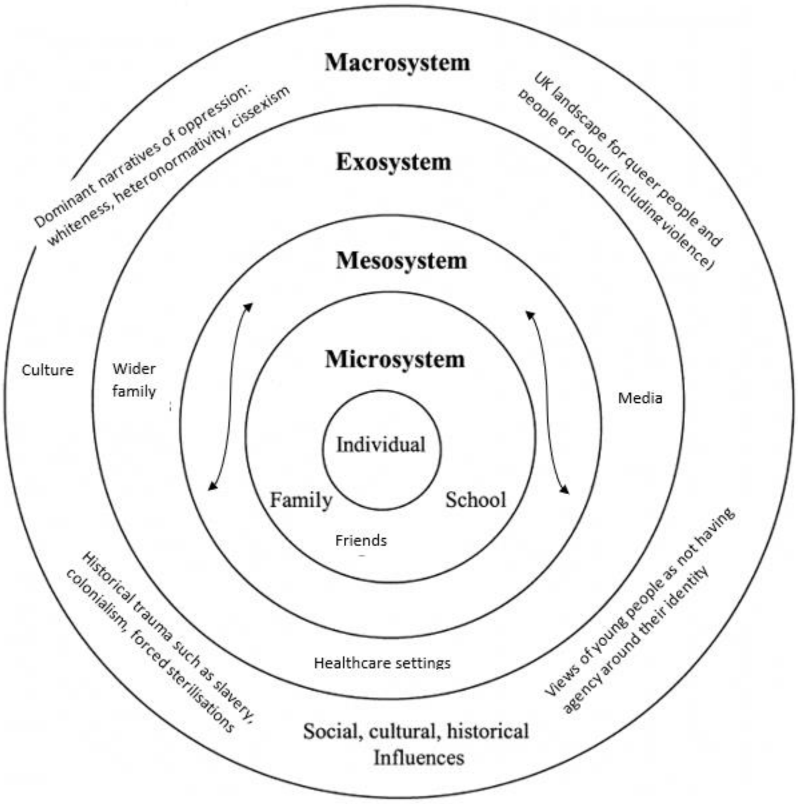
Research suggests that trans people who hold multiple minoritised identities are likely to experience more psychological distress than those who only hold one minoritised identity (Grollman, 2014), and that negative outcomes are particularly concerning for LGBTQ people of colour (Cyrus, 2017). In a study of trans and gender diverse adults, Millar and Brooks (2021) found that racial and ethnic minority participants reported higher rates of psychological distress than their white counterparts whether or not they experienced more gender-related discrimination, showing the impact of systemic racism. They discuss discriminatory intersections experienced by this group as racialised transphobia. Other research found that the 'double marginalisation' of racism and transphobia caused a higher risk of sexual assaults amongst their participants, with those perceived to be 'visibly trans' most at risk (Staples & Fuller, 2021). Robertson et al. (2021) cautions that racism is based on race as a social construction and is likely to be weaponised in multiple forms. This demonstrates the role intersectionality plays for young trans and gender diverse people of colour. Professionals should consider an individual's unique experiences including resulting trauma (Atteberry-Ash et al., 2021; Richmond et al., 2012) and risk (Lytle et al., 2016) at all levels of service interaction.

De Vries (2012) eloquently discusses how trans people of colour present facets of their identity based on the interactions they are having with others. Reactions of others subsequently affect how they view themselves, with negative perceptions likely to be internalised and impact harmfully on the construction of self-identity. Racialised transphobia and internalised negative perceptions are part of the multifactorial picture of barriers to healthcare for those with multiply minoritised identities.

Trans and gender diverse people of colour experience discrimination, abuse and barriers at all levels of society. Figure 1 shows an ecological model (Bronfenbrenner, 1992; Katz-Wise et al., 2022) of the difficulties experienced by this group, from the individual to the social and cultural, with the mesosystem representing the interplay between the systems.

Figure 1

Ecological systems model for trans and gender diverse young people of colour



It is vital to avoid simplistic interpretations of intersectionality, instead positioning it in the context of systemic inequalities and a move towards change (Rosenthal, 2016). Feminist, queer and critical race theories are useful lenses through which to analyse and challenge the discriminatory contexts that intersections exist within (Boe et al., 2020). Community approaches

1.5. Resilience

Singh (2013b; 2014) discusses the resilience often found within trans and gender diverse communities, rooted in autonomously navigating one's own identity while experiencing supportive relationships. This contrasts the experience some have of feeling cut off from and struggling without supportive networks. Social media was also highlighted as a source of resilience. Trans and gender diverse people of colour have been found to show more growth relating to interpersonal development and personal strength when compared to white trans and gender diverse peers (Taube & Mussap, 2022). The factors contributing to resilience can be drawn on when thinking about what gender healthcare services should look like, including community alternatives.

1.6. International Context Of Trans And Gender Diverse Experiences

Understanding the trans experience at a global level provides insight into how to work more inclusively regarding gender and race and identify and eliminate unhelpful systems. Gender services in the UK are the product of many of the dominant social narratives described above which cause barriers for trans and gender diverse people in terms of healthcare provision and ease of ability to identify as one's preferred gender. Understanding the global context will help the UK provide better healthcare for this population. Internationally, there are varying levels of respect given to trans and gender diverse people. In some cultures these individuals are revered and sometimes given important roles within the communities (Young, 2019). Argentina and Denmark have the most legal rights for trans people, allowing people to self-declare their gender (Ryan, 2018). However thirteen countries make it illegal to be transgender (IGLA World, 2019), and globally many trans and gender diverse people suffer extreme violence and abuse. America has recently rolled back the rights of transgender people, meaning more discrimination, and challenges accessing employment and healthcare (Millar & Brooks, 2021). Internationally, referrals to gender services are increasing in adolescent populations (Kaltiala-Heino et al., 2018). This points to potential barriers faced by trans and gender diverse people of colour in other countries, which may or may not be similar to those in the UK.

1.7. UK Social Context

The UK context for trans and gender diverse people of colour involves intersecting experiences of discrimination (Davis, 2017). Factors such as negative media coverage, the current experiences of young people, and limited legal protections and recognitions play a role in perpetuating the existing barriers to gender care, as well as being detrimental to the health and wellbeing of this population.

These factors create a damaging social and legal context that young trans and gender diverse people of colour are forced to exist within. Here, the message received is that young people in marginalised racial and gender groups are less important, and should have fewer rights than others. This demonstrates not only the practical impediments to receiving relevant gender support, but the emotional barriers created by internalising these negative messages (LGBT Foundation, 2018).

Hate crime towards trans people and people of colour has increased in recent years (Home Office, 2021; Samanani & Pope, 2020). Brexit has been found to be linked to a rise in violent narratives, particularly toward racialised minority groups (Carr et al., 2020).

1.7.1. Media

Trans and gender diverse people in the media are portrayed as either a joke or a threat (Pearce, 2018b). The UK media is criticised for perpetuating stereotypes and demonising minoritised groups, and is particularly vehement against Muslim and trans people (TransActual, 2021). Negative media coverage has been linked to increased racially motivated and transphobic crimes (Samanani & Pope, 2020). Television and newspapers regularly platform people to debate trans 'issues', often questioning the existence of trans people, a practice which has been criticised by the head of The Office of Communications (OFCOM; Digital, Culture, Media And Sport Committee, 2020). Debates about 'free speech' result in a backlash to people losing their jobs for discrimination (BBC News, 2021).

Rickett et al (2021) reflect on how public discourse about trans lives is often how young people and their families "come to understand the stigma and discrimination associated with gender diverse identities and health service provision" (p.2). Trans media representation often focuses on white trans people, leaving trans and gender diverse people of colour lacking portrayal of bodies and experiences like theirs.

1.7.2. Young people

Young people in the UK are in a unique position at this point in time. Recently, there have been many shifts in narratives around sexuality and gender in recent years, arising from changes in the law such as the legalisation of same-sex marriage and section 28 (banning the 'promotion of homosexuality' in schools) being removed. Increased access to the internet via smartphones, social media and online gaming means that young people can access information faster than ever before, while facing risks such as exposure to porn and online bullying (Haddon & Vincent, 2015). However young trans and gender diverse people of colour can access online communities and find more representation of people who look like them than in the past. They can link in with movements and activism such as Black Lives Matter.

More children are in poverty than ever before, with young people of colour being particularly affected by austerity measures (Reed, 2020). The ongoing Covid-19 pandemic has had negative impacts on children's social and educational experiences over the last two years. Despite large cultural shifts within the last fifty years, young people continue to grow up within contexts where the 'norm' is still defined as white, straight and cis (Perry, 2001).

Changing ideas and beliefs about gender and the self are impacted by a young person's developmental stage (Chan, 2018). LGBT young people are likely to come out at a developmental period in which they and their peers are strongly opinionated (around age thirteen) meaning they are more likely to be discriminated against than in previous years when young people came out at a later age (Russell & Fish, 2016). As described previously, experiences of discrimination towards those in minoritised groups can affect their relationships, confidence and identity development.

Children and young people experiencing mental health difficulties can be referred to Child and Adolescent Mental Health Services (CAMHS) for assessment and intervention.

1.7.3. Policies and Laws

Under the current Conservative government, recognition of rights for LGBTQIA+ people progress slowly. The legal and healthcare systems of gender-affirmation are linked insofar as they are both available in theory to provide people with the means of feeling safe existing as they want to be seen by others. However they both entail a long and often bureaucratic process to be viewed in a way that society often expects of trans people. The time and difficulty of accessing gender-affirming processes could be seen as discriminatory, and systemic racism is also likely to impact access.

1.7.3.1. Equality Act: The 2010 Equality Act makes it unlawful to discriminate against transgender people. The Act uses the phrase "gender reassignment" which does not relate to medical transition, but describes 'transitioning' to another gender, thereby excluding non-binary and other genderfluid identities. However recent court cases have meant that gender identities outside of the binary are now included under the Equality Act (Hardy, 2020). The Equality Act also makes it illegal to discriminate on the basis of race. However huge inequalities on multiple levels still exist for people of colour in the UK (R. Singh, 2019).

1.7.3.2. Legal Barriers: At the time of writing, the government's Women and Equalities Committee have criticised the government for still requiring trans people to have a diagnosis of gender dysphoria to obtain a Gender Recognition Certificate, and requested that this be ceased (Women and Equalities

Committee, 2021). Gender Recognition Certificates are required to change legal documents such as birth certificates.

1.8. The Impact Of Culture

Culture can mean many different things, and writers warn against assuming a person's cultural identity based on racial and ethnic stereotypes (Keating & Robertson, 2004). Along with other social and personal experiences, culture shapes the way people think and feel, creating a cognitive framework through which they interpret their experiences (Markus & Kitayama, 1991). For example, collectivist societies value working together, having a support network and a widely held shared family narrative whereas individualist societies promote personal responsibility, self-motivation, and a comfort in spending time alone (Motti-Stefanidi, 2018). As children of migrants, existing within two cultures can cause cognitive dissonance due to contradictory values, negatively impacting mental health (Bhugra, 2005). It is important to acknowledge the very individual formation of identity and the personal meaning of culture of people from racialised minority backgrounds.

Some young people may feel unable to draw on family support systems due to differing cultural beliefs about gender, resulting in social and emotional withdrawal from their family unit. This isolation can threaten resilience and wellbeing (A. A. Singh et al., 2014). Concerns about support may also a be a reason that young people do not feel able to access gender services, as parent or carer consent is required for a referral for under 16's except in exceptional circumstances (GIDS, 2022b).

1.8.1. Familial And Cultural Barriers For Trans And Gender Diverse People Of Colour

A survey carried out by Stonewall Scotland (2018) with trans people found that one in seven participants were not out to their families. This could potentially be higher in populations of colour, given that 95% of trans participants of colour in a survey by TransActual (2021) into the lived experiences of British trans people said they had experienced transphobia from family members. Trans activists have warned that the expectations of gender healthcare normed on white people means that pressure is put on young trans people of colour to be out to their families, even if this is not safe (Zhang, 2021).The expectation of rejection is linked to psychological distress and whether someone is out (Rood, 2016), showing the difficulty of coming out to families who may not be supportive. In a study of trans and gender diverse people (over half of which were people of colour), expectation of rejection was linked to hypervigilance, anger towards self and others, self-hatred and exhaustion. Rejection itself was also linked to risk (Valdiserri et al., 2019).

Singh (2013b) notes that some parents of colour might think that only white people are trans, so would not presume it of their child. Parents of trans and gender diverse children have spoken about their uncertainty about their child's identity (Horton, 2022), need for more support and resources, and fear and worry for their child (Pullen Sansfaçon et al., 2022). Support from families can help mitigate psychological distress (Brown et al., 2020). Chan (2018) notes that parents of colour can draw on cultural strengths to be strong allies for their children. Support from parents has been shown to mitigate poor mental health in all trans youth (Wilson et al., 2016), including early support with social transitioning (Olson et al., 2016) which has been shown to mitigate psychological distress to the level of the developmental norm. Trans and gender diverse young people of colour may be less likely to seek out gender-related healthcare due to lack of support from their families and communities, although more research is needed in this area for a more nuanced understanding.

1.9. Healthcare

UK healthcare is chronically underfunded due to austerity measures, resulting in worsening care and longer waiting times (Viens, 2019).

It is important to situate healthcare for trans and gender diverse people within the knowledge that their bodies, emotions and experiences are often medicalised, a process which in part relies on diagnosis. Some people choose to avoid a healthcare pathway as they do not feel it is necessary or because they see no role for medical intervention relating to gender, while others feel that psychological or medical intervention is required to help affirm their gender identity. When seeking gender healthcare support, a referral into services is necessary.

Healthcare policies dictate how services are developed and maintained, and may be based on ideals that do not best support the needs of trans and gender diverse people of colour.

1.9.1. Diagnosis

Similarly to mental health (Timimi, 2014), sexuality has been pathologised; homosexuality was illegal (for two men) in the UK up until 1967, and was included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1973. This perpetuated a context where people who deviated from heterosexual norms could be punished or pathologised. This increases stigma and creates the belief that LGBTQIA+ people can be ‘cured’ which has contributed to the creation of ‘conversion therapy’ to ‘convert’ queer people ‘back’ to being straight or cis, with often incredibly harmful results (Stonewall, 2021). A National LGBT survey showed that trans people are twice as likely to have experienced this, with Black trans people and other people of colour much more impacted (Government Equalities Office, 2018). At the time of writing, conversion therapy has been banned for LGB people but not trans people, causing outcry amongst activists (Peter Tatchell Foundation, 2022).

The diagnostic term ‘gender identity disorder in childhood’ first appeared in the DSM III in 1980 under "psychosexual disorders". Neitling (2021) notes that clinicians who introduced ‘disorders’ of gender and sexuality into the DSM had little or no specialised knowledge. Yet the inclusion of this diagnosis, and early gender-related diagnoses for adults, problematised gender difference as a disorder of the mind, meaning that it could easily be conflated with mental illness. Authors argued that the diagnosis should be removed due to its basis in cis-hetero assumptions (Ault & Brzuzy, 2009).

‘Gender identity disorder in childhood’ was changed in 2013 to ‘gender dysphoria in children’, highlighting that this diagnosis relates to the distress felt by some gender questioning young people while recognising that not all will experience distress around their gender. However, trans and gender diverse young people in the UK are still required to be given this diagnosis or the diagnosis of ‘gender dysphoria in adolescents and adults' from a medical professional before receiving any intervention to medically transition. This means that gender healthcare continues to be gatekept, perpetuating the 'othering' of gender diversity (Valdiserri et al., 2019) and continuing the cis-hetero-centric dislike of difference that started with the diagnosis of homosexuality (Spurlin, 2019). Professionals have called for the removal of any diagnostic criteria alongside continued funding for support (Richards et al., 2015).

If people do not feel that they meet the criteria of diagnosis or generally 'not being trans enough' they may avoid healthcare services for fear of being rejected. This can be particularly hard for people with non-binary or other gender-diverse identities who may worry about healthcare professionals binary views (B. Vincent, 2020) and for people of colour who may experience stigma if health professionals have expectations of trans and gender diverse people being white, due to lack of representation.

1.9.2. NHS Context For Trans And Gender Diverse People Of Colour

Trans and gender diverse people of colour should have access to physical and mental healthcare and may wish to access gender-specific services for therapy, hormones and/or surgery. If experiencing mental health difficulties, people should be seen by their General Practitioner (GP) or secondary healthcare service (e.g. CAMHS or an Improving Access to Psychological Therapies service). In reality, these services often signpost trans and gender diverse people to specialist gender services regardless of their presentation, focusing on gender rather than offering mental health support. This process is known as 'diagnostic overshadowing' and has been highlighted as a cause for concern in the interim report of an independent review taking place for young people's gender services (Cass, 2022). Due to long waiting lists for Gender Identity Services (GIDS; for children and adolescents) and Gender Identity Clinics (GICs; for adults), diagnostic overshadowing may result in trans and gender diverse people self-managing symptoms or accessing help through charities or support groups instead of through healthcare services. Professionals are advised to work with presenting concerns instead of referring to gender services (Bonifacio et al., 2019). Many trans people report similar experiences in physical healthcare services, such as ‘trans broken arm syndrome’; when a person seeking care for a broken arm will still be asked how it relates to them being trans (Dietz, 2021).

A systematic review of international clinical practice guidelines (CPGs) for trans and gender diverse care shows huge gaps in care and dangerous cis-hetero assumptions, as critiqued by Dahlen et al. (2021). The World Professional Association for Transgender Health has created the Standards of Care and Ethical Guidelines to inform and guide professionals working with gender dysphoria (WPATH, 2012). These guidelines direct CPGs in the UK yet have been shown to be lacking in methodological rigour. Internationally, CPGs for trans and gender diverse people mainly focus on transition, and HIV and other sexually transmitted infections, leaving out considerations of general physical healthcare, mental healthcare, quality of life and mortality. This may be due to the top-down creation of guidelines rather than service-user informed relevant healthcare provision. Dahlen et al. recommend increased stakeholder involvement and improved quality of the evidence base that informs CPGs.

1.9.3. Organisational Policies

In 2019 World Health Organisation (WHO) removed gender identity disorder from the International Classification of Diseases Manual, which is used for diagnostic purposes alongside the DSM-V. This is a global statement that being trans or gender diverse is not a mental health disorder.

The service specifications for GIDS state that the service will be delivered in line with national and international guidelines regarding young people with gender dysphoria, such as those created by WPATH and the Endocrine Society, and NICE guidelines for psychosis, anxiety and depression (NHS England, 2016). As previously discussed, the WPATH guidelines do not meet good quality research standards. Guidelines and policies for this population acknowledge the lack of research in this area and suggest that policies may change based on new evidence. The Care Quality Commission states its expectations for GPs working with trans and non-binary people and says they are responsible to this group “regardless of their personal beliefs” (Care Quality Commission, 2021). GPs are the main source of referrals to GIDS. Other health professions can also refer. The Royal College of GPs (RCGP) has produced a policy and position statement which reiterates that GPs should work without bias and states that gaps in education and training for GPs should be “urgently addressed” (RCGP, 2019, p. 2). They suggest a shared care approach to medical interventions where appropriate.

There are no national policies for CAMHS to guide care for trans and gender diverse young people, meaning that they may not be supported to access the most suitable care pathway. Trans charity Mermaids recommends that parents should only ask the GP for a referral to CAMHS if there are mental health difficulties alongside seeking gender support, as “CAMHS often have no knowledge of gender dysphoria” (Mermaids, 2017, p. 3). The GIDS website advises that following assessment, therapeutic support and risk management should be provided by the local CAMHS, as GIDS works to shared care and multi-agency models (Davidson & Eracleous, 2009). GICs state that they prefer referrals from GPs and other NHS health professionals but will accept self-referrals as long as a GP is involved in some way.

These policies can be argued to show the influence of cis-centric biases creating services for trans and gender diverse people. Support is disparate and disjointed and is a long way from providing robust and high-quality standards in care.

1.9.4. Gender Clinics

There are currently ten adult gender clinics in the UK, three clinics for young people, and one clinic covering both groups (Gender Identity Research & Education Society, 2020). Six NHS pilot services opened recently aiming to streamline the process of receiving hormones (TransPlus, 2020). They are currently only for people over 17 who are already on a waiting list for a UK gender service.

At GICs, it takes a relatively short time to be prescribed hormones once consent has been ascertained. Surgical interventions can take a much longer time, and many trans and gender diverse adults choose to utilise private healthcare instead. However, this is only available to those who can afford it. In a survey of nearly 900 trans adults in the UK, the Scottish Trans Alliance (McNeil et al., 2012) found that 58% of participants said their mental health deteriorated whilst waiting for specialist care.

GIDS, which treats gender diverse young people, received 97 referrals in 2009-10. In 2021 the number was 2383 (Healthcare Safety Investigation Branch, 2022). Young people coming into the service undertake assessment at monthly intervals for at least six months. Following assessment, which includes exploration of gender identity, the young person may be given a formal diagnosis of gender dysphoria, which is required to pursue medical intervention in the form of hormone blockers. This treatment halts puberty to give young people more time to explore their gender, if this is felt to be the clinically indicated pathway. They will also be provided therapeutic support around their gender identity. If a medical pathway is not pursued, the young person will be discharged or will continue to receive therapeutic support only.

GIDS began the use of hormone blockers in 2011. This intervention is often criticised due to limited evidence for its long-term use in this population. However, the medication has been being used to manage precocious puberty in young people for many years (Chen & Eugster, 2015). A systemic review critiqued current research into the effects of hormone blockers, saying that many studies do not meet adequate research standards and found there was little or no change to gender dysphoria, mental health and psychological functioning (National Institute of Clinical Excellence, 2020b). However, other research indicates mainly positive psychological outcomes for trans and gender diverse people who have taken hormone blockers, including reduced suicidality and improved social and psychological functioning (Rew et al., 2021) Social support is shown to be key to good outcomes (Panagiotakopoulos et al., 2020). Studies show that white young people are more likely to be prescribed hormone blockers than other racial groups (Lopez et al., 2018).

Cross-sex (or gender-affirming) hormones, either oestrogen or testosterone, depending on the required effects, can be prescribed by GIDS to young people aged between 16-18 following at least a year on hormone blockers. Despite misleading statements from the media, surgery is never performed for medical transition on those under eighteen in the NHS. NICE has also criticised the quality of studies underlying the use of cross-sex hormones, however, the evidence appears to be more affirmative as to positive psychological outcomes and reduction of gender dysphoria (National Institute of Clinical Excellence, 2020a).

1.9.5. Critique Of Gender Services For Young People

The recommended NHS waiting time is 18 weeks (NHS, 2020); young people are currently waiting in excess of three years for GIDS (GIDS, 2022a) and approximately five years for GICs (Healthcare Safety Investigation Branch, 2022). A legal challenge has been brought against the NHS in protest of excessive waiting times (Good Law Project, 2020). The risks of delayed access to support and healthcare have been discussed by a variety of advocates (Rickett et al., 2021). The current gender healthcare has been heavily criticised by many trans and gender diverse people (BBC Three, 2021; Faye, 2022) as not fit for purpose. Waiting lists are often cited as one of the most difficult aspects of seeking gender healthcare (London Assembly Health Committee, 2022) and as heavily impacting mental health. There have been a number of suicides by young people on the GIDS waiting list (Biggs, 2022).

In 2020, GIDS was sued by Keira Bell, a young person who had been given puberty blockers and had gone on to take cross sex hormones, who argued that she should not have been able to consent to this process at sixteen. She won her original case; it was then appealed at the Judicial Review Courts and overturned (*Bell and Another -v- The Tavistock and Portman NHS Foundation Trust and Others*, 2021). Despite the appeal being overturned, ‘detransitioning’ is used by many people as an argument against young people receiving gender affirming treatment, despite studies reflecting that less than 1% of people who go on to get medically gender affirming surgery regretting doing so (Bustos et al., 2021) and those that do often doing so for reasons of societal pressure and discrimination (Turban et al., 2021). Some opponents have likened the use of hormone blockers on young people to experiments being carried out on children by the Nazis (Jeffreys, 2012).

There is currently a much larger proportion of people being seen at GIDS that were assigned female at birth compared to previous years (Cass, 2022), although it is unclear why. Young people of colour are disproportionately under-represented in referrals to GIDS when compared to both the national population and CAMHS, and this may be related to barriers that are specific (although not inherent) to different racial groups (de Graaf et al., 2019). Another notable statistic is the number of people who are neurodiverse at GIDS is much higher than in the general population (Cass, 2022) again without clarity why this might be. This can be linked to the underdiagnosis of autism in ethnic minority groups (Begeer et al., 2009), meaning that young people might be doubly susceptible to missed treatment or support opportunities. Looked after children are also over-represented in GIDS when compared to the national average (Matthews et al., 2019). These figures show the potential for these young people to experience multiple barriers to healthcare. Geographical inaccessibility and lack of family inclusion can also be barriers to gender healthcare (Carlile et al., 2021).

1.9.6. Alternative Gender Healthcare

Due to NHS barriers, some people utilise private healthcare. Trans and gender diverse people of colour surveyed by TransActual (2021) were more likely to be earning a low wage than their white peers, highlighting that this population may be less likely to be able to afford private care. Private provider GenderGP will charge £530 for the minimum recommended intervention for people wanting feminising hormones and £580 for people wanting masculinising hormones (GenderGP, 2022). Private providers cannot maintain the prescription of hormones on an ongoing basis and may need to transfer care to GPs. GPs often refuse to take over prescription (‘shared care’) and provision (Legge & Seal, 2019), leaving trans people without access to hormones. Private costs for top and breast surgeries start at about £6-7000; vaginoplasty costs about £15,000 and a phalloplasty costs from £40-70,000 (Zhang, 2021).

There are both NHS and non-NHS services which offer free blood tests for trans and gender diverse people on hormones, whether prescription or illegal.

1.9.7. Illegal Treatment

As the evidence suggests that trans and gender diverse people of colour may be less likely to be referred to gender services and less likely to be able to afford private healthcare, they may feel forced to obtain hormones illegally. It is difficult to gauge the numbers of people sourcing illegal hormones online due to the risks of disclosure, however, in one survey, 11% of trans participants said they sought treatment abroad which included buying hormones from other countries (Stonewall, 2018b). Mepham et al., (2014) found that almost a quarter of trans and gender diverse people presenting at a gender identity clinic self-prescribed hormones, with the majority sourcing these online and using protocols found online to determine usage. The risks associated with taking illegal hormones are similar to many from prescribed medications, but without regular health checks, users risk outcomes specific to cross-sex hormone treatment such as cardiovascular disease, cancers, osteoporosis and venous thromboembolism (Fabris et al., 2015). Healthcare providers have been encouraged to ask trans and gender diverse clients about their use of illegal hormones to ensure safer care (Metastasio et al., 2018).

1.9.8. Negative Outcomes

Limited access to gender healthcare can result in adverse outcomes. These include increased risk of mental health difficulties resulting from long waiting lists, living with gender dysphoria and a sense of hopelessness (McNeil et al., 2012). Zhang (2021) notes that trans and gender diverse people of colour are the group worst affected by lack of access. Trans and gender diverse people experience an increased risk of homelessness and unemployment difficulties but may need a gender recognition certificate to get a home and a job, which relies on a diagnosis of gender dysphoria. Evidence shows that trans and gender diverse people are more likely to experience abusive or risky sexual situations due to isolation, social exclusion and transphobia (Goldenberg et al., 2018; Rymer & Cartei, 2015), and trans and gender diverse people of colour in particular receive more societal discrimination than white peers (James et al., 2016). The negative impacts of these factors could be mitigated by support and treatment.

Trans and gender diverse people are likely to avoid general physical healthcare checks due to fear of discrimination, meaning that medical health needs could be missed if they are not seen by gender healthcare professionals (Metastasio et al., 2018).

1.9.9. Professional Bias And Lack Of Training

Trans and gender diverse people face difficulties when trying to receive both general and gender-specific care (Stonewall Scotland, 2019b), which is often linked to professional biases or lack of education (Canvin et al., 2021). For those with intersecting identities, these difficulties are exacerbated further.

Ellis (2015) found that of 621 trans people, a third reported being dissatisfied or very dissatisfied with their care in mental health services, which was unrelated to being trans. Some participants found that mental health professionals pathologised their gender identity, and others felt that the professional did not know enough about gender identity and being trans. Similar results were also found in Australia (Riggs et al, 2014).

A US study found that of 6,500 trans people, 28% reported harassment in their doctor's office, and 2% reported actual physical assault (Grant et al, 2011), highlighting the potential risk to safety of disclosing gender identity to professionals (Macapagal et al., 2016). Trans and gender diverse people have fed back that increased education and clinicians being open-minded and kind would greatly improve their experiences (Lewis et al., 2017; Sallans, 2016). Health professionals themselves have identified similar concerns about lack of knowledge and intractable systems (Mikulak et al., 2021). In a systematic review, Canvin et al. (2021) found that professionals with minoritised identities were more competent when working with trans and gender diverse people. Clinicians may conflate trauma and gender diversity, but rather than attempting to 'unpick' the two, they must be holistic and patient-led (Wren, 2019). Internalised transphobia can be damaging, and clinicians must ensure that they do not add to this.

Non-binary and other gender diverse people (that may or may not define as trans) experience specific barriers. Non-binary people experience higher rates of abuse (Lefevor et al., 2019), mental health difficulties and lower self-esteem (Thorne et al., 2019) than binary young people. Non-binary people's experiences of gender healthcare clinicians were negative (B. W. Vincent, 2016); with 'very impactful' discrimination experienced by up to 83% of UK non-binary people surveyed who had sought trans-specific healthcare (TransActual, 2021) and inflexible systems when recording gender identity (Scottish Trans Equality

Network, 2016). This notably and disproportionately impacts people of colour, who represent almost half of trans people in the UK (TransActual, 2021).

The obvious need for more training and education for healthcare professionals does not just apply to those directly working with trans and gender diverse individuals, but those who indirectly work with and/or refer these individuals. Clinicians are likely to draw on societal biases and beliefs unconsciously and this may impact decisions around referrals. GP’s have been identified as a specific barrier by trans and gender diverse young people (Children’s Right Alliance for England, 2016). Many GPs are not aware that they can legally prescribe cross-sex hormones (Legge & Seal, 2019), and the RCGP has said itself that there is a lack of training for GPs in this area (RCGP, 2019). GPs’ medicalised approach may mean they struggle to support trans and gender diverse people in distress (Checkland et al., 2008). Professionals are advised to begin by validating the young person’s experience (Bonifacio et al., 2019).

Parents of young gender diverse children in a recent study (Rickett et al., 2021) felt their concerns had been taken seriously by their GP, however most did not feel that the GP was knowledgeable or that they had received good advice and support. Over half had to inform their GP of how or where to refer their child. The same lack of advice, support and knowledge was echoed in parents’ feelings about CAMHS. They also felt the GIDS lacked appropriate knowledge about gender diverse children and their families. This has been supported by other studies (Carlile, 2020).

1.9.10. Professional Biases Specific To Trans And Gender Diverse People Of Colour

When thinking about the intersections of race and gender and how they might compound some of the difficulties experienced when engaging with healthcare professionals, the circles of fear model may be a useful framework. Pearce (2018a) speaks about how transphobia results in mistrust of healthcare systems. Trans and gender diverse people of colour will learn, experience and hear about stigma and discrimination in the healthcare system and so may avoid seeking help for gender support, and physical and mental health difficulties (Samuels et al., 2018). By the time of urgently needing help, their identity could be seen as part of the problem. Stigma is a systemic barrier to improved training provision (Poteat et al., 2013). Keating et al. (2002) recommend that the relevant training is implemented for professionals and that recruitment of, in particular, Black primary care staff is increased.

People of colour face more discrimination around their gender presentation based on biases of Eurocentric features (Anderson et al., 2020), which professionals are likely to have internalised. The Race Equality Foundation has highlighted the unique difficulties faced by racially minoritised trans and non-binary people, including the inability to be fully honest with healthcare professionals about their identities due to concerns about the response (Kattari et al., 2016).

Within gender services themselves cis and white professionals predominate (Fernando, 2017; Lindroth, 2016), and many people of colour have reported racism and higher rates of transphobia than white peers (TransActual, 2021). Therapists working in this area must aim to provide standardised care (McDowell, 2021) and understand their own identities and privilege in relation to their client's (Chang & Singh, 2016). White and cis professionals may avoid topics of gender or race for fear of making a mistake (Oaster, 2019).

Cultural, familial, societal, legal, psychological, and healthcare-specific difficulties all contribute to barriers that prevent access to gender services for young trans and gender diverse people of colour. However the disparate and broad nature of these factors highlight the need for utilising a more cohesive approach to explore potential barriers further.

1.10. Scoping Review

1.10.1. Objective and Rationale

A scoping review was undertaken to understand the research question: 'what is known from the existing literature about trans and gender diverse people of colour's experiences of barriers to gender healthcare?'. This review centred on the experiences of this group, explored the consequences of barriers to healthcare, and attempted to identify potential gaps in the literature.

A scoping review was used to ascertain the landscape of the current research into experiences of entering healthcare for trans and gender diverse people of colour. Scoping reviews are used as a systematic way of seeing what research is available in a relatively under-researched field (Peters et al., 2015). Yet it provides a more rigorous and wide-ranging search than using generic search engines. It is not as rigorous as a systematic review, as this is done where a field of knowledge is well established, and existing research can be brought together.

Scoping reviews allow more breadth as to the type of resource used (Peters et al., 2015), and therefore provides a better overview of new, emerging and non-peer reviewed evidence across a range of considerations of the topic and ideological research positions. It is a more descriptive methodology and therefore suited to an under-researched field without established theories or frameworks as it ensures that assumptions are not made inappropriately.

This review will therefore conduct an exploratory search of existing literature in order to ascertain what barriers already exist for young trans and gender diverse people of colour and how these relate to the UK context of gender healthcare. In this way a research question can be developed that is relevant and specific.

1.10.2 Methodology

The initial step in the scoping review was to ensure that there was a defined objective, corresponding to a clear research question. The initial literature review demonstrated the breath of factors arising from the research, however showed a lack of specificity into the intersectional experiences of young trans and gender diverse people of colour accessing gender healthcare in the UK. Due to this, the objective of the scoping review was used to attempt to combine the factors of race, gender diversity and access to gender healthcare to find data about the experiences of this population.

The sources used were any peer-reviewed or grey literature that was found using comprehensive searches of established databases. There were taken from any field, given the disparate nature of the relevant factors being researched.

There was high heterogeneity across publications, despite the limited field of study. An iterative and reflexive methodology was chosen to ensure that the scoping methodology would achieve in-depth and broad results, as exemplified by Arksey and O'Malley (2005). The PCC method was used; Population, Concept, Context (Peters et al., 2020), which helped to clarify the main concepts of the review and develop the research question. The primary question for this scoping review was what are the types of barriers that come up for trans and gender diverse people seeking healthcare. Following the PCC structure, the search terms identified were relevant to the populations 'trans and gender diverse' and 'people of colour', concept 'barriers' and 'referrers' and context 'healthcare'.

1.10.2.1. Search strategy: Following a limited search across several databases to determine accurate search terms, these were refined to ensure the search strategy was comprehensive. Initially common search terms were used and when these did not return many results these had to be widened. 'LGBT' and derivatives had to be used as 'trans' and related terms did not yield enough results.

The resulting search terms were:

Lgbt, lgbtq, lgbtqia, lgbt+, lgbtq+, people of colour, Black, Asian, race, BAME, refer, referrer, barrier, healthcare

The Boolean/Phrase search method was used to combine words with 'and', 'or'.

The final scoping search encompassed six databases, to encourage breadth of papers accessed. These were Academic search complete, CINAHL, PEP archive, PsychINFO, PubMed, and Scopus.

Following this, duplicate papers were removed and exclusion criteria used to screen the title and abstracts of the papers. The remainder were then hand searched and one paper was added through reviewing the authors other papers. Full text articles were then reviewed using the exclusion criteria.

1.10.2.2. Exclusion criteria: The following exclusion criterion were used:

- Papers which did not speak specifically about people of colour, and did not address this topic explicitly

- Papers which did not speak specifically about trans or gender diverse people, and did not address this topic explicitly
- Papers not specifically speaking about gender-affirming healthcare
- Papers written in another language, without accessible and reliable translation
- Papers before 2012, given how much the landscape has changed for this population

Not including people of colour and trans people would have meant that the review lost relevance, similarly if gender healthcare was not specifically included. Papers without accurate translation may have been reviewed incorrectly and as such provided inaccurate information. Including more recent papers meant an up-to-date review of a fast-changing evidence base.

Due to the scarcity of papers, papers from outside of the UK had to be included, and the age range of participants could not be specified.

1.10.2.3. Quality assessment

The Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018)) was used as a quality assessment tool for the final four papers found, although due to the nature of the study only one reviewer could appraise the papers against the advice of the tool's authors. Table 2 shows the MMAT checklist for each study showing if it did meet criteria (Y), did not (N) or it was unclear if criteria were met (cannot tell), following the tool protocol.

Table 2

The Mixed Methods Appraisal Tool checklist for scoping review studies

Mixed methods: Methodological quality criteria	**Study 1**	**Study 2**	**Study 3**	**Study 4**
Is there an adequate rationale for using a mixed methods design to address the research question?	Y			
Are the different components of the study effectively integrated to answer the research question?	Y			
Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Y			
Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Y			
Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Y			
Quantitative descriptive studies: Methodological quality criteria				
Is the sampling strategy relevant to address the research question?		Y	Y	Y
Is the sample representative of the target population?		Y	Y	Y
Are the measurements appropriate?		Y	Cannot tell	N
Is the risk of nonresponse bias low?		Y	N	Y
Is the statistical analysis appropriate to answer the research question?		Y	Cannot tell	Y

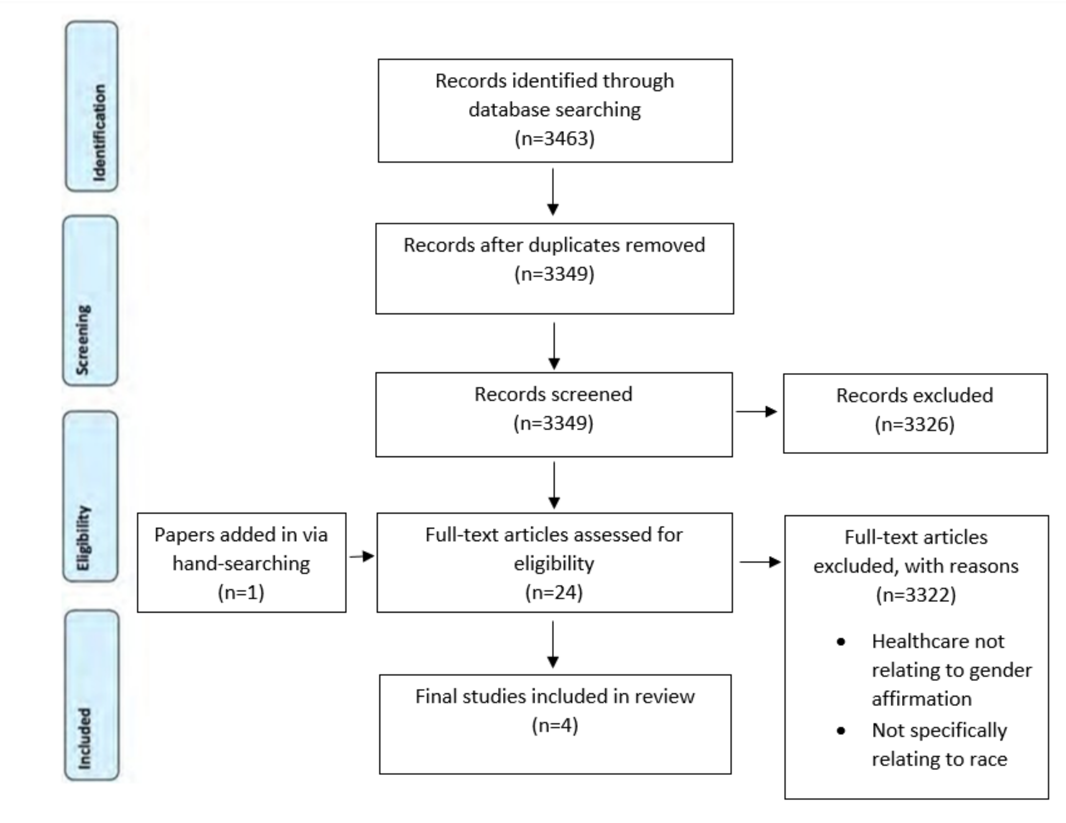
Using the MMAT shows that the papers used mostly meet high quality standards for the methodologies used. Study 3 had limited information available and so may not meet quality standards however was included as the study was mostly marked ‘cannot tell’ rather than ‘no’.

1.10.3. Results

In summary a total of 3349 papers were returned through the search. After reviewing titles and abstracts, this was reduced to 23 papers, with one other paper added via hand-searching other papers by the same authors (N=24). These were read in full text, reviewed using the exclusion criteria and reduced to four papers. This process is pictorialised in Figure 2.

Figure 2

Scoping review process



Four papers remained that referred to, or focused on, trans and gender diverse people of colour’s experience of accessing gender healthcare services.

The included studies were conducted in the US and published between 2020 and 2022. The age range of participants in the included studies was 16 to 65 years (3 studies, the other related to provider’s views). Two papers were qualitative mixed-methods designs of surveys carried out with trans and gender diverse people in the US and two were quantitative papers looking at how survey responses from this group or gender healthcare providers. Brief summaries of each study are provided below.

1.10.3.1. Study 1 (Goldenberg et al., 2021): 187 trans and gender diverse people of colour in the US were asked about their experiences of seeking healthcare (including gender-specific) and the stigma and affirmation they receive in this context. Cross-sectional surveys (N=187) and in-depth interviews (N=33) were collected using a Transformative Concurrent Mixed Methods approach. Results showed that participants received stigma in multiple healthcare settings, including gender. They described difficulties finding a provider, making an appointment, being misgendered and having to 'come out' to staff, experiences of dis/respect, lack of knowledge from professionals and professionals helping to access gender care. Gender affirmation increased resilience and motivation to seek primary care; stigma decreased it. Participants still wanted gender healthcare despite negative healthcare experiences. However, barriers came from family, or work and education contexts not being accepting.

1.10.3.2. Study 2 (Goldenberg et al., 2020): This study used survey responses from 27,715 trans and gender diverse people in the US; the study does not report how many were people of colour other than it being a small amount, which is a limitation, especially as race/ethnicity was one of the factors being researched. It looked at how state-level policies (such as religious exemption laws or non-discrimination policies) impacted access to gender healthcare. In nearly all states people of colour reported less access to gender healthcare (therapy and hormones) than white people, irrespective of policy. Low response rates from people of colour meant that racially-related factors could not be looked at in more nuance.

1.10.3.3. Study 3 (Douglas et al., 2022): This study investigated US gender healthcare provider's perspectives of black trans and gender diverse youth's gender affirmation goals and barriers to healthcare. A survey was used to ask 20 gender healthcare professionals about their interactions with approximately 90 young people. Professionals reported the young people were less likely to be out to family and to be receiving hormones, and were more likely to have reported wanting to socially not medically transition, than their white peers. Reported barriers included lack of family support, difficulties with referrals and fears of discrimination, and wanting to get gender healthcare from their primary clinician. They recommend that provision of care would be better suited to primary care. Limitations are that this study was done with (a small number of) providers, not young people themselves.

1.10.3.4. Study 4 (Lett et al., 2022): This study looked at the impact of systemic racism on access to gender healthcare (therapy, hormones/blockers, surgery). Cross-sectional secondary analysis was carried out on survey response data from 20,967 US trans and gender diverse people, of whom 3,524 were people of colour. The authors inferred experiences of discrimination for respondents and found decreased access to gender healthcare across all groups of colour, particularly in Black, Latinx and Native American trans people. Native American and Latinx people also reported the highest levels of severe psychological distress, while getting access to gender healthcare decreased severe psychological distress for all people of colour. A limitation is the inference of discrimination against people of colour rather than gathering data specifically about this.

1.10.4. Conclusion And Critique

In summary, the scoping review resulted in four studies that provide insight into the experiences of trans and gender diverse people of colour accessing gender healthcare. Although it was hoped that there would also be a focus on young people (as defined earlier in this paper) and UK healthcare services, a lack of results for papers combining all these factors meant that there was less specificity than desired to answer the research question. None of the studies looked at UK services. The studies did not all pertain to young people's experiences, which are likely to have unique facets.

The lack of results of this study are based partially on the limitations of terminology and the databases used. Rapid changes and nuance in language in the area of gender diversity means that some useful search terms may not have been utilised.

1.11. Current Study

1.11.1. Rationale For Current Study

Following on from the gap in the literature, this study looked at trans and gender diverse people of colour’s personal experiences of barriers to gender healthcare (GIDS and GIC) in the UK. The aim of this study is to use young people’s voices (that are often left unheard) to highlight where these barriers lie. It is hoped that despite a small sample size this will illustrate the impacts on this population and what and where changes could be made.

1.11.2. Research Question

The current research aims to use semi-structured interviews to allow breadth in a small research project and will be analysed using thematic analysis. The research will aim to understand how young people with marginalised identities experience and navigate barriers to gender healthcare and what impact this has on their identity and their pursuit of gender health support.

The question for this research is: What are the barriers to UK gender services (GIDS and GIC) for trans and gender diverse people of colour?

METHODOLOGY

2.1. Chapter Summary

This chapter will explore the epistemological positioning of this research and the design, process, data collection and analysis method employed in this study. Ethical considerations will also be discussed.

2.2. Epistemological Positioning

It is important for researchers to state their theoretical positioning explicitly. Doing so determines the nature and process of carrying out research, and helps to consider the impact of the research and the experience for participants.

2.2.1. The Researcher Position

I am a 35 year old white British cis woman. I identify as queer. I currently reside in London. My queerness has always been a large part of my identity, and queer friendships and spaces are very important to me. I also have personal experience of mental health difficulties and have worked in a professional capacity with many incredible people who also have a range of difficult experiences.

In my work and personal life I am always considering transformative ways in which people can care for each other. I try to resist unjust systems and work towards social justice, which is part of what led me to become a Clinical Psychologist, while holding a critical position. I try to take anti-psychiatry, anti-austerity, anti-racist and non-cis-heteronormative stances in all areas of my life, and this is very linked to and shaped by my queer identity. These stances involve thinking about who might experience the most harm from whiteness, cissexism and heteronormativity, and suffer most due to the wide-ranging impacts of austerity and the at times re-traumatising nature of the UK mental healthcare system.

I have worked with gender diverse young people and have many gender diverse friends, which makes me aware that the current healthcare system fails this group of people. Learning that the number of people of colour seen by GIDS is not representative of people of colour in the UK made me question whether this group was even more affected by the system.

I wrestled a lot with whether I am the right person to do this research and in some ways, the answer is no. However, groups that are shut out from systems should not be the only ones working to transform them. As a white cis trainee Clinical Psychologist, I believe I should engage in research that explores why these groups are under-represented.

With this in mind, I used Hale's (2009) rules for non-trans people writing about trans people and came from a non-expert 'outsider' position (Rosenberg & Tilley, 2021). I wanted to use the power, privilege and position I hold to amplify other voices.

2.2.2. Epistemological position

This research takes a social constructionist epistemological position. Epistemology is concerned with the theory of knowledge and how that knowledge shapes our 'truth' of the world. The social constructionist perspective is that knowledge is co-constructed through our interactions with other people. There is no one truth or way of knowing, but instead there are multiple, created by our experiences in the world and the social context we exist within. This research was produced and carried out within the frameworks of feminist, queer, and anti-racist theory. These lenses help us to be critical about research and ideas that are created through dominant narratives of whiteness, maleness, cisness and straightness.

Some theorists (e.g. Barker & Scheele, 2016; Butler, 1999; Gergen, 2011; Rosenberg & Tilley, 2021; Smedley & Smedley, 2005) take a social constructionist position to discuss the creation of queerness, gender, race and mental health as well as reflecting that constructions still affect and dictate the way we live our lives. However, social constructionism is not held here as an absolute, and some of the participant experiences will be described in a way that acknowledges critical realism. This is to ensure that their voices are heard without the potential of biased interpretation from the researcher.

Critical lenses lend themselves to a non-positivist approach to research. Positivism is an individualist way of working that imagines that the concepts being studied, i.e. mental health, race and gender, have one meaning or ‘truth’ that can be discovered through research, and these concepts are measurable and definable and can be studied without bias. Positivist research is likely to be used to ascertain information about a construct that has been reified (Willig, 2013). For example, a rating scale of depression presumes the existence of depression and that all participants will have the same understanding of what depression is. Qualitative methods have the potential to be more relativist, holding multiple truths. This is particularly important when researching topics around identity or personal values, as it recognises the different experiences people will have had and how they have constructed meaning around these concepts.

2.3. Qualitative Methodology

Qualitative methodology was chosen for this study as opposed to quantitative because the research question lends itself to an exploration of personal experience, which is the remit of most qualitative methodologies.

For this research, qualitative methodologies could be used in a non-positivist way to explore experience, without too many preconceived ideas being used in the research design. It was important that the data came from the community through an inductive rather than deductive process, acknowledging that this process will never be free from bias. Psychologists and researchers must be aware of the biases and lack of subjectivity implicit in carrying out research, particularly when working with people who hold identities, values or beliefs that are different to our own.

It is recognised that by using qualitative research, the results of this study are less likely to be able to be generalised to a broader population.

2.4. Thematic Analysis

Thematic analysis (TA) was chosen as the most appropriate qualitative methodology for this research. The aim of this research was not to create a new theory relevant to young trans and gender diverse people of colour’s experiences of accessing gender healthcare, but rather to shine a light into their under-researched experience, seeing if patterns arose from the data and if they could be linked to any pre-existing social and identity theories. Therefore grounded theory was not felt to be suitable. Interpretative Phenomenological Analysis (IPA) is a very individualised approach, and while the phenomenological experience of the participants is of course valuable, this research aimed to seek if there were shared experiences of the cohort that might help to understand the barriers they face within healthcare, rather than their singular experience (while recognising that everyone will have unique experiences).

TA was also chosen due to Braun and Clarke’s perspectives on the subjectivity brought into the research by the researcher. It felt like a genuine way to hold an open mind about an under-researched and at times polarising issue in research, particularly as a researcher who did not share the salient identities of the group. TA sought to see if there were themes present in the experiences, and how these themes can help to explain why barriers exist. In the same way that service level changes cannot be fully individualised, but must reflect the multitude of possibility for the differences brought by each service user, TA was used in this research to hear people’s stories while analysing for shared or relevant experiences.

TA is a theoretically non-specific qualitative approach that can be flexibly used across varyingly specific research questions and across a spectrum of epistemological stances (Braun & Clarke, 2006), drawing more on the researcher than a specific methodology (Braun & Clarke, 2018) and so the resulting research “inevitably and inescapably bears the mark of the researcher” (Clarke & Braun, 2014, p. 4). TA is used to find patterns of meaning within data (Braun & Clarke, 2018) and interpret these.

It is important in TA to reflect on the assumptions made in the interpretation of the data. To this end a reflexivity journal was used as recommended by Braun and Clarke (2006). The researcher is not neutral in the process of interpretation and so using a journal aids reflection on why certain codes and themes were selected and how this will influence the final results.

TA can be subjective and so lead to bias, as mentioned above. TA also has the potential to miss nuances in the data due to looking across data sets. However, the aim of this research is to explore barriers to gender healthcare for trans and gender diverse people of colour, and holds the hope that increased awareness would lead to positive change. Therefore it was felt that due to the current lack of awareness of health professionals around this issue, as well as the lack of current literature in this area, overall messages arising from the themes in the data may on balance be more important to identify than very specific nuance.

This work is not limited to one particular theory or model, and as such it was felt that a phenomenological or grounded theory approach would not be suitable. Reflexive thematic analysis (TA) was therefore chosen to analyse the data, following the Braun and Clarke model (Braun & Clarke, 2006, 2018).

2.5. Design

A qualitative approach was taken to explore the barriers to gender services in the UK for young gender diverse people of colour. Brief demographic information was collected, and participants were asked about their personal experiences and ideas about barriers relating to healthcare professionals and family, as well as other avenues of gender-related support or care, using a semi-structured interview.

Thematic analysis was used to gather data in line with the social constructionist position described above.

2.6. Consultation

It is preferable that people in a minoritised group being researched are part of the research team (Rosenberg & Tilley, 2021). In a study carried out as part of a doctoral thesis such as this one, co-working was not possible.

It was decided that a focus group would not be run as the anticipated difficulties of recruitment meant that the group would exhaust an already limited pool of participants. This meant trying to receive input in other ways. Trans people of colour who did not meet all criteria were contacted but declined to take part. Four people aided with consultation who held some relevant identities. Three of those people were specifically consulted on the content of the interview schedule; a white genderqueer person with Honduran/British ethnicity; a white Spanish non-binary person; and a cis Black lesbian. These people offered consultation for the interview schedule, and provided their time to review the questions. They were each paid for this service. They are referred to herein as the consultants.

One consultant highlighted that questions will be answered within the context of being a person of colour, so bias should not be added to the questions by making them specifically about race. Consultants reiterated the importance of checking a person's pronouns and their preferred language around race (e.g. person of colour, BAME), to name my own positionality as a white cis person and invite feedback on things I might say that may be jarring to the interviewee, as well as encouraging people asking for clarification on language used. I was also encouraged by the consultants to name what 'health professionals' meant i.e. doctors, nurses, psychologists, psychiatrists.

The consultants encouraged me to think about whose story I would be centring while carrying out the research and encouraged me to continue to examine my own prejudices, to be more impartial.

After the development of the interview schedule, a main consultant was recruited who identified as a young Black trans man. He did not fit the requirements for participation due to having been seen by GIDS. He was keen to be involved in the research and engaged in reflective conversations as well as offering specific advice into a Black, mixed-heritage, trans perspective, while cautioning both against making broad assumptions and not being aware of difference. He spoke about his own experiences in a way that allowed me to gain a more in-depth understanding, and reflected his experiences of some of my biases. The consultant was paid for his time.

2.7. Research Procedure

Semi-structured interviews were conducted via videocall on Microsoft Teams by the researcher with participants at a mutually convenient time. The researcher conducted all of the interviews.

2.7.1. Recruitment

Participants were young gender diverse people of colour aged between 16 and 25 who had had no contact with gender healthcare services in the UK, specified as NHS GIDS and GIC clinics. Individuals were recruited via sharing of a research advert (Appendix 1) on social media, and via the main consultant sharing the research information. This was a way of using snowballing as a sampling method to recruit people through someone already in the community.

After multiple conversations about my reasons for carrying out the research the consultant was able to encourage people to take part, reassuring them that I was a safe person to speak to. At his advice a video was created in which the researcher described why they were doing the research, the inclusion criteria, and the interview process, for him to disseminate to potential participants. This was a step taken to establish more trust in the researcher (see Appendix 2 for transcript).

Social media accounts were set up on Instagram, Twitter and TikTok. Accounts were named derivatives of @genderresearchuel and posts created using the research advert and relevant hashtags (Appendix 3).

Multiple charities were contacted via their social media accounts or email to share the research advert and/or disseminate it to relevant people or groups (see Appendix 4 for a list of these and the email template). The research advert was also emailed directly to interested colleagues who offered to share it, although no participants were recruited through this means.

People got in touch either directly via email, or via social media channels, and were then directed to the researcher's university email. They were offered the chance to ask any questions and check if they met the inclusion criteria. They were then sent an information sheet (Appendix 5), consent form (Appendix 6) and the date and time of the interview was arranged via email. The information sheet included information on the research purpose, interview procedure, inclusion criteria, limits of confidentiality, data collection and storage, right to withdraw, consent for publication and lead researcher contact details.

Participants were given a £10 voucher for their time.

2.7.2. Interview Procedure

Participants were emailed a link to join a Microsoft Teams meeting with the lead researcher. Teams does not require any downloaded software so it was felt to be easy to use. Interviews were audio and visually recorded via Microsoft Teams and automatically saved onto UEL OneDrive. Consent was sought for recording via the consent form, and also confirmed verbally before each interview. If the consent form had not been completed, the participant information sheet was jointly reviewed and the consent form was signed. This was to ensure participants felt they had given informed consent. The Microsoft Teams recording automatically produced a transcript of the interview (see Appendix 7 for an example). However the quality of the transcription meant it required proof-reading and editing by the researcher. After each interview the transcripts were saved onto UEL OneDrive and stored in password protected files using anonymous identifiers to protect confidentiality. Identifiable information was removed from transcripts at the point of transcription by the researcher.

2.7.3. Co-Production

Participants were offered the chance to review their transcripts after the interview, with a view to co-production. Participants could ensure that the information they were providing was accurate to their point of view and could also make edits or additions. Additions were encouraged as there was recognition of the difficulty some of the participants may have faced in working with a cis white researcher, or simply in opening up about a potentially difficult topic. Allowing participants to see their transcripts has been recommended as good practice, especially with topics that could be deemed as sensitive. It allows people to feel more in control of their contribution, and attempts to go some way towards flattening the recognised power imbalances between researcher and participant (Rowlands, 2021).

2.8. Materials

2.8.1. Interview schedule

The interview schedule (Appendix 8) was designed by the researcher, in collaboration with the three initial consultants. It was designed in line with the aims of the research and to address the research question: *What are the barriers for young people from racialised minority groups to accessing UK gender services?* Much of the existing literature did not relate directly to this subject, however research focusing on similar topics such as LGBT and racialised group's experiences of healthcare used qualitative methodologies and semi-structured interview schedules. As such, the interview schedule from this project was influenced by this related pre-existing literature. Semi-structured interviews provide freedom and flexibility as well as structure for both the researcher and participant (Willig, 2013). Open questions were used throughout; DeJonckheere and Vaughn (2019) discuss how open questions are most useful in a semi-structured interview to encourage a broad range of responses.

The interview began with an introduction detailing consent, confidentiality and project objectives, as well as information about the researcher's identity. Demographic variables were collected and then the main interview questions were asked, followed by an interview debrief. A debrief form (Appendix 9) was also used to thank the participant for their time, reiterate how their data would be used and confirm if the participant would like to receive a copy of the thesis, share university information should the participant require any further support or have questions related to the research, and to provide link to support organisations for trans and gender diverse people of colour.

The six main questions included in the semi-structured interview schedule asked were fairly disparate, covering relevant themes that arose as relevant from within the current literature. Participants were asked about their experiences of being referred to services. Ideas about the participant's understanding of the barriers to GIDS and GIC services. They were asked about factors they thought healthcare professionals should hold in mind when working with trans and gender diverse people of colour. Personal identity, support of family and other avenues of gender healthcare were also asked about. A final question was included that asked participants whether they wanted to add any other thoughts. This was so that other important aspects relating to this issue would not get missed. Additional prompts were used when needed to aid further exploration of participants' responses (Appendix 8). Interviews ranged from 22 minutes to one hour.

The researcher was flexible in their interview approach and used inclusive language, as well as humour if and when appropriate. When exploring information that had been given by the participant, the researcher repeated the language that had been used by the participant, to help them feel understood. As video-conferencing was used, eye contact and body language was used to try and help participants to feel relaxed during the interview. Some participants chose to keep their camera off.

2.8.2. Software

Microsoft Teams was used to record the interviews, and automatically saved the recording and produced a transcript when the interview stopped.

NVivo 12 software was used to code the data. This was downloaded from the University of East London Software Hub. Zotero was used for referencing purposes.

2.9. Method Of Analysis

Reflexive thematic analysis (Braun & Clarke, 2006, 2018) was employed to analyse the transcripts as described above. Transcripts were initially read through by the researcher and then subsequently reviewed and coded. Codes were recorded using NVivo 12 software. Themes were then developed using these codes (see Appendices 10 and 11 for examples).

In this research TA focused more on latent themes, while recognising that it is impossible not to infer semantic meaning onto the data.

Braun and Clarke (2006, 2018) describe a six phase process, and this was the basis by which the data were analysed:

1. In the first phase the researcher familiarised themselves with the data by reading and re-reading transcripts; noting items of interest; reading actively, analytically and critically.

2. In the second phase codes were generated. Coding was done inclusively, comprehensively and systematically, with each data item given equal weight. At the end this phase a list of codes and all the data relevant to each code collated. During coding, the researcher ensured to reflect on the cultural landscape that themselves and the participants reside within (social values, norms and assumptions).

3. In the third phase, themes were generated. The codes were organised into potential themes with all the coded data relevant to the theme attached. The researcher ensured that there was a central organising concept to

each theme.

4. In the fourth phase, potential themes were reviewed. The 'nature' or character of the potential themes began to be identified. Questions that were asked at this time were around the quality, content and boundaries of a theme. The researcher ensured that the theme worked in relation to both the coded extracts and the entire dataset.

5. In the fifth phase, the themes were defined and named or labelled. These names or labels linked to the central organising concept and a definition or description of the theme was created. The specifics of each theme were refined.

6. In the sixth and final phase, the analysis was written up. This included thinking about the order of themes, the inclusion of data extracts and writing the analytic commentary. Finally the analysis was linked to the initial research question, the literature and the wider social context.

Themes do not emerge passively from the data but are produced via an iterative process and are actively generated by the researcher (Braun & Clarke, 2018; Taylor & Ussher, 2001). This process was aided by the researcher's commitment to maintaining a reflexive journal throughout (Appendix 12), using this to reflect on the process of creating themes. Braun and Clarke (2018) encourage researchers to let go of codes and themes at all stages if they are not relevant, using reflexivity to help with this. This was also supported by use of the reflexive journal.

Steps 3, 4 and 5 describe how the themes were created. This as an iterative process; themes arose and then were then subsumed again by other themes. The reflexive log (Appendix 12) demonstrates how a developing theme was integrated into other emerging themes to ensure that they were more balanced in content. This ensured that the themes were not simply broken down into positives and negatives/barriers but given contextual nuance. As themes became more cohesive and strengthened there was movement from less developed themes as they were broken down and integrated. Central organising themes were developed that ensured the themes were clear and distinct. These also ensured that the themes answered the research question. Some of the initial themes spoke to experiences outside of the research question and so were not retained.

In many instances the data was coded twice, which allowed for more flexibility when building themes and again lends to more nuanced analysis.

The number of themes changed following their initial development, which is usual especially given the reflexive nature of this model. As core themes came to the surface, the most relevant ones were developed where it was felt that they best captured the qualitative contributions of the participants.

The iterative process also involved going back to the transcripts throughout to ensure the themes were relevant to the initial data and to the central organising theme.

I was aware of the potential for bias in this study, due to aforementioned reasons of identity. The ways in which I attempted to mitigate this were to utilise reflective spaces offered by the university, read books and articles, watch videos made or written by trans and gender diverse people, and/or people of colour, and speak to trans friends and friends of colour. I was also working with trans and gender diverse young people at the time. These steps ensured that I kept relevant perspectives in mind, heard from a variety of voices so that I did not view groups as monolithic, and took the time to reflect on some of my automatic assumptions arising from analysis of the data. I also kept a reflective log both for general reflections and for use when analysing my data, as another way to mitigate the inevitable bias that arises from an ‘outsider’ doing research from without a certain group (Rosenberg & Tilley, 2021).

These spaces and process helped me hold in mind potential biases around gender, race, religion and culture but also meant that I was more aware of not trying to fit the data into my preconstructed ideas about what barriers existed and why. Instead I attempted to work from a bottom-up perspective that was directly informed by the participants.

Braun and Clark (2021a) discuss that saturation should not be operationalised for sample size as this leads to a neo-positivist way of working. Although there was felt to be some saturation of data, limited recruitment response meant that only six interviews were carried out in total.

2.10. Participants

There is no set rule regarding number of participants when using thematic analysis. In fact, Hammersley (2015) warns against prescriptively allocating sample sizes without thought, particularly before the data has been fully collected.

2.10.1. Demographic Information

Demographic information was collected at the point of interview to enable the researcher to understand the characteristics of the sample. Variables included age, racial identity, gender identity and preferred pronouns.

Racial and gender data were gathered to recognise differences and similarities experienced by different racialised groups.

2.10.2. Inclusion Criteria

The inclusion criteria related directly to the research question. Participants were aged 16-25. This was to ensure current and recent gender healthcare contexts were being considered. Participants had to self-identity as a person of colour. This group was identified due to the recent evidence showing that they are disproportionately under-represented at GIDS. However this amalgamates many different groups into one, potentially ignoring the multitude of racial identities and widely differing experiences it includes.

Participants must not have been seen in any capacity by a GIDS or GIC. People were included who had been referred to these services but who had not been seen. People who had not been referred were included.

2.10.3. Exclusion Criteria

People were excluded if they had been seen on a regular basis for psychological support and/or medical intervention, or for a one-off appointment, at UK NHS gender services. The rationale was for participants to be people for whom barriers meant that they had not yet received any healthcare from gender services, as those that had may have experienced lesser barriers, or barriers which may have been difficult to determine retrospectively. The research would then examine whether there were any factors that affected people without access to gender healthcare specifically, as they were likely to have been experiencing barriers at the current time.

People had to be living in the UK at the time of the research, as the study looked at gender healthcare in the UK. This included UK nationals and people who had recently come to the UK or who were not originally from the UK.

There was a relatively high rate of people asking to take part in the research and then ceasing contact. There were twelve initial contacts, but only six final participants, meaning that six people dropped out after receiving a reply email to their initial contact.

2.11. Ethics

Ethical approval was gained from the University of East London Psychology Ethics Committee. An ethics application form was completed by the researcher then sent to the supervisor and then on to the relevant ethics committee member for approval (Appendix 13). The research project was also approved via Research Manager. Official standards were adhered to throughout the project, including the Health and Care Professionals Council standards (2016) and The British Psychological Society Code of Human Research Ethics (2014).

The participants were informed that pseudonyms were to be used. Although standard to psychological research, it felt particularly important to protect the privacy of this cohort due to potential negative consequences of identification. However, some of the participants requested use of the first initial of their name. This style was used for those participants in order to provide ownership of their contribution. It should be noted that this is in the context of these young people likely already having changed their name from the one they were given at birth to one they feel more accurately defines their identity. Grinyer (2002) discusses participants feeling empowered through the use of real names in research, although cautions that this is a complex topic.

2.11.1. Informed Consent

The consent form and participant information sheet were emailed to participants after email contact clarifying the inclusion/exclusion criteria. These described the research being carried out (including that it would be recorded) and detailed that research participation is voluntary and that the interview can stop at any time without reason. Participants were asked to read both forms and sign the consent form. Participants were asked verbally at the start of the interview if they had any questions about the forms, and if they still consented to being recorded and their information being used.

2.11.2. Anonymity And Confidentiality

Anonymity and confidentiality were referenced in the participant information sheet and discussed again verbally before the interview began. Anonymity and confidentiality were maintained throughout the project and measures were put in place to minimise risk of data breach, in line with General Data Protection Regulation (GDPR) (UK Research and Innovation, 2020).

The researcher anonymised the data at the point of transcription and participants were assigned a pseudonym or chose an initial. Anonymised transcripts, participant’s names and corresponding aliases were stored securely in a password protected file. The participant information form informed participants that as per university research data management policy, research data will be retained up until the time of any journal publication or deleted after five years.

The possibility of research publication was also referenced in the participant information sheet and discussed again verbally after the interview was completed. Respondents were asked at this point if they wanted a copy of the final paper.

2.12. Risk Management

A risk assessment was carried out as part of the thesis approval process. A UEL risk assessment form (Appendix 14) was completed and signed off by the supervisor. The risks highlighted were emotional distress for both the participants and for the interviewer which were mitigated in the ways described below.

2.12.1. Emotional Distress For Participants

Participants in this study may have experienced emotional distress both during and after the study, due to discussion of intersecting sensitive topics. Specifically, people may not have had an opportunity to more formally discuss their frustration with the gender healthcare system and this could lead to increased distress. Conversely, people may have felt empowered by having a platform for their thoughts and feelings, as well as a hope that their words could be used to inform health professionals and help future young trans people of colour.

To mitigate risk, the debrief form provided web links and telephone numbers for trans and gender diverse and LGBTQIA+ support groups as well as general mental health support in the event that they felt distressed.

2.12.2. Emotional Distress For The Interviewer

The researcher was aware of the potential for discussions about emotional and psychological distress, given experience working with trans and gender diverse young people and information in the literature about potentially poor wellbeing in the participant population. This risk was mitigated by being able to speak to a supervisor, and in supplying the debrief form with support information, thereby knowing that participants were aware of different forms of support.

2.13. Dissemination

Participants were made aware that the hope for this study was that it would get published in a journal, and potentially delivered at a conference. All journals that have published research on race, gender (specifically trans, non-binary and gender diverse research) and healthcare systems will be considered. The journals being considered are Journal of LGBT Youth, Gender and Society and The International Journal of Transgender Health, in part due to their impact factors.

This work will also be presented at GIDS. This will help healthcare professionals working with trans and gender diverse young people to be aware of the barriers faced by people of colour who do enter their service, as well as potential changes that can be made for outreach to people of colour who may face barriers much earlier in the process of speaking to gender healthcare services.

The research findings will likely be of interest to mental health practitioners and groups offering support to trans and gender diverse young people. Suitable contacts from the following organisations and charities will be sent a summary of the findings via email such as Mermaids, Stonewall, Gendered Intelligence, Gender Identity Research & Education Society (GIRES), TPOCalypse, Fusion, House of Rainbow, Imaan, Naz and Matt Foundation, Purple Rain and UK GIDS and GICs.

All participants opted to be sent a copy of the final paper.

RESULTS

This chapter provides an account of themes and subthemes collated from interviews with six participants.

Following this chapter discussion of data interpretation will take place, including relation to literature, policy and practice, identifying therein any clinical implications.

3.1. Demographics

Demographic information for the six participants is shown in Table 3 in their own words, to demonstrate the nuances of identity.

Some young people chose to use initials as pseudonyms, others asked the researcher to choose a pseudonym for them.

Table 3

Participant demographics

Pseudonym	**Age**	**Racial identity**	**Gender identity**	**Pronouns**
Shan	16	Singaporean	Genderfluid	He/they/she
Z	18	South Asian/Pakistani	Trans guy (androgynous)	He/him
T	16	Half Asian, half white. So I guess just mixed	Trans man	He/They
Parker	16	I usually just say Asian, but my mum is Chinese and my dad's Japanese	trans binary man	He/him (but fine with they/them)
Isambard	18	Mixed Afro Caribbean and white	Male	He/him
Nasir	17	Mixed race	Transmasculine	He/They/It

3.2. Themes

Themes resulting from data analysis are summarised in Table 4. The themes are described below using quotes from the participants throughout.

To enable the reader to access the content of the quotes, small adjustments to the text have been made (Braun & Clarke, 2021b), for example […] has been used in quotes where information has been removed (such as interjections to clarify on behalf of the interviewer). Additionally, the text represented in purple shows where the participant who wanted to review his transcript added more information for clarity.

Table 4

Themes

Theme 1	**Discrimination and difference**	**Number of quotes**
Subthemes	Discrimination in healthcare *Discrimination is defined as unjust or unfair treatment based on the groups a person identifies with or are perceived to identify with. The selected quotes lead on from the introduction of the participant's views of white cis-het privilege, and discuss discriminatory beliefs and processes present within healthcare systems.*	40
	Differences and advantages of white (and cis-het) people over (queer) people of colour *This subtheme explores the distinct experiences of people of colour and white people. While not a monolithic experience, many people of colour will be recipients of racism and white people will not. In this subtheme it is clear how damaging this can be. This subtheme looks at how discriminatory views come up in the social experiences of participants and how they feel about them.*	33
	Representation *This subtheme describes the participant's beliefs and experiences about the lack of representation throughout history, online, within cultures and in healthcare, of other trans and gender diverse people of colour, impacts them and wider society.* *The participants talked about what lack of representation does to them. For some, it meant that they were not aware of their own identity for a long time.*	41

Theme 2	**The development of Self: from individual to community**	
Subthemes	Family, community and cultural views on gender, queerness and sexuality *This subtheme describes the interplay for the participants between family and cultural views regarding identity. For some, their cultural background meant that their family held rigid views on gender, however, participants were keen to emphasise the importance of separating out race, religion and culture where necessary.* *Participants drew attention to the divide between cultural elders and the younger generation and reflected on cultural values and complexities.*	168
	The impact of religion on gender identity *Religion can play an important role for some families in their cultural beliefs around gender and can inform ideas that get used as a way to disallow alternative gender identities for participants.*	59
	Being a trans or gender diverse person of colour *This subtheme focuses on how participants' identity is regarded by others, and thoughts about their intersecting experiences.* *The participants discussed their experiences of being 'out' as trans or gender diverse to certain people but not to others, depending on their perception of safety and trust.*	213
	Acceptance and support *This subtheme explores both acceptance of self and receiving acceptance from others. Participants discussed how negative views from others impacted their mental*	118

	health. Non-acceptance of identity may be based on lack of understanding about gender diversity, which is also discussed here. This subtheme also shows how trans and gender diverse people of colour attempt to find support in a society that is not always accepting, and within a healthcare system that is not receptive to their needs. *Most of the participants said their families were accepting of their identity in various ways, even if this had taken some time or that they still made mistakes. However they also described difficult and unaccepting experiences.*	
Theme 3	**Health**	
Subthemes	Referrals and waiting lists *This subtheme looks at the actual system of referral to gender services, potentially a part of the process where there are the most barriers. It also explores how waiting lists impact the participants. While the NHS in general struggles to meet patients' needs, there is a particularly long wait for gender services, and this perception of inequality can have a negative impact on wellbeing.*	115
	Illegal Hormones *This subtheme relates to the use of illegal hormones by trans people. One participant is currently using illegal hormones; participants discuss their experiences of being offered them, experiences of people they know, and feeling as if they are not left with much choice but to use them. This subtheme shows that participants have a good understanding of illegal hormone use in their community, discussing it as a potential option despite known risks.*	23
	Suggestions for healthcare professionals	84

	The subtheme presents participants' suggestions for working with young trans and gender diverse people of colour, acting as a directive for professionals and will be further expanded within the recommendation for practice in the Discussion. Participants reflected how health professionals must think and work holistically, with understanding to walk alongside them on their gender journey.	

3.2.1. Theme 1: Discrimination And Difference

3.2.1.1. Subtheme 1: 'health professionals can just be nicer to white people and be more sensitive to white people': Discrimination in healthcare: Discrimination is defined as unjust or unfair treatment based on the groups a person identifies with or are perceived to identify with. The selected quotes lead on from the introduction of the participant's views of white cis-het privilege, and discuss discriminatory beliefs and processes present within healthcare systems.

Shan:

> **I think um in the medical industry as a whole. Um I know I've heard of some things, like some false things like […] oh black people experience pain differently or these races experience these things differently and false things like those can also be like carried on to like the gender identity field and in the NHS […] I definitely think it's a systematic thing.**

Firstly, Shan highlights specific racist beliefs in healthcare, describing these as 'false' and how discrimination is 'systematic' throughout healthcare. Their awareness of this and knowledge of the inaccuracy may compound the hopelessness for people of colour about accessing fair healthcare.

The next three quotes show ways in which discrimination is present in healthcare, but also how that discrimination makes people less likely to try to get help when needed.

Parker:

> **Also, 'cause sometimes health professionals can just be nicer to white people and be more sensitive to white people. And um obviously if you're a person of colour and the people who are working with you and the health professionals who you have kind of around you, are, being insensitive to t- towards you in terms of your race, that's like really going to deter you from getting the medical help and care that you need.**

Parker:

> **So like say, a trans person of colour wanted to get top surgery on the NHS and but the doctors around them were being kind of racist to them or insensitive towards them in terms of their race. Then they could just kind of go. Well, I don't really want this anymore. If the people around me are gonna, you know, make me feel terrible.**

T:

> **Like if you look at medical textbooks until recently, they're all about white people. […] Say different things are different with people of colour like BMI for example. […] Like, that's racist and. […] Yeah, 'cause, it's built on white European bodies like so. […] But yeah 'cause like the example like of, for example black women like how, that it’s just assumed by doctors that they don't feel pain. Like it, it's like things like that that make people not have trust with in the NHS and with doctors. So I think that can be applied also to. Like trying to access trans things.**

T and Parker both talk about how trans and gender diverse people of colour may feel specifically deterred from accessing healthcare due to systemic racism. Parker discusses how white professionals are nicer and more sensitive to white service users. This could represent a view that white clients receive preferential healthcare treatment. T reflects on how medical standards like the BMI are built on racism, and these quotes are illustrative of a ‘lack of trust’ from people of colour towards healthcare providers due to the fear of the harm that they might experience.

Z:

> **I've also read about sort of difficulties, like with health professionals navigating like trans spaces. Some don't want to be offensive and say and question their decisions because. […] I think some healthcare professionals might feel like they're being sort of. Transphobic or like unsupportive and stuff like that? But I think um. That is kind of useful with the decision making.**

In this quote Z highlights how informed decision making has to involve questioning and exploration from professionals, however hesitancy to ‘say the wrong thing’ may mean they avoid questioning if concerned they may cause offence. This links to white and cis fragility, where instead of saying the wrong thing they say nothing for fear of negative repercussion, potentially leaving service users with inadequate or inaccurate discussions around things like risks and side effects.

These quotes show how discriminatory practices in healthcare can lead people of colour to disengage from the system, and how these practices originate from societal and professional biases.

In contrast, Nasir highlights healthcare experiences, unrelated to gender, where they have had positive experiences.

Nasir:

> **And like when I've gone to hospitals, I've actually had a really good experience as a trans person in hospitals um like nurses are really nice and lovely and they put my preferred name most of the time.**

Then T’s experience:

T:

> **When, like my friend told me about someone she knew, a trans woman who was on hormones. Um. Got sent to a gynaecologist. […]**

> **They just don't know like what they're doing or what trans people are. It's just a bit silly.**

T’s story demonstrates how a professional’s lack of understanding, can lead to confusion and a waste of patient’s time.

3.2.1.2. Subtheme 2: ‘I feel like white LGBTQ people have a much higher chance of getting the on the waiting list’: Differences and advantages of white (and cis-het) people over (queer) people of colour: This subtheme explores the distinct experiences of people of colour and white people. While not a monolithic experience, many people of colour will be recipients of racism and white people will not. In this subtheme it is clear how damaging this can be. This subtheme looks at how discriminatory views come up in the social experiences of participants and how they feel about them.

The participants discuss how gender roles, often binary, are constraining to themselves and others. Rigid views on gender negatively affect everyone but have a detrimental impact on trans and gender diverse people. Young people around adolescent age are exploring and developing their identity and so are likely to be highly influenced by prevailing views on gender. The participants also reflect on how cissexism (the dominance of cis identities above all others) affects them.

Z:

> **It begs the question that it's just these sort of people throughout history have just been erased just to create this narrative that oh we’re all binary we’re all men and women and that we’re all heterosexual like, no, like if there if there's people today, there must have been people back then, so.**

Z speaks about how people feel that gender diversity is a new thing, but actually it is just that history has been written by cisgender heterosexual people, erasing people outside of the binary. This shows the uphill struggle that trans and gender diverse people have in validating their identities.

Nasir:

> **But um, so then to find out like trans people existed because, like, people don't tell you they're trans a lot of the time. And that's that's a good thing. If you know, you have to protect yourself, then you should do that you shouldn't have to be out because cis people say you should be out.**

Nasir picks up on a number of important points in this extract. He had been talking about how he did not know trans people existed for a lot of his life, but then says although he would benefit from the representation, it is actually a cis need to ascertain the gender of others. This need is often based on fear of the 'other', or anger that trans and gender diverse people break what they see are the 'rules' of gender. These quotes show the weight and influence of ideas about gender have been carried throughout history.

The perception that queer spaces are more accepting does not always hold true for trans and gender diverse people of colour. Negative wider social narratives about race and gender are perpetuated within these spaces too.

Z:

> **I feel like there is a bit of erasure with being. Ummm, a person of colour and being in queer spaces. The majority of them are white spaces**

Here Z talks about how queer tends to equal white when it comes to queer spaces.

Z:

> **I think that's why maybe a lot of white queer people don't understand the struggles that coloured queer people do because they haven't really understood. How that culture [would respond].**

Continuing by saying that due to the lack of representation of people that look like him, not only does he not have any representation, but white queer people do not have a complete understanding of the variety of ways in which a person's culture may affect their queer identity, meaning that this is ignored and trans and gender diverse people of colour struggle to feel seen. He also highlights how 'erasure' is different to, and more subtle than ‘exclusion’; people of colour may be invited to queer spaces but lack of representation can leave them feeling unwelcome there.

Nasir:

> **I know in, within, within the LGBT community…Like people of colour trans people of colour get it the worst and they do majorly get it from their... queer people, other queer people that are white and cis-het. […] And that's horrible 'cause it's your community.**

Nasir discusses how people of colour suffer most under the whiteness and cissexism within the LGBT community and the resulting “horrible” feelings.

T:

> **This kind of stereotype of like trans men being like skinny and white as well, from what I've seen online. […] Which also plays into it, like the racism within the trans [unclear] community.**

Nasir and T show how the more intersections a person holds, the more possibility there is of discrimination. T also highlights that those who are already marginalised due to being trans or gender diverse can themselves turn that discrimination in-group, towards people of colour.

Parker:

> **It's harder for it's like if you're, you know, cis, cis-het and white it will be easier for you to find more opportunities in like anything. Whether that's like getting jobs or just stuff that you want. And I guess just being, um, like, genderqueer and also being a person of colour can just make things harder.**

Parker wonders whether the intersections of his race and gender identity make his life more difficult, than for white cisgender people.

Z:

> **Uh, my my experiences with that has been very different to people that I know who are white and they didn't usually have to go over that**

> **guilt and that shame [internalised homophobia/transphobia from cultural/religious beliefs] and that sort of um realisation.**

Z speaks about how white people may experience less guilt and shame related to internalised self-dislike. This quote highlights the interplay of culture and religion that some experience in negative ways relating to their identity, that non-religious white people in the UK may not experience to the same extent.

Shan:

> **Some people may not be taken…how do I say this? Um, as seriously as maybe like white, sort of LGBTQ people, because I feel like white LGBTQ people have a much higher chance of getting the on the waiting list**

T:

> **Um it's just like combined with the fact that it's generally harder for black people specifically to access healthcare. Um and also if you think about it like. Poorer people.**

Nasir:

> **'Cause like everyone that I know that has started T[estosterone] they're a white trans person?**

These three quotes highlight the views that white people have an advantage when it comes to accessing healthcare, both generally and specifically related to gender, with Shan identifying that white individuals are more often referred to gender services as they are taken 'more seriously'. T reflects on the intersection of money, which ties into the wealth of different racial groups (Parker also highlights this later in his interviews), as well as class divisions.

3.2.1.3. Subtheme 3: 'It's nice to have people that have gone through the same experiences as you': Representation: This subtheme describes the participant's beliefs and experiences about the lack of representation throughout history, online, within cultures and in healthcare, of other trans and gender diverse people of colour, impacts them and wider society.

The participants talked about what lack of representation does to them. For some, it meant that they were not aware of their own identity for a long time.

Nasir:

> **And representation is so important because if I saw…Anything like that growing up, I definitely would have noticed and realised a lot earlier and I could have got help a lot earlier as well.**

Z spoke about how lack of representation makes it hard to envision his future and “see himself”.

Z:

> **It's not there it's. It's like you don't have any sort of anyone to look up to any like sort of. Um elders as well. You don't know how your life will map out [as you get older] if you're. Uh, attracted to this same sort of gender as yourself [how do same-sex relationships work are they held to the same rulings (religiously) that straight-couples do?] or you obviously identify as a different gender than what you were born with [how do you fit in culturally if your gender changes? there are separate spaces/roles for males/females in south asian culture]. You just. You just feel a lot of erasure. […] There isn’t that sort of representation *at all* about er how non straight relationships work. If they even exist.**

Participants talked about what lack of representation meant for their families, communities and culture, with Nasir specifically wondering about his Mum having a non-cis identity if she had had the opportunity to think outside of what she had always known.

Nasir:

> **they definitely would have been more fluid if they had representation and like love growing up because some of the things that my Mum says to me, I'm like, no, cis person would ever really think like that,**

> **like you're not mad. 'Cause we were having a conversation one time and she said to me that she understood that people feel both masculine and feminine, but they didn't. She didn't understand why they had to put a label on it.**

Nasir reflects on how it feels to have support in the form of shared experience:

> **It's nice to have people that have gone through the same experiences as you. So like other brown trans people, its, really nice [laughs] yeah.**

This contrasted with Isambard’s experience, who identified that they did have representation.

Isambard:

> **Interviewer**
>
> **What it looks like to transition I suppose and what it looks like to have, you know, be on hormones or be on T or whatever. Do you feel like in the community you have that you've you've got that representation?**
>
> **Isambard**
>
> **Yeah. Yeah, definitely.**

This subtheme shows the difficult journey of realising and accepting your identity when you did not know it existed.

3.2.2. Theme 2: The Development Of Self: From Individual To Community

3.2.2.1. Subtheme 1: ‘I love my culture, but that's one aspect of it that, I’m..uncomfortable with’: Family, community and cultural views on gender, queerness and sexuality: This subtheme describes the interplay for the participants between family and cultural views regarding identity. For some, their cultural background meant that their family held rigid views on gender, however, participants were keen to emphasise the importance of separating out race, religion and culture where necessary.

Participants drew attention to the divide between cultural elders and the younger generation and reflected on cultural values and complexities.

Z:

> **I think the younger ones. Younger sort of [younger generation]. In the my culture, especially are very open to. Sort of change [more 'progressive']**

T:

> **they're..still kinda getting used to the idea because just old people.**

Isambard:

> **Uh well my grandparents usually just say it's 'cause they're old. […] Er my cousins are fine with it. They usually use the right thing. It's just mostly the older members of the family that don't.**

Nasir:

> **Um, see that I was thinking about this the other day as well, and with older like my older family members, I do feel that like, they would, they would have, not that they would have been trans, but they definitely would have been more fluid if they had representation and like love growing up**

This cluster of quotes reveals the participant's thoughts about how the older people in their individual cultures act in response to the participants being trans or gender diverse, which range from "getting used to the idea" to blaming getting pronouns wrong on age, while younger generations are seen as more accepting. Nasir feels that older family members may have been more fluid in their own identities if they had known about gender diversity when they were young.

Z:

> **They don't. They don't like that, but if it's like in their own sort of. On their lawn [concept of what other people with think, culturally you can commit sin in private and protect your honour], like they don't really care like that sort of stuff.**

Z describes how the perception of others may be a big part of cultural acceptance. In his interview Z talks at length about the effects and weight of cultural pressure. He also mentions how, while not all families of colour share collectivist values, his does and this means that it would be hard to hide his transition without questions from others and the resulting judgements and consequences.

Shan:

> **I guess I go sometimes I don't wanna feel as feminine look as feminine, but I feel like I don't really have the opportunity to talk about it much because of my culture.. Cos I love my culture, but that's one aspect of it that, I'm..uncomfortable with.**

Shan reflects on the difficulty of reconciling loving a culture that does not accept his gender.

Participants described how fixed views about gender and sexuality can be incredibly limiting for them, especially when interacting with family members.

Z:

> **I've had to explore sort of the binary like how is that defined and stuff like that um. I would say in Islam and stuff like that, it is very man woman and you can't change anything [there are specific roles for men and women in islam - their responsibilities, their appearance, their rights - not much overlap].**

Nasir:

> **but to [my Mum, gender is] a social box**

T:

> **People just have to fit into boxes.**

These three quotes show the cultural beliefs about gender roles and that these reinforce the binary. For T, he is talking about how people view gender in Vietnam, and Z highlights gender roles in Islam.

Some of the participants discussed feeling that their safety might be at risk due to the non-acceptance of their identity by people in their community.

Z:

> **I think. There's also like maybe a fear of. Abuse, maybe like it might. It might not even be like er logical** [paranoia]**, but it is kind of sort of in the back of your mind** [referencing to the perceived risk of honour killing by not sticking to cultural expectations and gender norms]**. If I um sort of stand for something that is so wholly sort of inappropriate in my sort of er community, what will happen to me like what, what, will other people think about that** [is there a risk of violence/abuse?]**?**

Shan:

> **I think safety is a very big reason**

Shan explains feeling that professionals working with trans and gender diverse people of colour should centre and explore the safety of that group, and any risks linked to non-acceptance in their communities. Z reflects on safety being a barrier to treatment for people of colour. He expresses that he will always be aware of his safety in the wider community if he were to present as male (he currently has to present as a woman).

3.2.2.2. Subtheme 2: 'you're saying that God made a mistake when he was making you': The impact of religion on gender identity: Religion can play an important role for some families in their cultural beliefs around gender and can inform ideas that get used as a way to disallow alternative gender identities for participants.

Shan:

> **They feel more negatively towards sexuality they think, oh like, because I come from a Muslim family it's generally looked down upon, homosexuality, but when it comes to my gender identity, they feel more like it's OK if you wanna look more masculine or more feminine just don't you know, like like like other women and stuff like that you know.**

Other participants also highlighted this difference between how gender and sexuality are perceived in their religion, with a notable lack of language around gender diversity but language existing to describe same-sex experiences. Not only is their gender identity being denied, but restrictions around their sexuality based on the perception of them being a woman predominate. Religious direction on homosexuality, for example in the Qur'an, is limited, and Z describes how the most expansive schools of thought usually encourage people not to act upon 'same sex' desires, illustrating (through the story of Lōt) warnings about how Allah punishes homosexuals.

Z:

> **It's more so um the fact that you were saying that. […] God made a mistake when he was like making you so the act of. […] Not being what you were naturally created to be is [idea that Allah SWT is omniscient but also all-loving - if it were better for you to be the gender you identify as then you would have been created as such], that's the thing].**

Z also made clear the differences between religion and race; white religious families can hold rigid views on gender and sexuality too and white trans and gender diverse people should not be excluded from consideration of religious trauma because they can be subject to many of the same difficulties.

Parker:

> **[My Mum] grew up in a um like a very, in quite a like bigoted Christian culture. And but it so it took a bit longer for her come round, but she is accepting of me now.**

Parker considers how his Mum’s religious context impacted her acceptance of him. This illustrates that acceptance is possible for religious parents, but that it might take a longer time for them to consider alternatives to religious teachings.

Nasir:

> **And I know with certain stuff like, with certain people of colour that they they're they're they come from like, religious backgrounds. Because I come from like a Muslim background and every per- like every brown person that I know that is trans comes from a Muslim back- background and that can be difficult within itself as well because there's like a certain guilt around that**

Nasir reflects on the guilt that Muslim trans people might experience due to the conflict their identity creates with their religion. Z references religious guilt in his interviews, describing how “the fear of God” will always get in the way of his personal development, with guilt a potential barrier in self-acceptance and seeking gender-affirming care.

Nasir:

> **Um, religion has definitely had, it impacts on like my transness, but also on just me as a person like I didn’t. It affected my childhood. It affected my childhood badly, which is why, I don't like to think that it affects me now, but it does affect me now. Um just even the fact that. [ironic laughing noises/exasperation?] Just even the fact that I won't befriend someone because of they how they look now because of the**

> **experience of I had before.**

Z:

> **[In fact, my parents as a minor abused the responsibility they had over me - I was subjected to a minor but traumatic kind of religiously centred conversion therapy]**

Z and Nasir both talk about their experiences of religious trauma with past religious experiences having affected them in the present, including how they relate to other people. Z speaks about how he feels the religious trauma around his identity will never leave him. The quote here shows him speaking about his experience of conversion therapy, something which disproportionately affects people of colour and people from religious backgrounds.

The participant's reflections show that the separation between gender diversity and religion can add more difficulty to being accepted by yourself and others.

3.2.2.3. Subtheme 3: 'it's like having two different names, like one for home then one for college': Being a trans or gender diverse person of colour: This subtheme focuses on how participants' identity is regarded by others, and thoughts about their intersecting experiences.

The participants discussed their experiences of being 'out' as trans or gender diverse to certain people but not to others, depending on their perception of safety and trust.

Nasir:

> **I'm not out to my mother. She knows that I use a different name and I don't hide it around her like I have pronoun badges and I'm constantly losing them so she's definitely seen it.**

Parker:

> **So apart from my close friends, most people don't really know that I'm trans.**

Parker:

> **for me and for most of my friends, we kind of experience coming out or being out at a younger age so then like experiencing people like not accepting us and then having to find new friends who are more like us earlier.**

Isambard:

> **So it's like having two different names, like one for home then one for college.**

Isambard highlights the difficulty of being out in one context and not another, which could lead to ‘code-switching’ to avoid the cognitive dissonance of not having your identity validated at home. Parker’s quote emphasises the change for young queer people of coming out earlier, facing discrimination from their peers and then having to find a safe group of people to relate to.

T:

> **Yeah, I mean and then within like within the gender services there’s so much like. If they decide that you’re trans enough to get hormones or get surgery whatever.**

T’s quote denotes fears of not being “trans enough”, highlighting experiences of trans and gender diverse people where they have to prove their identity to cis people. People are advised not to discuss uncertainty, fluidity or non-stereotypically-binary parts of themselves with professionals, so that they will be allowed to access gender-affirming treatment. This reflects T’s fears of gatekeeping within gender services.

Three participants mentioned experiences of binding, which for many trans and gender diverse masculine people is a way of managing their body to feel more comfortable.

Mental health problems were discussed by most of the participants in relation to their gender identity.

Shan:

> **like for me I struggle [unclear] time, had anxiety, depression and so I feel like getting the mental support as well is extremely important**

Z:

> **You need to be very. You need to be very strong and sort of in your mental. Health and stuff like that and I didn't have that**

Participants discussed some of the difficulties of being trans, such as being outed by others, being misgendered, people using a non-preferred name, adults dismissing their identity as “a phase or that it's just a stylistic choice or just being confused” (Shan), and feeling dysphoric.

Shan:

> **With my personal experience of being gender fluid, on some occasions, I'll feel like extremely dysphoric like I. Like I just. I can't take it. You know I want to be, I want to look masculine I want to be tall I want to be skinny, you know but then um like maybe like. A few weeks later that will completely flip and I’ll, I'll be happy with my body you know I'll be happy feeling feminine**

Intersectionality is very present for this group. Participants talk about the effects of multiple identities potentially resulting in increased discrimination.

Most participants saw their gender and race as unconnected initially when asked directly, but later brought in lots of reflection about how different parts of their identity intersected.

Parker:

> **Yeah, I guess like um just the more minorities you are, the harder it would be for for like in terms of just opportunities to do things**

T:

> **It's different to be like. A trans person of colour than to just be a trans person. […] 'cause obviously like there's the discrimination and**

> **like the…So it's just coming from two different places, but also I think like with my family, like cultural things that also makes a difference**

Z:

> **I've heard people [queer south-asian muslims in media] talk about like having two separate, like clashing identities of having like two arms […] You can either have one [either give up islam/cultural identity or supress homosexual/transgender identity for the sake of Allah/cultural pressure, ie. "cutting one arm off"] or something like that.**

Z talks eloquently about how the intersections of queerness and religion are difficult to manage. He later talks about how this has affected his mental health and is the "root of my problems".

Nasir:

> **'cause I know barriers I face as a trans person, but I guess I've never considered the fact that I'm brown has affected that as well.**

Nasir reflects on how intersecting identities may create more difficulties.

Z:

> **I don't feel like I have to, uh? Hide myself at all. Um. No, actually no. I think that's kind of untrue, but it's like I, I don't care.**

This quote shows that there may be a need for participants to hide their identity. Z is speaking about being out to his family. He initially says that he does not feel that he has to hide himself, then corrects himself and says that he does not care. This shows that he does feel there is a need to hide but does his best to exist authentically despite that.

3.2.2.4. Subtheme 4: 'how accepting your family is really does depend on your ethnicity': Acceptance and support: This subtheme explores both acceptance of self and receiving acceptance from others. Participants discussed how negative views from others impacted their mental health. Non-acceptance of identity may be based on lack of understanding about gender diversity, which is also discussed here. This subtheme also shows how trans and gender diverse people of colour attempt to find support in a society that is not always accepting, and within a healthcare system that is not receptive to their needs.

Most of the participants said their families were accepting of their identity in various ways, even if this had taken some time or that they still made mistakes. However they also described difficult and unaccepting experiences.

Parker:

> **Um, but I think that the fact that my grandparents are like very traditional Chinese Singaporean people does very much impact how accepting they are of me.**

T:

> **But they're [immigrant parents] just gonna have like. A different response to their kid being trans. Just generally.**

These quotes highlight how the participants feel that race and culture are likely to mean less acceptance from their families.

Nasir:

> **Because I can't be arsed to like, have that conversation with everyone in my family, you should learn, you should know this already or you should try to learn it from, for your kids. So I just it's not my responsibility to educate or like grown people, or so I'm not gonna do that.**

Nasir speaks about how educating oneself is the family member's responsibility.

Z:

> **I will say that, uh, my parents haven't really helped me with sort of um my things [getting gender affirming clothes, letting me go see my GP as a minor for gender services] that I need like to help my**

> **dysphoria and stuff like that.**

Z says that his parents have not been actively supportive, and later says that they have ‘turned a blind eye’, meaning that Z is in a place of existing within but not fully being seen by his family.

Shan:

> **…. lots of um like people of colour like the I think parents or families think that's [service access]unnecessary maybe? Or that you know, simply thinking it's just a phase and so even trying to get in contact in the first place could be hard.**

Shan reflects on a how dismissive view of gender diversity from families of colour in feeling that gender services may be “unnecessary” for their child, thus creating a barrier. She later says that she has not pursued a referral in part because their parents would need to know.

Isambard:

> **It kinda gets a bit annoying, but then I know that after a certain time they'll probably come around and then they'll help me with it eventually, ‘cause that's normally what they do.**

Isambard expresses hope that his parents will “come around” as they say that they currently do not understand and want him to think about it more, which he finds frustrating.

Participants also speak about often not telling wider family about their gender identity, or having to hide it when with them, essentially presenting as the wrong gender. This subtheme shows what it is like to have ambivalent or unaccepting families and the impact that can have on personal feelings about identity, as well as creating a barrier to receiving healthcare.

T:

> **Uhm, so my dad who is white? He is. Mostly just like a little bit like uneducated. My mum. She grew up in Vietnam and she like. I mean, she wasn't like outwardly transphobic, but she just didn't. Accept it.**

Shan:

> **I feel like my family have a hard time grasping that […] I feel like they don't see it how I do […] They don't really completely understand gender fluidity […] I don't think they completely understand, uh? Being transgender and gender identity as a whole**

Z:

> **My parents don't really. Uh, get it. […] Um. I don't think they really get. My identity I have explained it like many times**

Isambard:

> **Er my mum's a bit like I'm not sure really how to describe it. Erm. Well, she doesn't really understand it that much.**

Nasir:

> **With like my cousins and stuff, um. They don't really get that kind of stuff. They understand like. Sexuality is like a spectrum and stuff, but like they don't really get trans and stuff**

The quotes in this subtheme demonstrate the lack of understanding of gender diversity in the participant's families.

Z:

> **I think most of my um sort of issues in like mental health stems from. Um, obviously my experience not being accepted as trans and my sexuality and all the things that I had to go through and all that kind**

> **of stuff. Umm, I do feel like, if I was accepted and I was able to be free like that, it does beg the question. Would I still need to access? Kind of mental health services.**

Shan:

> **LGBT, LGBTQ like er people of colour, [unclear] be very conflicted ‘cause like I did mention earlier, a few times that you know it's not always accepted so I think causes lots of mental problems […] And then to accept yourself for who you are.**

Parker:

> **I mean it is just a fact that. Di- well like some ethnicities and stuff like their backgrounds will be more accepting of queer people and some just won't be. Um, some of my white trans friends, their parents are pretty accepting of it. And so like I think. Um, how accepting your family is really does depend on your ethnicity.**

Parker highlights his belief that acceptance is different based on ethnicity. He reflects on the difference between white families and families of colour, suggesting that white families may be more accepting.

Isambard:

> **So my grandparents are white, but they like, they seem fine with it. Er my mum is black is fine with it as well. Uh, most of the family are I think I don't know anyone who isn’t. Erm they just have, like, difficulty with names and pronouns and stuff.**

Here Isambard shows that his experience of acceptance is not based on ethnicity. However acceptance may be partial, in that they may accept a change or difference in Isambard, but still struggle with using names and pronouns in a way that might feel best for him.

T:

> **And obviously like I wish it could have been like they accepted me from the start. But I'm just glad that they do now. 'cause like they could have just never so.**

T later talks about only being taken seriously by family members now he is on hormones. With these thoughts he reflects the tentative and tenuous nature of acceptance.

Nasir:

> **especially with young trans people as well, because most of the, like a lot the time they're not getting. They, they're not getting [sound of frustration] accepted by adults, especially when they're extremely young, like when I came out to like my teachers and stuff, it felt really good to have someone to like an adult acknowledge my gender identity.**

Nasir highlights how good it felt for its identity to be accepted, and interestingly speaks about adult acceptance as very important. This may be because adult views are seen to hold more weight, given the power that they have compared to young people. As the adults are teachers, Nasir's identity is being validated by someone in a position of authority.

Acceptance and support often go hand in hand. A few of the participants spoke about the places that they got support from as being friends, family, school and charities. Support from others can particularly help combat negative thinking and experiences.

However, the participants also highlighted what they feel is a lack of support, particularly for trans and gender diverse people of colour.

Z:

> **Er, here's not a lot of youth sort of LGBT places. There isn't a lot of mainly co- um person of colour LGBT places.**

Z also talked about how there is little local support for trans and gender diverse people of colour, and feels what support there is is London-centric. He said that he feels this is a barrier in him not being able to make decisions sooner, because he could have asked questions about how to navigate a trans identity within the cultural context that he is in.

Shan:

> **I've come across a few companies that will give away binders to young people, teenagers, and I've contacted them once**

Shan later reflected how many young people are in a similar position seeking binders from charities, making them feel alright about not having heard back yet. Yet this also demonstrates the volume of requests small charities will be getting from young trans people about gender-affirming items.

3.2.3. Theme 3: Health

3.2.3.1. Subtheme 1: Referrals and waiting lists: This subtheme looks at the actual system of referral to gender services, potentially a part of the process where there are the most barriers. It also explores how waiting lists impact the participants. While the NHS in general struggles to meet patients' needs, there is a particularly long wait for gender services, and this perception of inequality can have a negative impact on wellbeing.

Some of the participants spoke about their confusion and uncertainty about the referral process.

T:

> **he said that that's for everyone that they have to go through CAMHS first. I don't like that...I just don't see how they're related like. 'cause you don't need. A service that isn't. Like it, it's not a gender service at all, CAMHS. So I don't understand why they have to decide that you're trans for you to be referred to this trans service like it just doesn't make sense. Um. And it just makes it, like, unnecessarily difficult for people to access it.**

Shan:

> **I wanted to be referred […] I'm gonna be honest I um, I haven't got too much knowledge about it […] I'm still looking into the whole thing […] I don't know too much about it**

T displays frustration about being told to go through CAMHS so they can 'decide if you're trans' before being referred to gender services, particularly because

CAMHS are not a specialist gender service and do not specialise in this type of assessment. He later refers to the GP saying that everyone has to go to CAMHS first; however this is not the case. This confusion comes directly from the referrer being misinformed about the referral process. Shan shows their lack of understanding of the process despite wanting the referral. This highlights how young people might access information about the process and how they might not be aware of where to start.

Nasir:

> **Yeah. And also I, because I knew when I was 16, but I've I didn't want my my parents to be involved in any way possible. So I made sure that I was 17 and I didn't have to ask for my parents' permission before I asked for it.**

Referral specifications at GIDS say that young people cannot be referred under 16 without parental consent. Nasir shows that he ensured that his parents did not need to be part of his referral by waiting until he was 17. This illustrates that some young people will wait for referral due in part to lacking parental support.

Healthcare professionals making referrals hold a lot of power; not only are they adults, but they are in a position of authority and perceived as gatekeeping access to specialist provision given their role. The four participants who had pursued referrals in some form had experienced some positives, but also complications.

Nasir:

> **[GP] was just like, oh, I assume that means you um, you're you're a trans man. And I said, yeah er and then she says she's going to try and do the best she could, but she hasn't had, like, had any experience with this whatsoever. Basically that was it.**

Isambard:

> **They were just mostly kind of neutral about it. They didn't really ask much, to be honest.**

Nasir explains how the GP had no experience dealing with trans and gender diverse people. This speaks to the lack of training that GPs have. Isambard received a “neutral” response without much exploration; this could relate to a lack of knowledge or be linked to discrimination, resulting in an inability to meet the needs of a young trans person of colour.

Nasir:

> **Um I asked my GP to refer me to a gender dysphoria clinic um, for hormone treatment, but they haven't responded to me, and it's been like a like a month now.**

Isambard:

> **No, he didn't really give me much information, which is part of the reason why my parents moved doctors for me.**

Isambard:

> **So I don't know if the details went through or not. But then recently when I went hospital, it turns out, that I'm like. In the process of being like on a list for them.**

Z:

> **I was like in my heart. I kind of did say yes, , but then at the same time I've got. Sort of. Uh, I didn’t want to do that […] I believe she [GP] was white so she didn't really understand that I had this sort of. Wasn't so easy for me to say yes [due to cultural pressures] […] Yeah, I feel like. I was offered I just. Declined it.**

T:

> **The reason that I just didn't really want to bother, like even trying to get on the waiting list with GIC was because I knew that it would take, like […] six years. I thought like, maybe that's like, a kind of, general thing, or at least something that like, some other people experience like just not having any hope in it.**

Z and T describe how they might want a referral but do not feel able to. For Z this is around cultural pressures; his quote poignantly shows how he wanted to say yes but had to say no. In his interview Z discusses at length that cultural barriers mean that he would not be accepted or supported by his community were he to go down this route. He also reflects on how the GP being white meant that she was unlikely to understand the conflict he was experiencing. T expresses their hopelessness about long waiting lists means not wanting to pursue a referral at all.

Participants reflect on the difficulty of knowing that it is going to take an extremely long time to get gender-service support.

T:

> **I think at the moment the waiting list time is something like six years, but then that's just gonna keep getting longer and longer. And realistically, I'm not gonna get like. Actually seen by them until like well into my 20s.**

Isambard:

> **it turns out, that I'm like. In the process of being like on a list for them, that will probably take a few other years as well.**

Nasir:

> **I don't have that [chance to take testosterone as a teenager] because I didn't come out until much later and also the the waiting list is really, really long.**

These quotes show the participant’s sense of hopelessness regarding waiting for gender-services. Nasir speaks to the missed opportunities he feels he has had due to coming out later.

Parker:

> **From what I've heard from like err two of my friends who are also trans the NHS services, just aren’t very good so I've just decided to wait um and you know do stuff privately.**

An alternative to long waiting lists is private healthcare. Private healthcare is only available to those who can afford it, however, the reduced waiting times are seen as extremely appealing to people keen to move on with their transition. Parker reflects on what he has heard from other people about gender services and how this has meant that he has actively chosen to avoid that route and use private healthcare.

Isambard:

> **I haven't looked outside the NHS I was going to go private, but then I realised that that would have to like involve my parents 'cause they'd probably be the one funding it and I don't think they'd understand that much of it, to be honest, so.**

Isambard shows that relying on other people to pay for private treatment is a barrier. He is not able to pursue private healthcare due to his parents' lack of understanding.

3.2.3.2. Subtheme 2: 'I've just been like, hi, I'm trans, I need hormones': Illegal hormones: This subtheme relates to the use of illegal hormones by trans people. One participant is currently using illegal hormones; participants discuss their experiences of being offered them, experiences of people they know, and feeling as if they are not left with much choice but to use them. This subtheme shows that participants have a good understanding of illegal hormone use in their community, discussing it as a potential option despite known risks.

Z:

> **I was offered the illegal hormone [from a friend who was taking illegal hormones] but I I didn't. I didn't think if you just took a one off testosterone shot [it wouldn't have been sustainable] if that's gonna have any effect on you. So I just didn't do it so umm.**

Here Z discusses a risk of illegal hormones that is about lack of effects rather than the presence of side effects. People taking illegal hormones need to ensure that they can take them consistently to achieve the desired effect.

T:

> **Yeah so I got my hormones through a friend […] Yeah I’m DIYing mine. […] 'cause with the NHS like you have to get a referral before they approve you or if not you have to wait like 10 years and then with this like I've just been like, hi, I'm trans, I need hormones and then I got given them with a couple weeks.**
>
> **Interviewer: And you do feel like it's being done safely and everything?**
>
> **T: Oh yeah, yeah it’s cool.**

T highlights a couple of points, firstly the difference in waiting times for hormones through gender services versus illegal hormones; juxtaposing the lengthy wait in the NHS versus simply stating his identity and receiving hormones within two weeks.

Here T mentions “DIYing”, which is where trans and gender diverse people undertake their own hormone regimen, highlighting the separation between what should be happening and what is happening, and also links to how lengthy waits, lack of awareness and potentially transphobia have impacted on people having to rely on self and community care.

T explains that they do not see a problem with people using illegal hormones if they need them:

> **If people need hormones and this is where to get them then, and it like, obviously if they're being safe and everything, then I don't really see an issue. But like ideally we wouldn't have to go and break the law to yeah.**

This shows the normed attitudes towards the use of illegal hormones and potentially a resignation about the perception that, if services cannot help then what other options are there? T also notes that if only there were other pathways available, young people would not have to engage in illegal paths.

However in contrast to the sense of not having a choice, Parker reflected that he would not want to “mess up his body” and so does not see illegal hormones as his only option:

> **Yeah, I I, I I don't want to get like hormones or anything illegally 'cause, I just like I don't want to mess up my body, and I'm just like, I wanna be careful with that 'cause, obviously like, you know, like, if I take medication that can’t always be reversible and stuff and I know that I do want to go on hormones, but I want to do it safely. So I'm gonna wait a bit to get all my healthcare and stuff.**

Nasir:

> **No, but I'm. I'm like, I'm definitely thinking about it. Like if I can find anyone, I would do it because there's no like, the fact is, I'm gonna end up having to get private healthcare, and I can't afford private healthcare. So that means I’m gonna have to wait until I'm out of uni and I have a steady job and I can't wait that long. It's not, like, I physically cannot like, I need to change, something needs to change. So. It [frustrated noise] That's my only option at the moment, like going illegal.**

And later:

> **Yeah, that's the only option I have. Wait, wait until I'm like, out of uni and that's gonna take me over three years and that, I can't do that [laughs]. It's too much.**

The difference between participants’ feelings of how much of a choice they had may depend on a number of factors, including long waiting lists and access to finances. It may be that those with access to finances would not view illegal hormones as an option, as they could pay for private healthcare, illustrating further inequality. However those who cannot afford private healthcare may see the pay-when-you-can-afford nature of illegal hormones as the only way in which they can achieve the physical outcomes that they desire. Potential side effects and lack of monitoring may be seen as acceptable risks compared to the distress caused by not achieving physical transition.

Another aspect highlighted by Parker and Nasir's quotes is the willingness to wait for hormones. Parker feels able to decide to get gender-affirming healthcare later and Nasir is clear that he cannot wait a long time. This will be a personal decision likely based on levels of psychological distress and dysphoria.

Nasir highlights the casual and community nature of accessibility when he says people he knows get it from their boyfriend or friends.

3.2.3.3. Subtheme 3: 'basically like don't be racist don't be transphobic': Suggestions for healthcare professionals: The subtheme presents participants' suggestions for working with young trans and gender diverse people of colour, acting as a directive for professionals and will be further expanded within the recommendation for practice in the Discussion. Participants reflected how health professionals must think and work holistically, with understanding to walk alongside them on their gender journey.

Shan:

> **take into consideration about how you're going to help that child […] how you can help them cope first of all and help them with things maybe such as like taking hormones or binders that you know they can transition safely**

Shan's quote shows multiple factors that he finds important. The phrase "help them cope" shows their belief that it is likely a trans and gender diverse young person of colour *will not* be coping at the point of meeting with health professionals. Shan's use of the word safely relates to risks from hormones and binders and more widely from within society and in healthcare for young trans and gender diverse people of colour, so emphasising the importance of holding safety in mind for young people is vital for their provision of care.

Shan and Nasir (later in his interview) also highlight the importance of healthcare providers working specifically with young people by using the word 'child'.

Z:

> **along this whole journey you need people to sort of. Check up on you, question you, to make an informed decision because it is a big one.**

Z advocates for supported decision making due to the serious nature of the decision being made. Z highlights the balance of wanting to feel supported in his identity while also needing people to ask the big questions around identity and transition to ensure that young people are making the best decisions for their care.

T:

> **Like there's a lot of gatekeeping as well. […] I think that like. They [health professionals]. Just should like accept people you know like. Um. Not like, put their own ideas on to…**

Through the phases “gatekeeping” and “own ideas” T recognises ways in which professionals may be biased. Gatekeeping here means that certain services are kept out of reach of certain groups of people, due to assumptions and biases about the needs of that group. Professionals may implicitly think that a young non-binary person of colour does not seem gender diverse enough due to having only seen white binary trans representation, and so may believe that they do not reach the threshold for referral to gender services. Gatekeeping is also woven throughout the process of transition given the long waiting lists and bureaucratic systems faced by trans and non-binary people.

Z:

> **…the sort of step of confusing religion and culture. But it's that sort of asking around oh. What's the sort of like religious standpoint in your household, or um. Their cultural background um that kind of stuff I think should be kind of asked about maybe.**

Z talks about the need to not conflate the influence of religion and culture. Z recognises the importance of *asking* rather than assuming a person's cultural background. Being misunderstood is likely to be a barrier to feeling supported by professionals.

T:

> **like just to be more understanding of. Like. I guess how, like being trans would tie into everything else as well. I think like yeah, there only really, well the main issue is just like a lack of understanding and education.**

T highlights the need for professionals to undertake their own education as well as a requirement for it to be provided by the NHS. He speaks about the intersections of how being trans links with other factors in his life, related to his experience of mental health services. This has been echoed by other participants discussing internalised negative feelings towards self, resulting in poor mental health.

Isambard:

> **Uh, probably like how they, if they contact the family about it or not, or how they refer to them like when they're around family members. Just in case there's like that can build tension in relationships with family.**

Parker:

> **How health professionals will interact with their parents like the parents of the trans people and stuff, and how much they'll say to them they should be kind of that of sensitive about that because with some nationalities is it just more common to be more accepting of queer people and some it's just not like for example.**

Participants expressed how important referrer communication was, and how it had the potential to cause problems within the family, due to the cultural factors previously described. Parker and Isambard show that the “tension” felt in the family may be due to difficulties around acceptance of gender identity, and professionals must be “sensitive” to this in order not to alienate the young person and their families. These extracts also show the potential for there to be a split in the family; with ruptures impacting trans young people in their need to have family onboard to access a medical pathway for treatments.

Isambard:

> **And like kind of body type kind of thing as well. Like, there's probably a lot more dysphoria and stuff.**

Isambard asks professionals to recognise that there will be differences in people’s perceptions of their bodies depending on race. He explains that people of colour are likely to experience higher rates of dysphoria, which is likely to be based on the over-representation of white trans and gender diverse bodies in the media, as discussed earlier, as well as the over-representation of white bodies in general, meaning that it can be hard to separate the conflation of race and gender norms when experiencing dysphoria.

Z:

> **Uh, spaces where we could kind of be safe and getting over that internalised homophobia and transphobia, think maybe you should just kind of go into more of that. Like internalised um homophobia and transphobia.**

Z speaks about the importance of ensuring that the spaces trans and gender diverse people of colour are going into are considered safe.

T:

> **Just basically like don't be racist don’t be transphobic, and that kind**

of thing.

T summarises the baseline of how professionals should work with this group.

DISCUSSION

4.1. Overview

The aim of this study was to explore the barriers faced by young trans and gender diverse people of colour when accessing gender healthcare services in the UK.

Through this chapter, I will attempt to discuss the implications and limitations of the findings within the current study, linking these to findings within the current literature. I will then make recommendations for clinical practice and further research in the field.

4.2. Participant Demographics

The participants in this study identified as either genderfluid, transmasculine and trans male. It is of note that there were no trans woman or transfemme perspectives.

The age range of participants was 16-18 years. While this was limited, it provided a focus on a very specific age range, and as such provides insight to a time that is a key developmental stage in young trans and gender diverse people's experience (Bockting & Coleman, 2016; Cicchetti & Rogosch, 2002).

The prevalence of mental health difficulties in this population (Coelho et al., 2019), may have had an impact on what participants felt able to discuss. Neurodivergence may have impacted communication as trans and gender diverse people are more likely to be autistic (Warrier et al., 2020). This may have meant that participants presented more concrete, literal presentations of their experiences within the research (Kelly et al., 2018). Any autistic participants may have appreciated the containment and structure of video calling (Zolyomi et al., 2019).

Whilst the demographic representation of this sample showed variability in ethnicity (see Table 2), a larger range of ethnicities would have given more nuance to the contexts of the experiences within different populations.

4.3. General Reflections

The results from the current study show the damaging impact barriers to gender healthcare in the UK has on young people of colour. Barriers seem to emanate less from discrete or isolated incidents and more from systemic shortcomings. Barriers are not limited to healthcare but include cultural, societal and internal processes. The barriers that participants encounter in accessing support are multi-faceted and they themselves intersect, mirroring the participants' intersecting identities. The UK has gone from leading on LGBTQIA+ rights to being 14th in Europe (International Lesbian, Gay, Bisexual, Trans and Intersex Association Europe, 2022), which is likely to have a trickle-down effect on services for this population.

Lack of acknowledgement of discriminatory experiences can be damaging to mental health (McLaughlin et al., 2010), however the participants spoke about being left without places to talk, or experiencing discrimination from the very services supposed to be providing that support. Of note, outside of therapeutic family work within gender services, it is difficult to work with families to change views of gender at an individual level, therefore change must be undertaken by healthcare systems. While "soft" reform of services is likely, the barriers highlighted through this research show that this is unlikely to serve POC well. Radical change is needed for all marginalised groups under-served by the current UK healthcare system (Faye, 2022).

There is a mixed picture of suicide rates in trans and gender diverse people of colour (McNeil et al., 2017), however, a recent US study showed nearly double the rates of suicide attempts in Black and multiracial young LGBTQIA+ people when compared to their white peers (The Trevor Project, 2021). Barriers to accessing help will only serve to exacerbate and increase risks to vulnerable groups.

4.4. Analysis Of Themes

4.4.1. Discrimination And Difference

4.4.1.1.Discrimination in healthcare: Many of the participants mentioned racial biases within healthcare, paralleling the experience of a “one size fits all approach” to healthcare provision for trans and gender diverse people of colour noted by Zhang (2021).

The results showed how present healthcare discrimination is for the young people; how attuned participants are to systemic racism and transphobia directly affecting their healthcare. Participants demonstrated evidence of mistrust and avoidance of services (Keating et al., 2002; Rymer & Cartei, 2015). Service avoidance compounds other relevant factors and impacts the level of care received by young trans and gender diverse people of colour. Evidence shows that Black trans and gender diverse young people are more likely to access services if their gender is affirmed (Goldenberg et al., 2019).

4.4.1.2. Differences and advantages of white (and cis-het) people over (queer) people of colour: The participants’ awareness of white privilege, and their comparable disadvantage, is gained from their lived experiences, providing them with the unwelcome understanding of who society serves. Of concern is the resulting impact of lack of agency or control on participants’ mental health, potentially exacerbating feelings of low self-worth. This is reinforced by society’s lack of response to their needs and engenders feelings of hopelessness, which can be predictive of suicidality (Hirsch et al., 2017).

The participant’s experience of discrimination is starkly backed up by research; trans and gender diverse people of colour in the US have less access to gender-affirming treatment when compared to their white peers, from scoping review studies by Goldenberg (2020), and Lett (2022), who link poor access to the impact of systemic racism.

LGBTQIA+ spaces may feel more welcoming than other spaces, yet they can contribute to a sense of erasure due to being white-dominated and the experiences of racism and cissexism within (Stonewall Scotland, 2019a). Allyship is requested from straight white people but must also come from within the queer community. LGB people must not sit back and watch their trans siblings suffer (Craggs, 2021).

4.4.1.3. Representation: Devor's (2004) 14-stage theory of identity formation for trans people highlights two important aspects: witnessing and mirroring. He argues that people need to be witnessed by those dissimilar to them and find acceptance there (which many of the participants have not had), but they also need to be mirrored; be reflected back by people who are like them.

The themes that the participants brought up reflected Singh's (2013b; 2014) research about the difficulties for young trans and gender diverse people of colour of connecting with systems around them and the impact of the resulting social and emotional withdrawal. This research also shows that it is hard to find people who 'get' this group's experiences. This is particularly linked to a lack of role models. It brings up the question of whether life might be different for the participants if they had experienced positive representation of self.

Lack of representation can link to prejudice. If society does not see trans and gender diverse people of colour identities, then they are going to judge participants against the 'norm' of "white skinny trans" people; meaning that people outside of the group are more likely to experience discrimination and stigma.

4.4.2. The Development Of Self: From Individual To Community

4.4.2.1. Family, community and cultural views on gender, queerness and sexuality: During analysis, it became clear that culture was a more relevant focus than race when thinking about barriers to gender services within the family. Ethnicity, culture and religion are separate but interrelated constructs, of which culture is the broadest. Assumptions should not be made about a person's culture dependent on their race or religion (Keating et al., 2002), however, there may be connections that mean specific barriers for different groups of people (de Graaf et al., 2019). It is important that clinicians find out about an *individual's* culture and what that means for their experiences within healthcare. Assumptions result in discussions around culture being based on whiteness as the norm; people of colour require their experiences to be viewed through an informed and sensitive lens (Howard et al., 2019). We all exist within cultural contexts. The cultural background of whiteness in the UK is somehow seen as more progressive than other cultures, when, as mentioned in the introduction, it was white colonialists who sought to restrict and punish gender diversity in other countries (Akala, 2018).

Most of the participants brought up the generational gap regarding acceptance of gender diversity; age was more of a definitive factor than race in the level of acceptance, as participants with white and non-white grandparents said that both groups struggled to accept them. Cultural views around gender and sexuality appeared to feel outdated and uncomfortable for the participants. Differing views might be held by family in other countries and seem incongruent with young people's current social context (Ching et al., 2018). The research on intolerance of gender diversity shows it is nuanced and likely to be linked to multiple factors, including strong adherence to social convention, hierarchies and gender roles (Makwana et al., 2018). Participants showed hope in the progressive views of their younger family members.

4.4.2.2. Religion: Many participants mentioned how religious beliefs added to feelings of guilt and shame, whether from internal or external sources. Only 25% LGBTQIA+ people of faith think their religious community welcomes trans people (Stonewall Scotland, 2018).

Words describing gender diversity do not exist in some languages (Henriquez, 2019), making acceptance and nuanced family discussions difficult. Gender diversity is also absent within religious teachings, however, language regarding sexual diversity exists where it is condemned. Participants described ambivalence for gender diversity with simultaneous criticism of homo/bisexuality creating a unique tension, especially as trans and gender diverse people are less likely to identify as straight (Grant et al., 2010). As quotes from the research suggest, people who are wrongly seen as their birth gender may fear repercussions of 'same-sex' dating. Religion may be an important barrier to gender healthcare for some young people, as discussed by the participants, due to fear of repercussions from family and God (Taslim et al., 2021). 51% of conversion therapy is carried out in religious settings (Stonewall, 2021). Some religious groups are supportive of LGBTQIA+ people, and progressive religious interpretations of religious texts exist, such as the Qurʾān (Zaharin & Pallotta-Chiarolli, 2020).

Two people spoke about how white peers had had similar experiences regarding how gender diversity was viewed within their religious family contexts, showing that religion may be a key factor in non-acceptance above race.

4.4.2.3. Being a trans or gender diverse person of colour: Young people become aware of their gender at around age three (Goldhammer et al., 2022), which as noted previously lends to a gendered context for brain development. The participants in this study are developmentally in adolescence, characterised by puberty including the development of secondary sexual characteristics, which is notably a time of great difficulty for trans and gender diverse young people. This is often a time of confusion and curiosity about identity as described above (Erikson, 1968), and for most, emerging sexual interest in others. These factors, alongside being a trans or gender diverse person of colour, could render young people increasingly vulnerable when beginning to share themselves with others, and potentially being challenged or judged on their identity (Simons et al., 2021). Young people may also have their identity questioned by adults, who have more power and can minimise the experiences of younger people, seeing gender diversity as just a phase as discussed by one of the participants. Within the family stages, it is often a time of seeking independence and separation from or potentially conflict with parents; although this differs cross-culturally (Bulcroft et al., 1996; Ecklund, 2012). It may take trans and gender diverse people of colour longer to make sense of their feelings and emerging identity, resulting in delayed support-seeking and experiencing distress for longer.

Interestingly, most of the participants in the current study did not initially consider their race and gender connected, which may have been a failure of the question phrasing. As the interviews continued however, participants began to reflect on the links between gender and race. Minority stress and intersectionality models show the impact of intersecting identities; increasing risk of mental illness and poor healthcare treatment (Cyrus, 2017; Millar & Brooks, 2021).

4.4.2.4. Acceptance and support: Young people shared examples of familial support, yet exploration showed that this support was often minimal. One interpretation is that the lack of explicitly negative response from parents was preferable to addressing their feelings about gender diversity directly, potentially rupturing the relationship and, at the extreme, raising concerns about personal safety. It may be easier to maintain stable dynamics within the family, although doing so can risk poor psychological wellbeing due to having to hide one's identity (Valdiserri et al., 2019). It could also be the case that basic needs being met is sufficient for the young person. The young person may feel that the meeting of their basic needs is sufficient support. Research from the scoping review showed that professionals working with young trans and gender diverse people of colour in the US thought that this group were less likely to be out to their families and less likely to want to medically transition than their white peers, and linked this to lack of family support (Douglas et al., 2022) This shows the impact that familial support can have on the trajectory of gender identity development as relates to healthcare.

Intolerance and prejudice stem from lack of acceptance. A sense of belonging can help mitigate depressive symptoms caused by ethnic discrimination (Thibeault et al., 2018), but how can trans and gender diverse people of colour belong in societies that are so rejecting of them? The participants allude to societal rejection in social and healthcare contexts throughout, which is backed up by research from the scoping review (Goldenberg et al., 2021). Societal prejudice often leads to a reduction or removal of rights for marginalised groups e.g. trans and gender diverse people not being included in recent bans of conversion therapy (Peter Tatchell Foundation, 2022). Trans and gender diverse people and people who can get pregnant are linked in the battle against loss of rights over their bodily autonomy (Berruti, 2022).

The effects of migration may impact how accepting families are of gender diversity. Traumatic experiences of change and the need to assimilate may be passed to the child (Bhugra, 2005), therefore identity development at individual and group levels may be impacted due to perceived or experienced threat (Schwartz et al., 2018). Personal associations with treatments of LGBTQIA+ people in families' country of origin may be difficult for young queer people.

Participants noted how few charities existed to support or represent them outside of London. Meaningful support is likely to be even harder for rural trans and gender diverse young people of colour. Alongside that, peer support is hugely valuable yet can be difficult to find. Safe support spaces for LGBTQ young people of colour have been shown to aid the development of a sense of authenticity and empowerment against discrimination (Gamarel et al., 2014). This is sorely needed given the experiences discussed by participants in the current study and the negative outcomes that result from experiences of discrimination.

Marginalised groups are sometimes said to be ‘hard to reach’. Not only does this homogenise these groups but puts the onus on them to create better accessibility. A more appropriate phrase might be ‘easy to ignore’ (Lightbody, 2017).

Non-acceptance and lack of support is likely to create sadness, frustration and isolation for this population as reflected in the participants’ experiences, and therefore should be seen as another barrier to gender healthcare.

4.4.3. Health

4.4.3.1. Referrals and waiting lists: It is important to name that this research does not aim to promote the need to automatically refer trans and gender diverse people of colour for medical intervention (Ashley, 2019). Some people will choose not to receive talking therapies or medical intervention to ‘transition’ and will be just as valid in their identity. However, for those that do want a referral and are not able to access it due to the barriers discussed by participants, the question arises: what is being offered instead?

The current study’s results show that participants’ individual experiences with referrers tended to be viewed by them as positive or neutral, which is in stark contrast with evidence from other trans and gender diverse youth showing GPs can be a problematic barrier (Children’s Right Alliance for England, 2016). This suggests that discrimination is likely to be more systemic in nature; making it more subtle and insidious and so harder to challenge (Akala, 2018). Poteat et al. (2013) argue that stigma is the basis for the lack of training provided to GPs. A participant describes their GP saying they would try their best despite having no experience with trans and gender diverse people which is unlikely to be a conversation between GPs and people in less marginalised groups.

The comparison between gender and other services' waiting times is viewed as a particular injustice by those needing and reaching out for support, especially given health inequalities themselves have such a negative impact on wellbeing (Elias & Paradies, 2021). Rickett et al (2021) make a connection between the phrase 'waiting to be seen' regarding waiting lists, and trans and gender diverse people waiting to be seen for who they are. Does this mean that trans and gender diverse people of colour are being looked away from, and what does it mean for how they view the importance and validity of their identities (Kuper et al., 2018)?

4.4.3.2. Illegal Hormones: An important finding of this research is the use or knowledge of illegal hormones amongst participants, which is line with the small amount of research on this topic (i.e. Mepham et al., 2014). It is not known if illegal hormones usage is higher in young trans and gender diverse people of colour compared to their white peers, however results highlight a potential risk. It could be suggested that young trans and gender diverse people of colour may use them more if they are less likely to be referred into services. The physical risks of unmonitored illegal hormones use is outlined in the Introduction, so alongside risk it is worth noting the isolation of being on treatment without medical support.

Participants noted the stark difference in waiting times for prescribed legal hormones through gender services versus illegal hormones, with a wait of three years compared with a few weeks. As T's quotes revealed, the lack of treatment pathways can make young people feel as if they do not have much choice but to take illegal hormones, and may take them without their family being aware, which is likely to be very difficult for the young person. Potential risks may be disregarded ("yeah it's cool"), or felt to be worth a reduction in gender distress. Having a strong support network may help (information on how to use illegal hormones often comes from the online trans community).

Lou Sullivan's diaries (2019) beautifully illustrate the history of barriers to gender healthcare access. This is mirrored in this study's findings, as are the feelings of hopelessness and anger. Whilst it is important to not generalise results too readily due to small sample size, the current study illustrates just how on the periphery of healthcare this group are, and it may be this which pushes young people to seek their own paths. Marginalised groups are often excluded from healthcare for reasons out of their control. An example of this is in the AIDS/HIV crisis when policies and services in the UK took a long time to be created due to the perceived value of groups that the illness was seen to affect (the 4 H’s; homosexuals, heroin users, hemophiliacs, and Haitians; Baker, 2022). Private healthcare is available, but only for those who can afford it, emphasising the class implications of barriers to healthcare.

4.4.3.3. Suggestions for healthcare professionals: These suggestions are a call for equity rather than equality; ensuring that different, tailored resources are used for minoritised groups in order that they reach the same outcomes as, for example white, cis, heterosexual service user groups.

The results highlight the need for increased learning, education and training on the part of health professionals. Participants reflected a hope for thoughtfulness from professionals that they may not have felt they received themselves. The participant’s suggestions sounded very protective of future young people (especially in the use of the word child), showing how the trans and gender diverse community care for and support each other, and wish for improved care in the future even if they did not experience it themselves.

As participants emphasise, professionals should do their own learning, not make young people into the educators. Black, and trans young people are often seen as older by white adults (Stone, 2018); professionals should remember that these young people are children. While professionals working with gender questioning young people acknowledge that there are many tensions and uncertainties in the work (Wren, 2014), “cisgender fragility” (Oaster, 2019) should not get in the way of professionals’ learning.

Mikulak (2021) writes about what is essentially the weaponised ignorance of professionals, showing how power in healthcare settings is used when working with trans and gender diverse people, including how acknowledging lack of training is sometimes as far as professionals will go in thinking about their role in creating or maintaining barriers to healthcare.

4.5. Critical Review

Despite this research being conducted on a group with intersecting identities of race and gender, it is important to think about those who have additional identities that might add further barriers to gender healthcare and may be made to feel invisible. Examples of these may be people non-binary people of colour (Ghabrial, 2019), disabled people (TransActual, 2021) and non-English speakers (Henriquez, 2019).

Nearly half of studies into trans and gender diverse lives were shown to not report any information related to race (Moradi et al., 2016) making it hard to form a clear idea of the barriers to gender healthcare for people of colour. More research is needed in this area (Bignall et al., 2019).

4.5.1. Limitations

One of the main limitations of the research is the very small sample size. An anonymous quantitative study is likely to have increased the breadth of responses, however given the subjective and sensitive nature of the research question, a qualitative approach was chosen (Willig, 2008). Recruitment was anticipated to be a challenge. The small sample size is mitigated somewhat by the quality of the quotes, documented experiences and investment from participants. There are various debates about the sample size of qualitative studies. Braun and Clarke (2021a) caution against operationalising a set number of participants. Generalising from six interviews is difficult, yet Guest et al. (2006) found that “the magic number of six” was enough to support the basis of finalised themes when analysed retrospectively.

Six people got in touch and then did not respond further; this could have been due to concerns about the safety of the interview process, or due to realising that they did not meet inclusion criteria (such as being UK-based). As such, being a white cis researcher felt like a barrier during recruitment. I used informal spaces to discuss the impact of my whiteness on the research, and reflected on feedback from the main consultant. Due to the Covid-19 pandemic, interviews had to be carried out online. While this may have increased access in some ways, due to reaching people outside of the geographical area the researcher was based in, it also brought up the potential difficulty for some young people to be able to access a private and confidential space to discuss things that they might not want their family to hear, especially if they were not out. The study was disseminated via social media and the main consultant; this may have meant there were individuals without online access who were not reached.

It would have been preferable to have more gender diversity amongst participants. Having more masculine-identified participants echoes the current over-representation of people in services who were assigned female at birth (de Graaf et al., 2018), but is still a limitation.

No pilot study was carried out within the current study. While it may have made little difference to the overall quality of data gathered, it may have helped refine the interview process and increase the ease of both researcher and participants within the context of the interview.

Some feedback that was received from the participants is that it was not clear what “gender services” meant in the research advert, as NHS services (GIDS and GICs) were not specified. This was clarified in interviews but may have caused confusion for potential participants.

The main consultant requested for people to be included who had had a one-off appointment at GIDS in order to move them from the young person’s waiting list to the adult waiting list, but no other contact. This was due to feeling that this group had experience of similar barriers as they had not actually received any treatment from gender clinics. It was decided not to include these people so as not to conflate the experience of those who had never experienced services with those who had minimal contact.

A decision was made not to collect more demographic data than was necessary for the research question. However, a scarcity of thorough demographic data has been criticised particularly within trans research as it means lack of generalisability (Moradi et al., 2016).

The factor of age was not explicitly explored in the interview, and may have yielded some useful reflections, although the participants being in such a small age bracket might have precluded a broad range of experiences.

4.6. Recommendations

4.6.1. Training

General: Activists recommend reading books by, and getting training from, trans and gender diverse people of colour. Training on working with trans and gender diverse people, and the intersection of race, should be provided across all healthcare and educational settings (Choudrey, 2022).

Resulting from the data: Professionals must be responsible for their own learning as well as that provided by their service. Training delivery must consider the implications of discrimination for both parties within the healthcare relationship (i.e. safety for the young person, unconscious biases for the professional). This includes GPs, psychologists, nurses, other physical healthcare doctors, psychiatrists, therapists, counsellors, social workers, advocates as well as those in administration and reception roles. The relevant settings may be GP surgeries, general physical healthcare, general mental healthcare, gender-specific healthcare, private therapists, endocrinology services, social care settings and inpatient units.

Training should also cover family working, and should not be limited to models based on white straight families. Awareness of different cultural norms and wide varieties of family units is vital to ensure not just understanding but nuance. Differences and similarities should be thought about. Training can also be delivered by religious leaders so that the impact of religion is considered sensitively and thoughtfully.

Training should also deliver information, reflection and exercises around whiteness, so that professionals are aware of the insidious nature of whiteness and how it might play out in their practice without them realising, leading to experiences of discrimination or micro-aggressions for young trans and gender diverse people of colour.

4.6.2. Systemic Changes

General: Many trans and gender diverse people and cis allies call for a localised, informed consent model to support trans people with hormone access, rather than services being gatekept by the need for mental health professional involvement (Schulz, 2018). Although this research relates to the present system, recommendations can be taken forward for use in future iterations of gender services (Cass, 2022).

Existing services should consider how spaces can be made safe and affirming for young people (Call et al., 2021), including by systems and people parallel to the process (such as health records and receptionists).

There are a lack of policies regarding pathways for trans and gender diverse young people in CAMHS; this should be developed to ensure best care, including provision of support around gender identity.

Ensuring collaborative involvement with this population at all levels of service provision will guide safer practices.

Resulting from the data: Services should not make assumptions about service users (Choudrey, 2016). Support groups should ensure they employ a diverse range of staff rather than assume trans and gender diverse people of colour will feel comfortable receiving support from cis white people. Representation matters.

System-wide changes can be made to support processes such as ensuring that referrals consider young people holistically, and are sympathetic to some of the reasons why a young person of colour might struggle to ask for support around their gender, or why they do not want their family involved. Reflective spaces or spaces where risk is discussed should be used in part to ensure that risk is being discussed in an intersectional manner, including those faced by people outside of the clinician’s own identities and expertise. Using reflective tools such as Johari’s window within team meetings can help people recognise where their blind spots are and increase self-awareness for their client’s benefit (Rasheed, 2015). Making changes to processes like these require discussion and reflection at all levels by all those involved, including clinical and non-clinical service managers.

4.6.3. Individual Practice

General: Professionals can establish rapport, safety, and trust by modelling the use of pronouns, as well as ensuring aspects of the therapy environment are trans-affirming (Estevez, 2020). This is relevant for all professions and contexts as listed above.

Clients can be helped to recognise and challenge internalised negative beliefs regarding their identity, develop a positive body image and navigate body dysphoria (Singh, 2018). Cover (2013) cautions against labelling queer youth as *either* resilient or vulnerable and instead recognise the capacity for people to be both.

It is not just people of colour who see queerness as white; white clinicians will underestimate queerness in people of colour due to lack of representation (Poon, 2011). Narratives around LGBTQIA+ young people contribute to the idea of them being deficient, as well as viewing their experiences as monolithic or homogeneous (Horn et al., 2009). Professionals must ensure they see the person as an individual.

Resulting from the data: Following on from the suggestions from the participants to health professionals, professionals must ensure that they are attuned to intersections, particularly how they arise in young people given their racial, gender and cultural identities. Ecklund (2012, p. 256) advises that “when working with children, intersectionality is considered both an individual and family construct.” Professionals must work reflexively.

Clinicians need to witness trans and gender diverse people of colour (Devor, 2004). All interactions should use unconditional positive regard towards this population to mitigate the lack of acceptance and support from other areas of their lives. Supervision should be used effectively to ensure that the young person is being thought about holistically, especially if they do not share some important identity characteristics.

When working with this population, use of illegal hormones should be discussed for reasons of support and risk. Service users should feel able to discuss the barriers they may be facing; this may involve professionals naming potential difficulties while avoiding assumption and generalisations. Work with service users can also include encouragement of resilience and empowerment, and ways to identify and celebrate strengths and (trans) joy.

4.7. Future Research

The current study highlighted some important areas worthy of further research. It may be useful to look at the impact of religion as a barrier to gender services as well as a barrier to gender diversity identity development. Family and community beliefs about gender diversity cross-culturally, and the impact of lack of representation could also be studied. These unexplored areas show the importance of ensuring consideration of people must be holistic.

4.8. Summary

The key research finding from this study was how the barriers for young trans and gender diverse people of colour accessing gender healthcare were intersectional and systemic. Interlinking discrimination based on race, gender, and other factors impacted how able the participants felt to pursue this pathway. Implications around religion, lack of representation and cross-cultural beliefs are useful to consider for future research. Use of affirming spaces, reflexive practice, and naming barriers within all contexts of healthcare provision is recommended.

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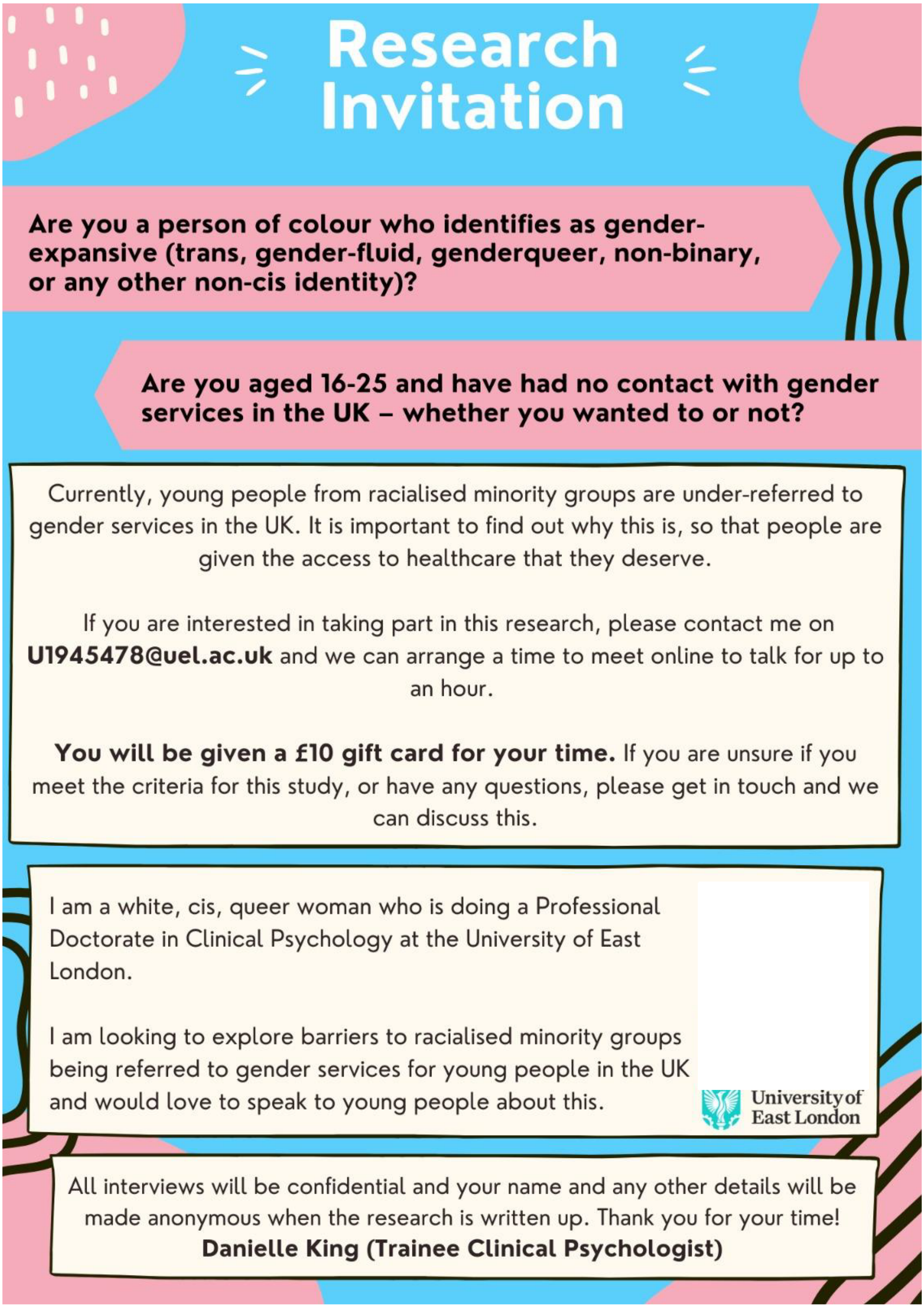
APPENDICES

Appendix 1: Research advert



Research Invitation

Are you a person of colour who identifies as gender-expansive (trans, gender-fluid, genderqueer, non-binary, or any other non-cis identity)?

Are you aged 16-25 and have had no contact with gender services in the UK – whether you wanted to or not?

Currently, young people from racialised minority groups are under-referred to gender services in the UK. It is important to find out why this is, so that people are given the access to healthcare that they deserve.

If you are interested in taking part in this research, please contact me on **U1945478@uel.ac.uk** and we can arrange a time to meet online to talk for up to an hour.

You will be given a £10 gift card for your time. If you are unsure if you meet the criteria for this study, or have any questions, please get in touch and we can discuss this.

I am a white, cis, queer woman who is doing a Professional Doctorate in Clinical Psychology at the University of East London.

I am looking to explore barriers to racialised minority groups being referred to gender services for young people in the UK and would love to speak to young people about this.

University of East London

All interviews will be confidential and your name and any other details will be made anonymous when the research is written up. Thank you for your time!
Danielle King (Trainee Clinical Psychologist)

Appendix 2: Transcript for recruitment video

Transcript for recruitment video

Hi,

My name is Danielle, I’m a trainee clinical psychologist at the university of east London, and I’m doing this research as part of my doctoral training. I am queer, white and cis.

I am doing this research because I work with gender diverse young people, and have many gender diverse friends which makes me aware that the current healthcare system fails this group of people. Learning that the number of people of colour seen by GIDS is not representative of people of colour in the UK, I questioned why this group was even more affected by the system and wanted to see if I could be helpful in getting those voices heard.

I wrestled a lot with whether I am the right person to do this work and in some ways the answer is probably not. However, groups that are shut out from systems should not always be the ones to do the work to get back in. As a white cis person I believe I should be part of breaking down barriers rather than leaving the work to others.

However I do understand why as a researcher some people might not want to take part for reasons of safety, trust and past negative experiences. But if you are curious then I do encourage you to get in touch and ask any questions you have.

The people I want to talk to are those who have not yet had any contact with gender services, by that I mean GIDS and GIC (NHS services). This means not being seen by GIDS or GIC at all. People who have been referred or who are on the waiting list can be included. This is because I am looking at the barriers to people gaining access to these services rather than those who have actually been accepted into those services, although I am aware there is a lot of overlap in negative experiences for these groups.

I am working with a trans person of colour who is giving me amazing feedback on the study which I am incorporating into my work wherever possible.

Lots of people have asked what will happen to the research. In the worst case it will be presented at GIDS and just be used as part of my academic study. In the best case it will be published (this is the aim) and possibly presented at a conference. In these cases it will be more likely that healthcare professionals can learn from some of the things that people discuss in the interviews.

I'll just do a very brief overview of what will happen if you take part.

I'll ask you to read an information sheet and sign and send back a consent form.

I will ask you if you:

Would like to choose your own pseudonym
Would like to edit your transcript after the interview
Would like to receive a copy of the paper later this year when it is finished

We'll arrange a time to meet online

I'll let you know a bit about me – I'm queer, I'm also cis and white, this means that I might get things wrong sometimes – I welcome feedback on this if you are comfortable to do so.

I'll ask a couple of basic questions e.g. age and gender and racial identity

I'll then ask six questions about your experiences, and a seventh question asking if you want to add any thing else.

Thanks so much, please get in touch if you're interested!

Appendix 3: Hashtags used on social media

Instagram	Twitter	TikTok
#gender #trans #transyouth #mental health #race #racisminpsychology #racisminmentalhealth #transphobiainmentalhealth #intersectionality	#gender #trans #transyouth #mentalhealth #race #intersectionality	#trans #poc #mentalhealth #transgender #genderfluid #genderqueer #UK #gender #queer #research #lgbt #lgbtq #QTIPOC #transpoc #uktrans #transpoclivesmatter #ukgenderclinics

Appendix 4: Email sent to organisations and List of charities contacted

Hello,

I was wondering if you would be able to disseminate my research project - the flyer is attached above. I am struggling to recruit and looking for help to reach the group the research is focused around; young trans people of colour who have not been referred to UK gender services, to find out why they think that is.

It would be fantastic if you were able to share my research to any relevant people or groups. I am also able to send a 4 minute video explaining the research aims and process, if that would be useful.

Many thanks,

Danielle King
Trainee Clinical Psychologist
Sent to:
SPECTRA
Open Barbers
Imaan LGBTQI Muslim Support
Doing It For Ourselves
Black Beetle Health
Just Like Us
Kaleidoscope
Pride in Gloucestershire
Youth Pride MCR
House of Rainbow
LGBT Foundation
Allsorts Youth
Diversity Trust

Gendered Intelligence
Mermaids
The LGBT+ Partnership
The LGBT Forum
LGBT Best
Blossom LGBT
HIDAYAH LGBT
Exist Loudly CIC
Gaysian Faces
Inclusive Mosque
Voices 4 LDN
Queer Muslims of Manchester
Naz and Matt Foundation
CliniQ
GIN LGBTQIA Indian Network UK
Gender Swap
Trans Care Project
The Kite Trust
Trans Youth Allies
Blaq UK
Colours Youth UK
Rainbow Foundation
Pride in the UK
Mindline Trans
Out Proud Parents
Purple Rain Collective
QTIBPOC Creatives
London LGBTQ Centre
British Asian LGBTI
Sal Helpline
Black Trans Foundation
TransActual
Black Minds Matter
Black LGBT Fund

Stonewall UK

Appendix 5: Information sheet

University of
East London

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a Doctoral student in the School of Psychology at the University of East London and am studying for a Clinical Psychology Doctorate. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

I am looking to explore why young gender-diverse people of colour may experience barriers to UK gender services.

Currently, young people from racialised minority groups are under-referred to gender services in the UK. It is important to find out why this is, so that people are given the access to healthcare that they deserve.

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to involve young people ages 16-25 who are gender-diverse and part of a racialised minority group / identify as a person of colour.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect.

You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to take part in an interview, in which you will be a series of questions about your experiences. The interview will be for a maximum of one hour. This will take place via Microsoft Teams online, and the interviews will be recorded. You will be paid a £10 shopping voucher for your time.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times.

You will not be able to be identified by the data collected, on any written material resulting from the data collected, or in any write-up of the research. Your name will be replaced with a false name if you are quoted.

You do not have to answer all of the questions asked and you can stop your participation at any time.

You may find talking about some issues distressing. If this is the case you can break or stop the interview completely at any time. Some information will be provided on services you could choose to use for support. It is hoped however that people will feel positive about contributing to knowledge about barriers to gender services in the UK.

What will happen to the information that you provide?

The material you provide will be securely stored. Personal contact details and data will be stored on UEL OneDrive.

The recordings will be transcribed after collection, with names or other identifying details anonymised. The recordings will then be deleted with the transcriptions used for analysis.

The anonymised data will be seen by my supervisor and examiners. The data may also be published in an academic journals.

After the study has been completed all contact details will be deleted. Transcripts will be retained up until the time of any journal publication or deleted after five years.

If you choose to withdraw your data from the study you can do so up to three weeks after your interview, after which time analysis may have begun.

Can I change my mind?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. Separately, you may also request to withdraw your data even after you have participated data, provided that this request is made within three weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:

Danielle King U1945478@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Paula Corredor-Lopez. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: p.corredor-lopez@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Appendix 6: Consent form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Title of research: Looking at barriers to UK gender services for young people in racialised minority groups

Contact person: Danielle King

Email: u1945478@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	

I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using Microsoft Teams.	
I understand that my personal information and data, including video recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview data may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant’s Name (BLOCK CAPITALS)

……………………………………………………………………………………………
…………………………………………….

Participant’s Signature

……………………………………………………………………………………………
…………………………………………….

Researcher's Name (BLOCK CAPITALS)

……………………………………………………………………………………………
…………………………………………….

Researcher's Signature

……………………………………………………………………………………………
…………………………………………….

Date

……………………..……………………………………………………………………
…………………………………………….

Appendix 7: Extract from transcript

00:04:16.880 --> 00:04:27.130
Danielle KING
Um, and we've got up to an hour, but you can say as much or as little as you want. Some people like talking loads and some people just like to give kind of short answers and either is fine. So no pressure.

00:04:17.090 --> 00:04:17.460
Isambard
Yeah.

00:04:28.090 --> 00:04:28.600
Isambard
OK.

00:04:29.420 --> 00:04:29.800
Danielle KING
K.

00:04:30.450 --> 00:04:37.990
Danielle KING
So the first question is, could you tell me about whether you feel that your gender and race are connected, and if so what that means to you?

00:04:39.400 --> 00:04:40.160
Isambard
Uhm.

00:04:41.060 --> 00:04:44.490
Isambard
I don't really think they’re that connected to be honest, but.

00:04:45.260 --> 00:04:45.870
Isambard
Uhm.

00:04:47.080 --> 00:04:56.710
Isambard

I haven't really thought much about the race thing being connected to the gender, so like I didn't think they would like have connections, but it could be it could be, I'm not sure.

00:04:58.370 --> 00:05:03.280
Danielle KING
Mmm-hmm. Well, I guess it's what it means for you. So if you don't feel that for you personally, they're connected then.

00:05:04.920 --> 00:05:05.300
Danielle KING
Yeah.

00:05:05.300 --> 00:05:08.310
Isambard
Yeah, I don't really feel personally that they’re connected for me.

00:05:09.200 --> 00:05:11.990
Danielle KING
OK. So they're like 2 separate identities that you hold?

00:05:12.930 --> 00:05:13.370
Isambard
Yeah.

00:05:14.840 --> 00:05:15.770
Danielle KING
Cool. OK.

00:05:17.150 --> 00:05:17.900
Danielle KING
Uhm.

00:05:20.420 --> 00:05:34.260
Danielle KING
So again, I know this kind of came up in the email, but just for this these questions. So did you ever want or try to be referred to gender services in the UK? And by that I mean like NHS services like GIDS and the GIC.

00:05:30.710 --> 00:05:31.100
Isambard
Yeah.

00:05:35.340 --> 00:05:37.100
Danielle KING
So can you tell me about that?

00:05:36.160 --> 00:05:36.880
Isambard
Uh, yeah.

00:05:38.680 --> 00:05:43.290
Isambard
Uh, well I phoned my doctor, like back in October about it.

00:05:44.260 --> 00:05:54.810
Isambard
And he said he’d send my details to them. But then I had to change doctor’s surgery. So I don't know if the details went through or not. But then recently when I went hospital, it turns out, that I'm like.

00:05:56.210 --> 00:06:02.290
Isambard
In the process of being like on a list for them, that will probably take a few other years as well.

00:06:03.790 --> 00:06:09.200
Danielle KING
OK, so you found out that you were on the waiting list when you went to hospital rather than through your GP.

00:06:10.130 --> 00:06:10.500
Isambard
Yeah.

00:06:11.470 --> 00:06:11.960
Danielle KING
K.

00:06:12.720 --> 00:06:19.270
Danielle KING
So it wasn't clear from your GP and because of the change in GP, whether you were actually on the waiting list or not.

00:06:20.830 --> 00:06:21.280
Isambard
No.

00:06:21.790 --> 00:06:22.070
Danielle KING
K.

00:06:23.130 --> 00:06:29.880
Danielle KING
And did your GP like talk to you much about it and say, you know, this is the process, there's a long waiting list or not?

00:06:30.580 --> 00:06:31.170
Isambard
Uh.

00:06:31.380 --> 00:06:37.230
Isambard
No, he didn't really give me much information, which is part of the reason why my parents moved doctors for me.

00:06:38.100 --> 00:06:39.640
Danielle KING
OK, OK.

00:06:40.480 --> 00:06:41.180
Danielle KING
Uhm.

00:06:41.850 --> 00:06:45.510
Danielle KING
So when did you find out about the long waiting list or is that something you knew already?

00:06:47.760 --> 00:06:51.190
Isambard
Er that was something I already knew. Like going into the process.

Appendix 8: Interview schedule

Interview Schedule

My name is Danielle, I'm a trainee clinical psychologist at the university of east London, and I'm doing this research as part of my doctoral training. Thank you so much for taking part.

Ask if people want to read their transcripts back.

Ask if people want to choose their own pseudonym.

I'm queer and have experience working with gender diverse young people, but I'm also cis and white, and this means that I might get things wrong sometimes – so please feel free to stop me and let me know at any point. Also please do ask for clarification if the questions don't make sense.

How old are you?
How do you refer to yourself in terms of your race and gender identity?
How do you want me to refer to you?

1. Could you tell me about whether you feel that your gender and race are connected, and if so what that means to you?

2. Did you ever want or try to be referred to gender services in the UK? By that I mean NHS services such as GIDS and GIC.

    a. If not, why not?

    b. If you did want or try to be referred, what happened?

3. What things do you think health professionals (doctors, psychologists, psychiatrists) should take into consideration when working with gender diverse POCs?

   [Prompt – could you expand on these?]

4. What barriers did you/do you think gender diverse POC can experience when accessing gender services in the UK?

   [Prompt – could you expand on these?]

5. What do your family feel about your gender? Are they supportive?

   [Prompt – could you expand on this?]

6. Have you accessed trans healthcare outside of gender services? What has that experience been like?

7. Do you have any other thoughts about this topic that haven't been covered today?

Thank you for your time

Appendix 9: Debrief form

University of
East London

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research into the lived experience of young people in racialised minority groups who have not accessed gender services in the UK. This letter offers information that may be relevant in light of you having now taken part.

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided.

The material you provide will be securely stored. Personal contact details and data will be stored on UEL OneDrive.

The recordings will be transcribed after collection, with names or other identifying details anonymised. The recordings will then be deleted with the transcriptions used for analysis.

The anonymised data will be seen by my supervisor and examiners. The data may also be published in an academic journals.

After the study has been completed all contact details will be deleted. Transcripts will be retained up until the time of any journal publication or deleted after five years.

If you choose to withdraw your data from the study you can do so up to three weeks after your interview, after which time analysis may have begun.

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways you may find the following resources/services helpful in relation to obtaining information and support:

Mermaids: https://mermaidsuk.org.uk/
Stonewall: https://www.stonewall.org.uk/
Gendered Intelligence: https://genderedintelligence.co.uk/
TPOCalypse: https://genderedintelligence.co.uk/trans-youth/BAME.html

Fusion: https://www.gires.org.uk/tranzwiki/groups/fusion-bame-lgbt-young-people/
House of Rainbow: https://www.houseofrainbow.org/
Imaan: https://imaanlondon.wordpress.com/
Naz and Matt Foundation: https://www.nazandmattfoundation.org/
Purple Rain: https://purpleraincollective.com/

For general information about NHS Gender Services:

https://gids.nhs.uk/
https://www.nhs.uk/live-well/healthy-body/how-to-find-an-nhs-gender-identity-clinic/

Samaritans: Call 116 123 for free
Kooth mental health support for young people: https://www.kooth.com/
Call 999 if you need urgent medical support

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Danielle King U1945478@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Paula Corredor-Lopez. School of Psychology, University of East London, Water Lane, London E15 4LZ,

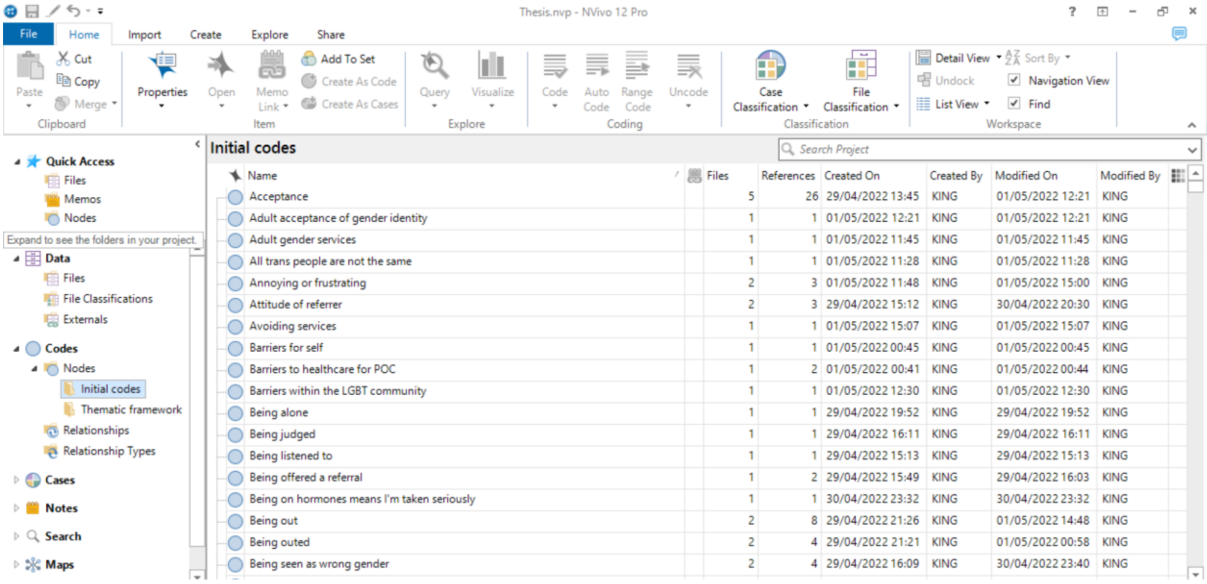
Email: p.corredor-lopez@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

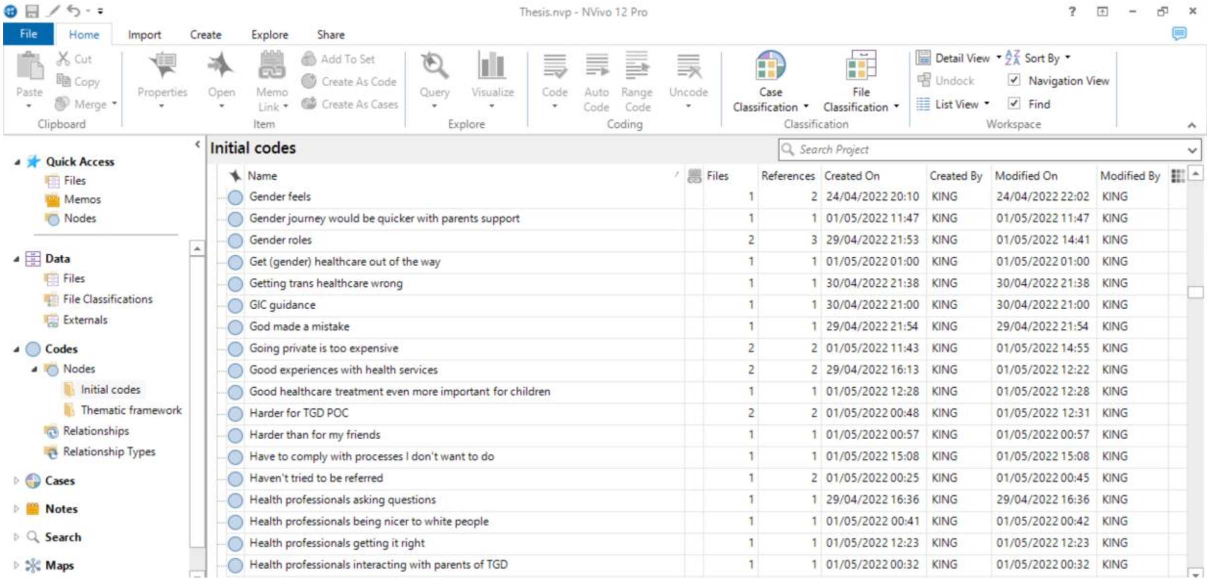
(Email: t.patel@uel.ac.uk)

Appendix 10: Initial coding



Initial codes

Name	Files	References	Created On	Created By	Modified On	Modified By
Acceptance	5	26	29/04/2022 13:45	KING	01/05/2022 12:21	KING
Adult acceptance of gender identity	1	1	01/05/2022 12:21	KING	01/05/2022 12:21	KING
Adult gender services	1	1	01/05/2022 11:45	KING	01/05/2022 11:45	KING
All trans people are not the same	1	1	01/05/2022 11:28	KING	01/05/2022 11:28	KING
Annoying or frustrating	2	3	01/05/2022 11:48	KING	01/05/2022 15:00	KING
Attitude of referrer	2	3	29/04/2022 15:12	KING	30/04/2022 20:30	KING
Avoiding services	1	1	01/05/2022 15:07	KING	01/05/2022 15:07	KING
Barriers for self	1	1	01/05/2022 00:45	KING	01/05/2022 00:45	KING
Barriers to healthcare for POC	1	2	01/05/2022 00:41	KING	01/05/2022 00:44	KING
Barriers within the LGBT community	1	1	01/05/2022 12:30	KING	01/05/2022 12:30	KING
Being alone	1	1	29/04/2022 19:52	KING	29/04/2022 19:52	KING
Being judged	1	1	29/04/2022 16:11	KING	29/04/2022 16:11	KING
Being listened to	1	1	29/04/2022 15:13	KING	29/04/2022 15:13	KING
Being offered a referral	1	2	29/04/2022 15:49	KING	29/04/2022 16:03	KING
Being on hormones means I'm taken seriously	1	1	30/04/2022 23:32	KING	30/04/2022 23:32	KING
Being out	2	8	29/04/2022 21:26	KING	01/05/2022 14:48	KING
Being outed	2	4	29/04/2022 21:21	KING	01/05/2022 00:58	KING
Being seen as wrong gender	2	4	29/04/2022 16:09	KING	30/04/2022 23:40	KING



Initial codes

Name	Files	References	Created On	Created By	Modified On	Modified By
Gender feels	1	2	24/04/2022 20:10	KING	24/04/2022 22:02	KING
Gender journey would be quicker with parents support	1	1	01/05/2022 11:47	KING	01/05/2022 11:47	KING
Gender roles	2	3	29/04/2022 21:53	KING	01/05/2022 14:41	KING
Get (gender) healthcare out of the way	1	1	01/05/2022 01:00	KING	01/05/2022 01:00	KING
Getting trans healthcare wrong	1	1	30/04/2022 21:38	KING	30/04/2022 21:38	KING
GIC guidance	1	1	30/04/2022 21:00	KING	30/04/2022 21:00	KING
God made a mistake	1	1	29/04/2022 21:54	KING	29/04/2022 21:54	KING
Going private is too expensive	2	2	01/05/2022 11:43	KING	01/05/2022 14:55	KING
Good experiences with health services	2	2	29/04/2022 16:13	KING	01/05/2022 12:22	KING
Good healthcare treatment even more important for children	1	1	01/05/2022 12:28	KING	01/05/2022 12:28	KING
Harder for TGD POC	2	2	01/05/2022 00:48	KING	01/05/2022 12:31	KING
Harder than for my friends	1	1	01/05/2022 00:57	KING	01/05/2022 00:57	KING
Have to comply with processes I don't want to do	1	1	01/05/2022 15:08	KING	01/05/2022 15:08	KING
Haven't tried to be referred	1	2	01/05/2022 00:25	KING	01/05/2022 00:45	KING
Health professionals asking questions	1	1	29/04/2022 16:36	KING	29/04/2022 16:36	KING
Health professionals being nicer to white people	1	1	01/05/2022 00:41	KING	01/05/2022 00:42	KING
Health professionals getting it right	1	1	01/05/2022 12:23	KING	01/05/2022 12:23	KING
Health professionals interacting with parents of TGD	1	1	01/05/2022 00:32	KING	01/05/2022 00:32	KING

Appendix 11: Initial themes

WHITE PEOPLE.POC, CIS.TRANS. HETERO.QUEER DIFFERENCES, DIS,ADVANTAGES
TRAUMA
TRANSITIONING
THINGS THAT HURT
THINGS SPECIFIC TO TGD POC
THE VIEWS OF OTHERS
SUPPORT AND ACCEPTANCE AND REPRESENTATION
SUGGESTIONS FOR HEALTHCARE PROFESSIONALS
SOCIAL BARRIERS
RELIGION
REFERRAL PROCESS
RACE
MISC
Mental health
LGBT IN OTHER COUNTRIES
LACKING
ILLEGAL HORMONES
IDENTITY - SELF
HEALTHCARE
GENDER
FAMILY AND COMMUNITY AND CULTURAL FEELINGS ABOUT GENDER, QUEERNESS AND SEXUALITY
DISCRIMINATION IN HEALTHCARE
BEING TRANS

Appendix 12: Reflexive journal

Reflexive journal

Interviews:

Worried I'm going to say the wrong thing

Present the evidence of your thinking and make sure it is your own/just one interpretation – thinking of this re "my parents are supportive"

Data analysis:

Read through once first just to re-familiarise myself

Constantly going back to the transcripts

When all the codes were themed, I went through and checked that the codes were not better off in a different theme

Had a theme of 'lacking' but integrated it into the other themes – this would give them a more rounded perspective in terms of addressing the negative dimensions of a theme

Also got rid of initial theme: THINGS SPECIFIC TO TGD POC – that is the participant group so all are negative so ok to break them down

Also moved things out on one theme into a different one e.g. 'Good healthcare treatment even more important for children' was in healthcare, but got moved to suggestions for healthcare providers (among others)

Took on board B&C's advice to let things/themes go at every stage.

Concerned that I am not providing enough information about specifically POC trans – am I being avoidant?

Struggled particularly with family/culture/community – left it until last – worried I won't do it justice

Struggled that I coded lots of the same things with different codes – but at the end it started to be ok especially when I could break down coded data more subtly/smaller chunks

Going back to the transcripts even at very late stages

Moved being trans into a theme, then back out – really hard to know what's best – then put back in again!!

Is 9 too many themes – but then surely that's quite subjective given the method?

May have been unhelpful to code different things with multiple codes. Now getting a bit lost and lots of things have already been used.

8 themes – then into 3

Appendix 13: Ethics form

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

(Updated October 2019)

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

1. Completing the application

1.1 Before completing this application please familiarise yourself with the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics (2015-16). Please tick to confirm that you have read and understood these codes: ☑

1.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

1.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. By submitting the application, the supervisor is confirming that they have reviewed all parts of this application, and consider it of sufficient quality for submission to the SREC committee for review. It is the responsibility of students to check that the supervisor has checked the application and sent it for review.

1.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (see section 8).

1.5 Please tick to confirm that the following appendices have been completed. Note: templates for these are included at the end of the form.

- The participant invitation letter ☑
- The participant consent form ☑
- The participant debrief letter ☑

1.6 The following attachments should be included if appropriate. In each case, please tick to either confirm that you have included the relevant attachment, or confirm that it is not required for this application.

- A participant advert, i.e., any text (e.g., email) or document (e.g., poster) designed to recruit potential participants.

Included ☑ or

Not required (because no participation adverts will be u☐)

- A general risk assessment form for research conducted off campus (see section 6).

  Included ☑ or

  Not required (because the research takes place solely on campus or online) ☐

- A country-specific risk assessment form for research conducted abroad (see section 6).

  Included ☐ or

  Not required (because the researcher will be based solely in the UK) ☑

- A Disclosure and Barring Service (DBS) certificate (see section 7).

  Included ☐ or

  Not required (because the research does not involve children aged 16 or under or vulnerable adults) ☑

- Ethical clearance or permission from an external organisation (see section 8).

  Included ☐ or

  Not required (because no external organisations are involved in the research) ☑

- Original and/or pre-existing questionnaire(s) and test(s) you intend to use.

  Included ☐ or

☑

Not required (because you are not using pre-existing questionnaires or tests)

- Interview questions for qualitative studies.

  Included ☑ or

  Not required (because you are not conducting qualitative interviews) ☐

- Visual material(s) you intend showing participants.

  Included ☐ or

  Not required (because you are not using any visual materials) ☑

2. Your details

2.1 Your name: Danielle King

2.2 Your supervisor's name: Paula Corredor-Lopez

2.3 Title of your programme: Clinical Psychology Doctorate

2.4 UEL assignment submission date (stating both the initial date and the resit date): 5th November 2020

3. Your research

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and details of your proposed research.

3.1 The title of your study: Looking at barriers to UK gender services for young people in racialised minority groups

3.2 Your research question:

- **What are the barriers for young people from racialized minority groups to accessing UK gender services**

3.3 Design of the research:

The study will use the qualitative methodology of Thematic Analysis.

3.4 Participants:

The research participants for this project will be young people aged 16-25 who identify as being in a racialized minority group and also as non-cis (i.e. trans, genderfluid etc).

3.5 Recruitment:

Recruitment will be through social media relating to trans youth, and charities supporting trans young people.

3.6 Measures, materials or equipment:

A schedule of potential questions / topics for discussion is attached.

3.7 Data collection:

Data will be gathered using semi-structured interviews.

3.8 Data analysis:

Thematic Analysis will be used to analyse the data.

4. Confidentiality and security

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

4.1 Will participants data be gathered anonymously?

No – see below.

4.2 If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?

Identifying references to participants will be removed from any material used in the write-up of the study. Participants' contributions will be reported using a pseudonym.

4.3 How will you ensure participants details will be kept confidential?

All identifying details will be anonymised. All participant information will be stored securely.

4.4 How will the data be securely stored?

Names and contact details for participants will be stored on UEL OneDrive, as will consent forms that will have been completed electronically. All contact will be carried out from the researcher's UEL email account.

4.5 Who will have access to the data?

The researcher, their supervisor, and examiners who may help code anonymised data.

4.6 How long will data be retained for?

Data may be stored for the time it takes to publish the study in an academic journal, but deleted after this point. Data will be deleted within 5 years of the end of the study. Video and audio-recordings will be transcribed and deleted after the end of the study but transcripts will be retained as above.

5. Informing participants

Please confirm that your information letter includes the following details:

5.1 Your research title: ☑

☑

5.2 Your research question:

☑

5.3 The purpose of the research:

5.4 The exact nature of their participation. This includes location, duration, and the tasks etc ☑ olved:

☑

5.5 That participation is strictly voluntary:

☑

5.6 What are the potential risks to taking part:

☑

5.7 What are the potential advantages to taking part:

5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questio ☑ sked):

5.9 Their right to withdraw data (usually within a three-week window from the time of their partici ☑ n):

5.10 How long their data will be retained fo ☑

☑

5.11 How their information will be kept confidential:

☑

5.12 How their data will be securely stored:

☑

5.13 What will happen to the results/analysis:

☑

5.14 Your UEL contact details:

☑

5.15 The UEL contact details of your supervisor:

Please also confirm whether:

5.16 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature.

No

5.17 Will the data be gathered anonymously? If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

No – see section 4.2 above.

5.18 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth?

Yes – £10 voucher per participant as it is ethical to pay those partaking in research.

6. Risk Assessment

Please note: If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as *possible. If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.*

6.1 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?

Participants could potentially find topics raised psychologically distressing. Information about freely available support for mental wellbeing will be provided (see attached).

6.2 Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised?

Potentially psychological distress from hearing trauma from others – this will be discussed with the thesis supervisor.

6.3 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant?

Yes; see attached for full details. These are freely available services for either general mental distress, or for LGBT people of colour specifically. It may be difficult for young people to talk about their experiences of discrimination.

6.4 Does the research take place outside the UEL campus? If so, where?

If so, a 'general risk assessment form' must be completed. This is included below as appendix G. Note: if the research is on campus, or is online only

☑

(e.g., a Qualtrix survey), then a risk assessment form is not needed, and this appendix can be deleted. If a general risk assessment form is required for this research, please tick to confirm that this has been completed:

6.5 Does the research take place outside the UK? If so, where?

If so, in addition to the ‘general risk assessment form’, a ‘country-specific risk assessment form’ must be also completed (available in the Ethics folder in the Psychology Noticeboard), and included as an appendix. [Please note: a country-specific risk assessment form is not needed if the research is online only (e.g., a Qualtrix survey), regardless of the location of the researc☐r the participants.] If a ‘country-specific risk assessment form’ *is* needed, please tick to confirm that this has been included:

However, please also note:

- For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on ‘sign in’ and then ‘register here’ using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.
- For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be

signed by the Head of School (who may escalate it up to the Vice Chancellor).

- For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by the Head of School. However, if not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).
- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

7. Disclosure and Barring Service (DBS) certificates

7.1 Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?

NO

7.2 If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm
that you have included this: ☐

Alternatively, if necessary for reasons of confidentiality, you may email a copy directly to the Chair of the School Research Ethics Committee. Please tick if you have done this instead: ☐

Also alternatively, if you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice. Please tick if you have included this instead: ☐

7.3 If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for their parent/guardian). Please tick to confirm that you have included these: ☐

7.4 If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language. Please tick to confirm that you have done this ☐

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

8. Other permissions

9. Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives or carers as well as those in receipt of services provided under contract to the NHS.

NO If yes, please note:

- You DO NOT need to apply to the School of Psychology for ethical clearance if ethical approval is sought via HRA/IRAS (please see further details here).
- However, the school *strongly discourages* BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
- If you work for an NHS Trust and plan to recruit colleagues from the Trust, permission from an appropriate manager at the Trust must be sought, and HRA approval will probably be needed (and hence is likewise strongly discouraged). If the manager happens to not require HRA approval, their written letter of approval must be included as an appendix.
- IRAS approval is not required for NHS staff even if they are recruited via the NHS (UEL ethical approval is acceptable). However, an application will still need to be submitted to the HRA in order to obtain R&D approval. This is in addition to a separate approval via the R&D department of the NHS Trust involved in the research.
- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA

approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

9.1 Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?

NO

9.2 If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?

YES / NO

9.3 Does the research involve other organisations (e.g. a school, charity, workplace, local authority, care home etc.)? If so, please give their details here.

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If th☐s the case, please tick here to confirm that you have included this written permission as an appendix:

In addition, before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as ‘my’ or ‘I’ with ‘our organisation,’ or with the title of the organisation. This organisational consent form must be signed before the research can commence.

Finally, please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

9. Declarations

Declaration by student: I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name (typed name acts as a signature): Danielle King

Student's number: U1945478 Date: 30/11/2021

As a supervisor, by submitting this application, I confirm that I have reviewed all parts of this application, and I consider it of sufficient quality for submission to the SREC committee

Appendix 14: Risk assessment form

UEL Risk Assessment Form

Name of Assessor:	**Danielle King**	**Date of Assessment**	**28/11/2021**
Activity title:	**Doctoral research**	**Location of activity:**	**UEL**
Signed off by Manager (Print Name)		**Date and time (if applicable)**	**28/11/2021**

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc)

If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

Research interview as part of doctoral research. 12 participants. Discussing barriers to gender services in the UK for racialised minority youths.
Overview of FIELD TRIP or EVENT:

Guide to risk ratings:

a) Likelihood of Risk	**b) Hazard Severity**	**c) Risk Rating (a x b = c)**
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity							
Hazards identified	**Who is at risk?**	**Existing Controls**	**Likelihood**	**Severity**	**Residual Risk Rating** **(Likelihood x Severity)**	**Additional control measures required (if any)**	**Final risk rating**
Emotional distress	Participant	Signposting to external services, participant to be informed that they can have	2	2	4		4
Emotional distress	Researcher	Discussion with supervisor, reflecting on distress within reflective aspect of written thesis, signposting participants to services	1	1	1		1

Review Date

A comprehensive guide to risk assessments and health and safety in general can be found in UEL’s Health & Safety handbook at http://www.uel.ac.uk/hrservices/hs/handbook/ and a comprehensive guide to risk assessment is available on the Health & Safety Executive’s web site at http://www.hse.gov.uk/risk/casestudies/index.htm. An example risk assessment is also included below.