“Why would they listen to you? You're just a crazy trans person”.

UNDERSTANDING THE EXPERIENCES OF THE TRANS COMMUNITY WHEN ACCESSING NHS MENTAL HEALTH SERVICES: A THEMATIC ANALYSIS

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A third, with love.

ABSTRACT

Background: There are significant health inequalities for the trans community in the UK, resulting in worse access, experiences and outcomes compared to their cis peers when accessing mental health services. With the current anti-trans rhetoric in the UK media, the mental health of trans people is further negatively impacted, with an increased risk of difficulties including depression, anxiety, and suicidal ideation. There is little research exploring the experiences of trans people when accessing support for their mental health, and no research specifically exploring experiences within NHS services.

Aims: To understand the experiences of trans people accessing NHS mental health services, with consideration of what happened, how this was understood, and how it was navigated.

Methods: Taking a critical realist stance, this research utilised a qualitative methodology. Eight white British participants aged 21-32, who identified as trans and had accessed NHS mental health services, engaged in semi-structured interviews. The transcripts of these interviews were analysed using reflexive thematic analysis.

Results: Four superordinate and four subordinate themes were generated. Participants approached services with low expectations, based on personal, professional, and shared community experiences. They shared positive, gender-affirming and negative, harmful experiences. They made sense of their experiences by considering systemic issues within the NHS, such as lack of training, knowledge, and resources. Also, the stage of their own journey and how they present to others, acknowledging the importance of ‘passing’. The participants coped with their experiences largely through self-advocacy before, during and after their appointments.

Conclusions: The study is limited by a relatively small sample, all white British and aged under 35, but the implications for clinical practice, training and policy within the NHS are still significant. Most notably the need for increased awareness, training and knowledge within the NHS.

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LIST OF ABBREVIATIONS

ADHD	Attention Deficit Hyperactivity Disorder
BPS	British Psychological Society
Cis	Cisgender
Cis/Het	Cisgender and heterosexual
DSM	Diagnostic and Statistical Manual of Mental Disorders
DoS	Director of Studies
EDI	Equality, Diversity, and Inclusion
ESR	Electronic Staff Record
GRA	Gender Recognition Act
GRC	Gender Recognition Certificate
GIRES	Gender Identity Research & Education Society
ICD	International Classification of Disease
IPA	Interpretative Phenomenological Analysis
LGBTQ+	Lesbian, Gay, Bi, Trans, Queer, Plus
MH	Mental Health
MHP	Mental Health Practitioner
NHS	National Health Service
PIS	Participant Information Sheet
RTA	Reflexive Thematic Analysis
TA	Thematic Analysis
Trans	Umbrella term for anyone non-cis
UEL	University of East London
VCAG	Visual Conformity with Affirmed Gender

1. INTRODUCTION

1.1 Chapter Overview

This chapter outlines both the current and historical context within which the current research is situated. It initially discusses the terminology used before considering the current UK climate for the trans community, including an exploration of legislation, rights, relevant media coverage and the impact of mental health difficulties. Next, a consideration of the current NHS context, how mental health services are funded, structured, and what training is provided for clinical staff relating to LGBTQ+ needs. Findings from a scoping review then explore relevant research papers in detail and outline the gaps in literature which allow the current research to contribute originality. Finally, the aims and clinical relevance of the current research are outlined, before explicitly defining the research questions.

1.2 Terminology

1.2.1 Trans and Cis

'Trans' will be used as an umbrella term to include any person whose gender identity is not the same as the sex they were assigned at birth. This will be inclusive of, but not limited to "...transgender, gender-queer, gender-fluid, non-binary, gender-variant, genderless, agender, nongender, third gender, bi-gender, trans man, trans woman, trans masculine, trans feminine and neutrois" (Stonewall, 2020). 'Cis' will be used to describe anyone whose gender identity is the same as the sex they were assigned at birth. As opposed to the full form of transgender and cisgender, the shortened, prefix only terms will be used.
This is in line with current NHS language and terminology, where trans is also used as an umbrella term (NHS, 2021).

1.2.2 NHS Therapist

‘NHS therapist’ will be used to describe any role within an NHS mental health service where a professional may have assessed or offered an intervention to a person accessing the service. In many services, this will include the psychological professions, inclusive of clinical or counselling psychologists, psychotherapists, CBT therapists, art therapists, or systemic therapists (NHS, 2017). In line with the NHS Long Term Plan, this will also include ‘mental health practitioner’ (MHP) roles comprising of nurses, occupational therapists, and social workers (NHS England, 2019). MHPs were introduced to provide community support alongside specialist mental health services and NHS Talking Therapies. As of 2023, 62% of primary care networks have a MHP in post so it felt prudent to include these roles given they may be providing the first point of contact within services for many people (NHS England, 2023b).

1.3 Trans Rights in the UK – The Current Picture

There is a general lack of marginalised voices in research (Pratt, 2019), and particularly a poor representation of and access to research undertaken by and for trans people (Marshall et al., 2019). Owing to this and the researcher’s position as an ally, the ‘current picture’ for the trans community in the UK was viewed, researched and understood from information and knowledge presented in media and news articles. Given the lack of empirical research, these form a large part of the researcher’s sociocultural experience and understanding as an ally, and equally this position likely determines the media stances observed by the researcher.

It is impossible to say accurately how many trans people live in the UK in 2024. The 2021 census reports that 262,000 (0.5% of the population over 16) reported their gender identity to be different than the sex they were assigned at birth (Office for National Statistics: Census 2021, 2023). Trans people are a marginalised community within the UK, and trans rights have been the subject of significant public discourse and policy changes in recent years. Public awareness, education, and advocacy are essential in the continued pursuit of acceptance and equality for trans people.

On the surface, progress seems to have been made in some areas. The UK has several prominent public figures from the trans community breaking through into ‘mainstream’ media. These include but are certainly not limited to Travis Alabanza (The Independent, 2022), India Willoughby (Sanderson, 2023), Katie Neeves (Dawson, 2023) and Fox Fisher (Diversity Power List, 2023). However, Amnesty International published their findings that the UK is in fact “back sliding” on trans rights. Under the current conservative government, the rhetoric has become “toxic” and risks breaching human rights conventions (Madrigal-Borloz, 2023).

1.3.1 Gender Recognition Act

Legal protection for trans people in the UK is confusing and unclear. The Gender Recognition Act (GRA) (2004) requires trans people to apply for a Gender Recognition Certificate (GRC) to ‘legally’ change their gender and be recognised as their ‘acquired gender’ (Fairbairn et al., 2021). The process for obtaining a GRC is lengthy and bureaucratic. It requires two medical reports, the first from either a doctor or clinical psychologist specialising in ‘gender dysphoria’. This must outline a diagnosis of gender dysphoria based on clinical history. The second report must be from a different doctor or clinical psychologist, who does not need to be a specialist. One or both reports must explain any gender affirmation treatment undertaken or planned, or the justification for no treatment (HM Government, 2012). The application must also include evidence of a person ‘living as their acquired gender’ for at least two years, showing change of name, pronouns, and gender markers. Obtaining a GRC is not required to update passports, driving licenses or medical records, but is needed to update birth certificates and be registered in death as your affirmed gender. Having a GRC does not change legal status as a parent (i.e. from father to mother) and a person can only be recognised as male or female, with no legal recognition of non-binary identities (HM Government, 2012).

Since 2018 there have been several government consultations and debates about reforming the GRA. In 2021, over 137,000 people signed a petition for the government to consider reforming the GRA (Petitions, 2022b). Alongside this, the Women and Equalities Committee published a report calling for reform of the GRA, outlining clear steps the government could take to progress trans inclusion

(House of Commons, 2021). One significant proposed change was for individuals to be legally able to self-identify their gender without the need for the above process. This would bring the UK more in line with the 11 European (over 30 worldwide) countries including Ireland, Portugal and Spain who have adopted these methods. This was debated in parliament in February 2022 and was denied (Fairbairn et al., 2021), with the government maintaining their response from 2020:

> *We want transgender people to be free to live and to prosper in modern Britain. We have looked carefully at the issues raised in the consultation, including potential changes to the Gender Recognition Act 2004. It is the Government's view that the balance struck in this legislation is correct.*

(Petitions, 2022b)

1.3.2 Equality Act

The Equality Act (2010) protects individuals from discrimination based on gender reassignment without the need to have undergone any surgery or medical treatment to be recognised as their affirmed gender. That being said, the definition within the act uses language such as 'transsexual' and 'reassigning', which are outdated terminologies and largely considered to be offensive in contemporary society (Clements, 2018; Stonewall, 2020). The Equalities and Human Rights Commission (2023) have updated their guidance on discrimination to remove the outdated language.

There has been significant attention given to proposed revisions of The Equality Act, as the government published a 'plan for action' for trans equality to follow the act in 2011, with no tangible updates since (HM Government, 2011).
The suggested revisions include language changes from 'gender reassignment' and 'transsexual' to trans as an umbrella term (House of Commons, 2016; Valentine, 2015) and the inclusion of gender identity as a protected characteristic (Petitions, 2020). Feast and Hand (2015), among others, called for the protection of non-binary identities, as they are not legally recognised in the UK. There has since been legal confirmation that non-binary identities are protected from

discrimination by The Equality Act (Fairbairn et al., 2022). More controversially, gender critical and anti-trans beliefs also have full protection under the act, and people cannot be discriminated against for holding these views (Brione, 2022).

1.3.3 Cass Review

The Cass Review (2024) is a recently published, lengthy report about gender services in the UK for children and young people. The report suggests a move away from gender-affirming care, including recommendations to stop access to medical treatment such as puberty blockers through the NHS. Recommendations for regional ‘hubs’ which focus on psychological treatment as would be offered for ‘other developmental struggles’ coincided with the 2024 closure of the London-based Tavistock gender clinic for young people. Several trans organisations released immediate responses to the review, noting it to be flawed, inaccurate, harmful, and transphobic (Mung, 2024; Trans Actual, 2024). These views are substantiated by a thematic analysis of the review, published in The International Journal of Transgender Health which identified four themes: prejudice, cisnormative bias, pathologisation, and inconsistent standards of evidence (Horton, 2024).

1.3.4 Access to Services

Following from The Cass Review, and with context that a similar review is being commissioned for adult gender services, another area of concern for trans people in the UK is access to healthcare.

Wait times for gender clinics are long, and people can expect to wait many years even for an initial assessment appointment. Most gender clinics make this information public and, at the time of writing, the wait time for The Tavistock (London) was approximately five and a half years, only slightly shorter than the Northern Region Gender Dysphoria Service (NRGDS) (Cumbria, Northumberland, Tyne and Wear NHS, 2024; The Tavistock and Portman NHS Foundation Trust, 2024). These long wait times have been shown to have a detrimental impact on the mental health of trans people, increasing suicidality, low mood and decreasing quality of life (Henderson et al., 2022). Owing to this, almost half of trans people who want to pursue some form of gender-based medical intervention have been put off by the long wait times (Stonewall, 2018b).

Trans people experience significant health inequalities in the UK across all healthcare services, meaning they have worse access, experience and outcomes as compared to their cis peers (Fish et al., 2021). These inequalities are due to services being generally heteronormative and the experiences of discrimination and transphobia, which are further compounded by stigma and the experiences of minority stress (Zeeman et al., 2018).

Trans people also face significant barriers when accessing mental health services. Although conducted in the US, a systematic review outlined fear of discrimination and expectation of incompetence from professionals as the main barriers (Snow et al., 2019). There is little empirical research into these barriers in the UK, and this is thought to be due to the efforts to ‘depoliticise’ the narrative; framing the UK as progressive in its LGBTQ+ healthcare policy, whilst being unwilling to acknowledge the discriminatory systems in which healthcare services operate (McDermott et al., 2021). McNeil et al. (2012) reported in a large national survey that, when accessing mental health services, 63% of trans people reported discrimination. Almost one third of people felt their gender identity was pathologised or conflated with their mental health difficulty, and some people reported concealing their true gender identity or avoiding services completely because of this. In 2018, the National LGBT survey concluded that 38% of over 108,000 respondents had a negative experience when accessing public, NHS healthcare services due to their gender identity (Government Equalities Office, 2018b).

1.3.5 Anti-Trans Rhetoric

In the UK media, there are widely publicised ongoing debates around trans rights in schools, workplaces, and other public spaces. Issues such as bathroom access, sports participation, and inclusion policies have sparked controversy and raised questions (Montiel-McCann, 2022). At the time of writing, the opposition to many of these inclusion practices and policies have been fronted by prominent public figures such as J.K. Rowling (Muir, 2023), Sharon Davies (BBC, 2019) and

Kemi Badenoch, the conservative Minister for Women and Equalities (Brown, 2023).

Many of these arguments and opinions have been imported from the USA, where they are experiencing what many call a ‘culture war’, not only for trans people but also people of colour, and other marginalised communities (Alfonseca, 2023; Jacoby, 2014). With an increase in the views of TERFs (trans-exclusionary radical feminists) and attempts to legislate trans peoples’ movements through ‘bathroom bills’ (Cox et al., 2021), the climate in the USA has created a ”...toxic discourse” in the UK where it “...has become entirely reasonable to question the extent to which trans people should be allowed into the public spaces” (McLean, 2021, p, 473-474).

These views are exacerbated by media reporting of trans-related stories and news pieces. Following the Leveson Enquiry in 2012, freedom of speech was protected in the media, but discriminatory reporting was not permitted. However, the UK media are still seen to ‘other’ and dehumanise trans people in nationally and internationally circulated articles (Akrivos, 2022). This was evidenced through reporting of the 2023 murder of 16-year-old Brianna Ghey in Warrington. Several articles were published by UK media outlets which misgendered Brianna and referenced her deadname (Kelleher, 2023). Deadnaming is to call someone by the name they were given at birth (Stonewall, 2020). There are also extensive media attacks on leading trans charities such as Mermaids, with allegations of safeguarding concerns in Autumn of 2022 leading to a temporary suspension of the service due to abuse received by staff (Bailey & Mackenzie, 2023). The leading LGBTQ+ charity in the UK, Stonewall, has also faced significant media attention claiming they over-focus on trans inclusion. Between 2020 and 2022 The Times published 178 articles about Stonewall, 47 of which suggested their advocacy for trans rights was detrimental to UK society and the rights of LGB and cis people (Gwenffrewi, 2021).

1.3.6 Public Opinion

In stark contrast to the anti-trans discourse seen in the UK and throughout the media, public opinion is generally very supportive of trans people. Almost 150,000 people signed a petition in 2022 to ensure trans people are specifically

and fully protected under any incoming bans of conversion therapy (Petitions, 2022a). Stonewall (2022b) found that the British public in fact have positive views about the trans community. The key findings of this report include:
no evidence of trans people being viewed as a ‘big issue’ facing the country; 24% of British people personally know a trans person, which increases to almost half of 18–24-year-olds; 31% feel ‘respect’ for trans people and 21% feel ‘admiration’; and people report being four times less likely to feel negatively towards trans people than positively.

It is of note that the original YouGov survey (2022) found more negative views on aspects of trans rights which could impact individuals. These included access to changing rooms, representation in sport, and access to NHS-provided surgery and hormones. These findings are set in the context that 65% of respondents said they paid little to no attention to the ongoing debates and discourses around trans rights (Smith, 2022).

1.3.7 Mental Health

Owing to the current landscape in the UK, trans people have been shown to be at significant risk of mental health (MH) difficulties. The Trans Mental Health Study (McNeil, et al., 2012) collected data from 889 trans people and reported 55% had experienced depression, 38% anxiety, and 27% stress. Stonewall (2018a) replicated these results and found that the LGBTQ+ community are generally at a higher risk of mental health difficulties, but this is increased for the trans community.

These mental health difficulties are not only more prevalent in the trans community, but are also more chronic (Watkinson et al., 2024). They were shown to have worsened during the Covid-19 pandemic (Kneale & Bécares, 2021; McGowan et al., 2021), with the lack of social support and access to gender-affirming service provision thought to have contributed significantly to this (Jones et al., 2021; Toze et al. 2021).

1.3.8 Transphobia and Power

When considering theories and ideologies which underpin transphobia and directly impact on the lives of trans people in the UK it is important not to define, overly explain or “justify the unjustifiable” (Cantle, 2005, p. 91).

There are however wider contexts and structures which contribute to these experiences. Much of this power and inequality can be understood by considering the UK as a society which preferences and prioritises white, heteronormative and cisnormative, binary male identities, among others (Bridges et al., 2023). Queer theorists highlight the ‘importance’ and ‘benefits’ of heteronormativity, a social structure which works to “...normalise, naturalise, support and privilege heterosexuality” (ALiGN, 2017). Butler (1990) stated the importance of separating sex, sexuality, and gender to fully understand power in relation to the dominant narratives marginalising the LGBTQ+ community. Hegemonic principles, namely the acceptance of and submission to dominant behaviours, physical structures and institutional systems uphold and exacerbate the transphobic landscape within the UK (Mocarski, 2019). Trans people are particularly impacted by hegemony of cis and heteronormative ideas and structures which aim to fulfil social reproductive roles, in that they do not ‘comply’ to binary ideas of gender and normative ideas of reproduction and ‘family’ which are seen to benefit political and economic structures (Nguyen, 2021).

1.4 NHS Mental Health Services – The Current Picture

NHS adult mental health services support adults aged 18 and over with any aspect of their mental health.

Historically, these services have been divided into three tiers: primary, secondary, and tertiary. Primary care is for mild to moderate difficulties and is considered the first point of care. This includes GP services, social prescribers, and NHS talking therapies. Secondary care is for more severe difficulties but that can be managed and supported by general services within hospitals and in the community. This includes community mental health teams (CMHTs) and inpatient care, either voluntary or via Mental Health Act (MHA) detention. Tertiary care is specialist mental health care, although usually delivered in secure units, this can involve community care from assertive outreach or crisis services (Garratt, 2023; Rethink Mental Illness, 2023).

Since 2021, these services are undergoing transformation according to the NHS Long Term Plan (NHS England, 2019). This will form new Integrated Care Partnership services between the NHS, local authorities, voluntary and social enterprise sector to integrate care between hospitals and GPs and mental and physical health care.

1.5 NHS Training Provision for Clinical Staff

Following the 2018 National LGBT survey, the government produced the LGBT Action Plan (Government Equalities Office, 2018a). From this, the NHS developed four areas of priority to advance the rights of LGBTQ+ people accessing NHS services. This included the development of training packages to "...improve healthcare professionals' awareness and understanding of LGBT communities, across all professions, to improve experience for LGBT patients" (NHS England, 2018). There is no definitive list available in the public domain which details the mandatory training for staff working in the NHS, and there are slightly different requirements for each profession. Having worked in the NHS for almost 10 years, the researcher is aware there is no mandatory training regarding LGBTQ+ awareness. Typically, minimal information is provided in the mandatory equality, diversity, and inclusion (EDI) e-learning, and this is combined with scenarios and legality regarding all protected characteristics.

At the time of writing, there is little structured guidance for offering gender-affirming mental health care or therapy in the UK. Although all professional and regulatory bodies have issued some guidance, a lot of this is outdated. Trans Actual have collated guidance from the NHS, regulatory bodies and professional associations relating to trans-inclusive healthcare. The psychological and therapy professions guidance, including those identified as therapists in this research, feature on the list. The most recent guidance from the Royal College of Nursing (RCN) in 2020, with other professional guidance from between 2016-2019 (Trans Actual, 2023).

The British Psychological Society (BPS; 2019) has issued guidelines for psychologists supporting gender diversity. This is a relatively short, 20-page document which also contains guidance relating to relationship and sexual diversity. The guidance mainly focuses on appreciation, recognition and knowledge that psychological professions *should* utilise, with less than half a page contextualising or further explaining the social, political and health inequalities faced by trans people. It advises psychological professionals to use ‘language which is inclusive of diversity’ and use the ‘preferred language’ of the person they are supporting. Professionals are encouraged to be responsible for their own knowledge and learning, to engage with literature outside of the ‘medical’ domain and reflect on their own limits. This guidance is currently undergoing a scheduled interim review, which will be completed by the original authors of the document.

1.6 Scoping Literature Review

This section will outline the scoping literature review which was undertaken as part of the research. This approach was chosen as scoping reviews are widely used within health and social science research, mapping existing literature onto emerging topics and identifying gaps to inform future research aims (Mak & Thomas, 2022; Pollock et al., 2021). The strategy employed will follow that of the Joanna Briggs Institute (JBI; Peters et al., 2020) and use a Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow chart (PRISMA; Moher et al., 2010). This draws on the original scoping review methodology by Arksey and O’Malley (2005) with suggested enhancements by both Levac et al. (2010) and Daudt et al. (2013). The method involves the following stages: identifying the research question; identifying all relevant studies; selecting studies using inclusion/exclusion criteria; charting the data; and reporting a summary of the results.

An initial search was conducted in 2022, in the early stages of research development, alongside identifying the research question and aims. This highlighted some relevant papers; their titles and abstracts were then analysed further to develop more formal search terms. The original terms were “trans”, “mental health”, “experience” and “United Kingdom”, and the development process of the search terms can be seen in appendix A. The final search terms, including Boolean operators, were “Mental Health Services” AND (“Trans” OR “Transgender” OR “Non-Binary” OR “Gender Diverse” OR “Genderqueer” OR “TGNC”) AND (“Experience” OR “View” OR “Perception”)

The full scoping review was conducted at the end of 2023. First, all relevant papers were identified by using the search terms in the following databases: SCOPUS, PubMed, ScienceDirect, EBSCO Academic Search Complete, APA PsycInfo, APA PsycArticles, and CINAHL Complete. These searches covered article titles and abstracts, but key words and/or index terms were removed. Early searches showed that many papers had ‘tagged’ the search terms but were unrelated to the research topic.

This initial search identified 385 records from across the databases. Grey literature was identified by reviewing the reference lists of relevant articles, and by searching using open-source platforms such as Google Scholar, five further records were identified. The results were then compiled, filtered and duplicates removed, leaving 199 papers. These were screened from titles and 154 papers were removed as they were not relevant to the current research, as some databases had included any and all research relating to all aspects of trans health and experiences.

Forty-five records were identified for further screening, which involved briefly reading the abstracts whilst considering the inclusion and exclusion criteria. Firstly, any papers not available in English were removed. Secondly, in terms of inclusion criteria, only qualitative studies were included as this aligned with the methodology of the current research. Thirdly, and again to align with the current research, only papers which considered experiences of adults who were aged over 18 and identified as trans were included. Finally, the experiences had to be within mental health services, as opposed to general healthcare or relating to mental health outcomes. Twelve studies remained, which were eligible for a full text review.

A review paper by White and Fontenot (2019) was hand searched in detail. This study reviewed seven previous studies relating to the experience of trans people accessing mental health services. Three were immediately excluded as they used quantitative methods and one other was a duplicate already found (Benson, 2013). Two further studies were excluded as their focus was too narrow, one focusing on older trans people aged 60-83 (Elder, 2016) and another only on substance misuse counselling (Lyons et al., 2015). The final study was included as it had not been found in the scoping review (McCullough et al., 2017). After being hand searched, the review paper itself was excluded.

Six further studies were excluded from the original 12, as their focus was either too broad, focusing on the whole LGBTQ+ community or too narrow, focusing on intersectional identities or treatment within gender identity clinics.

The full strategy for the scoping review and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow chart (PRISMA; Moher et al., 2010) can be seen in Appendices B and C respectively.

1.6.1 Overview of selected papers

Six papers were identified from the scoping review to analyse and include in the current chapter, the oldest paper from 2013 and most recent from 2021.
All six papers considered the experiences of the trans community when accessing mental health services. The first two papers discussed are from the UK and Ireland, followed by a paper from Australia. These are three nations with universal healthcare so are somewhat comparable to each other. This is then followed by three papers from the USA, where there is no universal healthcare system. These were included as not only somewhat of a comparison to universal healthcare but also to ensure there was enough breadth of research to consider in developing the current research. A table summarising key details of each included paper can be seen in Appendix D.

1.6.1.1 Ellis et al. (2015): The first study drew on findings from The Trans Mental Health Study (McNeil et al., 2012) to focus in on specific results regarding the experiences of trans people accessing mental health services in the UK. Using online surveys, the original study collected results from 889 trans people, 621 of whom answered questions relating to mental health services which had not been accessed for gender affirming medical treatment. Of these, 396 had accessed mental health services provided by the NHS. The study utilised mixed methodology, mostly gathering quantitative data to provide descriptive statistics. Some qualitative data was collected alongside these questions and content analysis was used to analyse these results.

Trans people reported mixed experiences when accessing mental health services, with 62.8% reporting to be (very) satisfied, whilst 33.8% were (very) dissatisfied. It is of note that privately accessed services were viewed much more positively than those provided by the NHS, with the former being described as “the one magnificent exception” when compared with “unhelpful” NHS services (p.7).

Two main themes arose from the qualitative data. Firstly, participants felt that mental health professionals working for the NHS lacked knowledge and experience relating to trans issues and working with trans people. Secondly, the professionals’ perception of gender was an important contributory factor, especially for positive experiences. Participants wanted to be viewed and affirmed as their gender identity, and if professionals didn’t understand the importance of this, it often led to harmful and pathologising experiences. Almost 30% of the participants felt their gender identity was not affirmed but rather conflated with their mental health difficulties. It is of note that there is no qualitative data within this study where participants report this happening, only expressing fear and concern that this could, or would, happen to them. It was the most commonly reported worry for trans people accessing the services, with participants reporting concerns that professionals would place blame or ignore nuances, treating gender identity as “...a symptom or cause” (p. 7) of mental health difficulties.

Overall, this study generated relevant and useful implications for clinical practice. ‘Gender dysphoria’ still being a mental health ‘diagnosis’, leading to the over-medicalisation of gender identity. Participants felt their mental health difficulties would not be taken seriously, either being viewed as a symptom of them being trans, or the cause. Next, the need for training and knowledge-building for mental health professionals, particularly within the NHS. With these professionals often acting as ‘gatekeepers’ for access to formal gender services, a lack of understanding could determine a person's access to gender affirming treatment including hormones and surgery. Moreover, for trans people seeking mental health support for non-gender related issues, a lack of understanding could lead to inadequate, negative, and sometimes harmful experience. Participants in this study were clear that their role should not be to educate professionals from whom they are seeking support, but that this should be prior knowledge professionals bring with them.

Although the only relevant study from the UK, it is not without limitation. Drawing on one element of data from a larger report somewhat loses the wider context of the information provided. The original data was also collected over 10 years ago, in which time the landscape in the UK for the trans community has changed drastically, with a significant increase in (largely negative) media attention. The qualitative data provided is not particularly rich, and the quotes and experiences from participants are somewhat lost. The original report seemed more focused on presenting the impact of descriptive statistics.

Although the study included participants from a wide age range (18-78), they were 86% white British, with fewer than 7% being from a racially marginalised background. Although other demographic data was collected (disability, religion, carer status etc.) many participants did not complete this information, and the experience of intersectional oppression was not considered.

1.6.1.2 Delaney and McCann (2020): This study aimed to explore in depth the experiences of trans people when accessing mental health services in Ireland. They recruited four trans people aged 20-45 and completed semi-structured interviews, analysing the results using interpretative phenomenological analysis (IPA).

Three themes were generated from the data: affirmative experiences, non-affirmative experiences, and clinician relationship. Affirmative experiences occurred when professionals understood the trans experience, process of transition and barriers faced by trans people. All four participants had worked with affirming clinicians, describing feelings of "relief, safety and comfort" (p.70), with two participants noting that they specifically sought out clinicians with more understanding following negative experiences. Non-affirmative behaviours included inappropriate, misinformed, discriminatory, biased, or transphobic behaviours. Participants described experiences of being misgendered, deadnaming, and questioning of identity. Similarly to Ellis et al. (2015), there were also experiences of professionals conflating being trans with having mental health difficulties. Finally, the relationship and rapport developed between person and professional was highlighted by all participants. Positive relationships included "...feelings of connection, trust and comfort" (p.71) whereas negative relationships did not feel genuine or supportive.

As the aim with qualitative data is not to produce generalisable results, but to produce rich data to understand experiences within a specific context (Polit & Beck, 2010). It is evident that the sample in this research is small with only four participants, however, this is above the minimum number for IPA (Creswell & Poth, 2018).

Demographic information was collected from the sample and, although there was some range of age and gender identity, the four participants were all highly educated and identified within the same sexuality spectrum. It is also of note that no data relating to ethnicity, religion or disability was collected, meaning the intersectional nature of these experiences cannot be understood.

The researchers suggested several implications for clinical practice within nursing as, although they focused on experiences with all mental health professionals, they reported that "narratives pertaining to nursing naturally came to the fore" (p. 69). These implications focus on development of practice, education and research for all healthcare staff working with trans people to improve experiences. They recommend mandatory modules to be included in nursing training, with future research focusing on the feasibility of this inclusion into curriculums. It is also recommended that this increase in training and knowledge acquisition is approached as a coproduced piece of work, drawing on current best practice guidance and including voices from the trans community. Implementation of these recommendations should support senior nursing managers, encouraging a top-down approach.

1.6.1.3 Lim et al. (2021): This study investigated a more specific area of mental health services in Australia: crisis helplines. These are widely used in Australia, forming an integral part of community service provision. They provide immediate support at any time of day, usually via telephone, to overcome geographic or access restrictions. Professionals are trained to deliver single contact interventions and/or to offer longer-term support via onward connection to emergency or traditional mental health services.

By completing an online written survey, 134 trans people shared their experience of crisis helplines, however, only 33% of respondents had utilised a crisis helpline service during a mental health crisis. The mean age of the participants was 26.5 and 81% were from a white background. The study used mixed methods, so similarly to Ellis et al. (2015) descriptive statistics were used to analyse quantitative data, and thematic analysis (TA) was utilised to analyse the qualitative data.

Of the 44 participants who had accessed services, there were mixed experiences. The level of satisfaction varied greatly, with similar numbers of people reporting being “very satisfied” (25%), as being “slightly” (21%) or “not at all satisfied” (16%). Interestingly, 23% of participants reported that clinicians’ familiarity with trans terminology was “good” and 44% reported acceptance of trans identities was either “good” or “excellent”. This is encouraging; however, most participants reported the professionals’ ability to provide specific, gender related support was “average”, “poor” or “terrible”.

Some of the positive experiences shared by participants were from LGBTQ+ specific helplines, which they had chosen because of assurances of acceptance and non-discriminatory services. When accessing these services, participants felt able and willing to disclose their trans identity which often led to more positive outcomes. They did not always feel able to disclose when accessing mainstream services but there were still some positive experiences, mostly feelings of acceptance. One participant shared that, although the professional’s knowledge was clearly lacking, they still accepted and affirmed his gender, and successfully supported him through his crisis.

The negative experiences were mostly described as instances of “casual cisgenderism”. Although not overtly hostile experiences of discrimination or transphobia, these more subtle assumptions and choices of language led to feelings of invalidation. There were also examples of seemingly more intentional behaviours, these “slights” (p. 678) or microaggressions were exacerbated by being in crisis, making them distressing. As 67% of the respondents had not accessed crisis helpline services, the researchers also investigated non-use. They found that the expectation of being discriminated against was the main barrier to making use of crisis helplines.

The results of this study were somewhat difficult to navigate, and the findings are only relevant to accessing crisis helplines which are usually via telephone. This removes a lot of relevant contexts from the experiences, such as visual gender conformity or ‘passing’, non-verbal cues and any knowledge of the professional’s identity. This did, however, provide a high response rate from disabled people (44%), voices which are not always present in healthcare research. The study also presented a clear implication for clinical practice. Although acceptance and affirmation are valued by trans people, and generally do make for positive experiences, these qualities do not substitute for specific competencies. As in previous studies, this highlights the need for trans-specific training programmes for professionals working in mental health services.

1.6.1.4 Goldberg et al. (2019): This USA study considered the experiences of trans students in higher education when accessing mental health services, with a specific lens on the “...types of interactions, dynamics and assumptions” (p. 63) experienced by non-binary trans students as compared with binary trans students. The results of a previous online survey completed by 506 trans students were used, with 430 completed qualitative answers analysed using TA. The participants had a mean age of 22 and 82% were from a white background.

As with the previous three studies, the results showed that trans people had a variety of both positive and negative experiences to report. Positive experiences were reported by approximately 17% of the participants and were closely linked to feeling affirmed and validated. These feelings were often the result of professionals using the correct name and pronouns and/or demonstrating knowledge of trans issues and identities. Professionals who elicited positive feelings were described as “accepting”, “well-educated”, “knowledgeable”, “helpful” and “supportive” (p. 80).

Negative experiences often involved the opposite, invalidating participants' identity by using the wrong name and/or pronouns and continued misgendering. As in both Ellis et al. (2015) and Delaney and McCann (2020), participants described negative experiences which involved professionals blaming mental health difficulties on a person's trans identity. In contrast to this, and not reported in previously mentioned studies, some participants felt that professionals did not address their trans identity at all, but rather avoided or ignored this as a reality, which was particularly observed with psychiatrists. A perceived lack of knowledge was also reported by most participants, and again a feeling that the professional wanted to be educated about trans issues by the person in front of them.

As with previous studies, the findings in this study highlighted a lack of training amongst mental health professionals. The differentiation between binary and non-binary trans people highlighted some more specific implications. Overall, non-binary trans people reported worse experiences, which suggests that most experiences were still rooted within binary ideas of gender. This means that professionals were more able to affirm and validate trans identities when they still conformed to binary ideas of male and female. The study was not specific to services on campus or via university programmes, but all participants were higher education students, which suggests a certain level of privilege and access to resources, especially within the American context where healthcare and higher education are privatised. This would not only impact on the types of services utilised, and professionals encountered, but also to the experiences they may encounter. Those not in higher education may have limited access to services, somewhat limiting the scope of the results as in previously mentioned studies.

1.6.1.5 Benson (2013): This is the oldest study presented from the scoping review but reported similar methodology and findings to those studies conducted more recently. The aim of this study was to identify and recognise experiences of trans people accessing therapy in the USA. There was an explicit focus on informing and improving clinical practice, to foster change in healthcare provision.

Six white and one Latinx trans persons aged 24-57 engaged with semi-structured interviews, the results of which were analysed using TA.

Three themes relevant to the experiences of accessing mental health services were generated from the data: problems in practice, therapist reputation and trans-affirming therapy. Problems in practice related to uneducated or ill-informed professionals. They spoke about the evident lack of training leading to worries about being stereotyped, misunderstood, and/or unsupported. Many participants felt professionals wanted to learn from trans people and, alongside financial concerns of accessing therapy, this led to worries of paying for therapy which would involve educating the professional. Owing to this, therapist reputation was important, most participants relied on the trans community and support groups to seek out "trans friendly" therapists. Being part of a wider community was useful for this but, within appointments, participants wanted to be seen as individuals. One participant said "...most counsellors that I am familiar with end up trying to fit a person into a profile rather than develop the profile around who the unique person is" (p.30). Accessing therapists who were well-informed, visible allies and actively engaged advocates led to the final theme: trans-affirming therapy. These therapists did not need to be educated, there was little worry about being discriminated against and they affirmed and celebrated participants' experiences with gender whilst supporting them with their mental health difficulties.

Again with a limited sample comprising largely white participants who were educated and employed, this study did present clinical implications for healthcare professionals particularly related to the need for training. Due to the positive experiences produced by accepting and affirming actions, the researchers expressed the need for training in these areas, and guidance on how to become a gender- or trans-affirming therapist. Alongside this, they recommended that professionals need to understand the importance of experience when working with trans people. Participants did not want to be seen as a nameless, faceless representative of the community who could act as educators, but rather as an individual accessing therapy like anyone else.

1.6.1.6 McCullogh et al. (2017): The final study also conducted semi-structured interviews and recruited 13 trans people in America, consisting of the most diverse sample of the six studies identified for this scoping review. The participants were aged 21-54, and were white (4), black (4), multiracial (4) and Latinx (1). As with Delany and McCann (2020), IPA was used to analyse the data and understand the experiences to inform clinical practice.

The study generated three themes relevant to experiences, and closely linked to those in previously discussed papers. Firstly, all 13 participants in this study reported carefully selecting the professional they chose to see, as also reported by Benson (2013). This was largely based on the identity of the professional in terms of race, ethnicity, sexual orientation and lived experience of gender identity. Participants also described their selection processes, which involved disclosing their trans identity whilst 'interviewing' the professional, to gauge the reaction and pursue people who appeared more comfortable with this disclosure.

Secondly, trans-affirmative approaches, which as in previous studies (Goldberg et al., 2019) were described as validating. All 13 participants could identify experience of these, and two subthemes emerged: therapeutic alignment and advocacy. Therapeutic alignment refers to the actions of professionals which fostered feelings of connection, trust, openness, acceptance, and support. These feelings were increased when relationships exhibited understanding, empathy, care, and empowerment. Participants also appreciated the honesty of therapists in disclosing their knowledge of supporting the trans community. Advocacy referred to the support of professionals relating to trans rights, reducing systemic barriers, self-education and adopting a social justice approach.

Thirdly, and conversely, trans-negative approaches. These experiences occurred when professionals exhibited a lack of knowledge. Participants felt invalidated when this occurred, and when professionals did not use the correct pronouns, or entirely avoided acknowledgement of their trans identity. Owing to the diverse sample in this study, a subtheme emerged relating to the lack of knowledge professionals had around the intersection of trans and racial identities.

This study differed from others in that the experiences of racially marginalised trans people were included, generating stand-alone themes relating to their experiences. This has significant clinical implications, as it changes the scope of training that has been suggested previously and would be required. It is also of note that most of the participants identified with gender identities on or closely related to the masculine spectrum. Other research has shown that trans women face more discrimination than trans men (Rudin et al., 2021), therefore, this could have resulted in a positive skew of the experiences shared by the participants in the current study.

1.6.2 Summary of Papers

The studies from the scoping review provide useful and relevant insight into the currently available qualitative research regarding trans peoples' experiences of accessing mental health services.

All six studies presented a range of both positive and negative experiences. They all presented affirmation of gender and trans identities as the main component for ensuring a positive experience. Affirming actions included using the correct name and pronouns, knowledge of trans experience and issues, understanding the process of transition, and barriers faced by trans people. These experiences fostered feelings of validation and acceptance. Two studies also identified the importance of the rapport and relationship participants were able to build with the professional (Delaney & McCann, 2020; McCullogh et al., 2017). The actions of the professional to develop and maintain this relationship allowed feelings of trust, connection, and support. There were more positive and gender-affirming experiences included in all six research papers than anticipated by the researcher.

All six studies attributed negative experiences to a lack of knowledge, training, and misinformed assumptions. Participants shared that it was evident that professionals were under-educated when it came to supporting trans people with mental health difficulties. This resulted in non-affirming actions and behaviours exhibited by professionals leading to negative experiences. These were similar throughout all six studies and included being misgendered, being deadnamed, poor language choices, and trans identities being questioned or ignored. Ellis et al. (2015), Delaney and McCann (2020) and Goldberg et al. (2019) all evidenced that their participants had experienced non-affirming actions through their trans identity being conflated with their mental health difficulty as either a cause or a symptom. Interestingly, none of the six studies overtly named these actions as harmful or transphobic, they are instead referred to as “problems in practice” (Benson, 2013), “transnegative” (Goldberg et al., 2019; McCullogh et al., 2017) or “casual cisgenderism” (Lim et al., 2021). Considering all studies highlighted that experiencing these actions led to feelings of invalidation, and anticipation or fear of transphobia led to avoidance of services all together (Lim et al., 2021), it is pertinent that these discriminatory behaviours be named explicitly in future research.

Benson (2013) and McCullogh et al. (2017) were the only two studies where participants detailed a selection process for identifying and accessing trans affirming therapists to increase the likelihood of positive experiences. Lim et al. (2021) also reported participants selecting LGBTQ+ specific helplines. Both former studies were conducted in the USA where there is more scope for selection, owing to their insurance and payment-based healthcare service. In other countries, with universal healthcare systems, and particularly within the NHS in the UK, there is very little opportunity to be involved in selecting the professional one has access to.

The findings from these studies and the implications they present provide a useful foundation for understanding this field of research. However, only one study had been completed in the UK and only somewhat considered experiences of accessing the NHS (Ellis at al., 2015). This study was a deeper exploration of results from a large online survey conducted over 10 years ago (McNeil et al., 2012). There have been significant shifts in the UK picture of trans rights and healthcare since, as discussed in section 1.3. Although the sample was large, and the findings significant to trans healthcare, it does not feel that trans *voices* were centred in this study. The use of online data collection seems to focus more on the statistical data rather than understanding individual experiences.

1.7 Current Research

1.7.1 Justification

There are few studies which consider the experiences of trans people when accessing mental health services, with only one study (Ellis et al., 2015) being relevant to a UK population. However, the data was collected over 10 years ago as part of much larger, quantitively data-driven research. No UK research was sourced which directly interviewed members of the trans community specifically about their experiences when accessing private or NHS mental health services.

Outside of the UK, much research is quantitative, review-based or focusing on the whole LGBTQ+ community. However, there are several qualitative pieces of research using semi-structured interviews specifically to focus in on this topic and understand experiences. Largely, the outcomes have been mixed, generating themes about affirming and non-affirming experiences. Participants considered these experiences in the context of what happened and why it happened, relating the latter specifically to the lack of knowledge that professionals have. All the previous research identified offer findings relevant to the experiences of the trans community accessing mental health services. The clinical implications they outline, namely around training for professionals could lead to significant improvements for trans people when accessing services.

A clear gap in the literature was identified from the scoping review, which the current research aimed to fill. No previous research in the UK has utilised face-to-face, semi-structured interviews to understand trans peoples’ experiences. This methodology would hopefully encourage members of the trans community to speak in detail about what they have experienced. The researcher’s position and context of the research within a clinical psychology doctorate would also allow space for exploration of the reasons for these experiences.

1.7.2 Clinical Relevance

This area of research has significant clinical relevance to professionals working in the NHS, particularly in mental health services, for several reasons.

Firstly, given that no studies in the UK have directly interviewed trans people about their experiences of accessing mental health services, either via the NHS or otherwise, there is a significant gap in literature to advise and guide professionals.

Secondly, the current landscape in the UK for the trans community, with increasing negative media attention, governmental policy shifts and substantial barriers to accessing gender-affirming care, is leading to increased mental health difficulties for the trans community (Bailey et al., 2017; Trans Actual, 2021) This is alongside worse experiences and outcomes when healthcare services are accessed, and the fear of discrimination stopping many people from accessing services at all. Accessing services via the NHS limits the scope of selecting a trans affirming or LGBTQ+ friendly therapist, therefore professionals need to understand these inequalities and ensure they are offering accessible, accepting, and affirming services.

Finally, as all professionals in the NHS are required to complete the same mandatory training, this should be standardised knowledge amongst professionals. As above, there is currently no mandatory training relating to the needs of the LGBTQ+ community. There is also very little recent and relevant guidance from professional bodies for working with trans people, making this is an incredibly clinically relevant area of research. The findings from this research aim to identify areas for training and policy priorities which are in line with, and expand on, the National LGBT+ Action Plan (NHS England, 2018).

1.7.3 Research Aim & Questions

Qualitative research questions can be conceptualised as an ‘inverted pyramid’. This starts with a broad question and then considers more specific or ‘driving’ questions within the research design (Agee, 2009; Kross & Giust, 2019).

From the scoping review detailed above, the researcher was keen to understand if similar, mixed experiences were happening when accessing NHS mental health services. Although there were clear themes from the previous research relating to affirming and non-affirming behaviour, the researcher did not want to approach the interviews or analysis with these ideas in mind. For this reason, the research question was kept broad, to generate themes directly from the experiences shared by participants in the current research, to reduce the impact of skew, bias, or leading questions.

This led to the development of a very broad research question, “exploring the experiences of trans people within NHS mental health services”, which was underpinned by three driving questions:

- What experiences do trans people report?
- How are these experiences understood?
- How are these experiences managed?

2. METHODOLOGY

2.1 Chapter Overview

This chapter will outline the epistemological stance and design of the research. This will be followed by any ethical issues which were considered and addressed, and then a detailed description of the research procedure itself, including the materials, participants, interview process and approach to analysis.
The chapter concludes with a positional reflexivity statement from the researcher.

2.2 Epistemology and Ontology

This research adopted a critical realist epistemological stance. Critical realism distinguishes between ontological realism and epistemological relativism, combining the two positions. Ontology is concerned with what we can know about the world (i.e. what is real) and epistemology is concerned with constructing this knowledge (i.e. what and how do we know this) (Kant, 2014). Critical realism therefore assumes that, although an objective reality does exist, it cannot be observed, therefore we make sense of this reality from our individual experiences and perspectives on the world (Vincent & O'Mahoney, 2017). This is relevant when conducting qualitative research, as the focus is not on finding a single and absolute truth but exploring multiple experiences and views to understand and interpret peoples perceived 'realities' in specific contexts (Sullivan & Sargeant, 2011). Critical realism also recognises the position of the researcher as an individual with their own experiences, perspectives, and views. It acknowledges how these can influence the interpretation of findings through their own lens and context (Mercier et al., 2023). This was considered the most appropriate approach for this research, as critical realism has a "…focus on explaining the enduring social relations that produce real-world problems" (Wiltshire, 2018, p. 525).

As critical realism suggests there is an objective reality, this can be viewed within the context of this research as NHS therapists having knowledge and training (or not) in supporting the trans community. Trans people then make sense of this reality within appointments considering their own experiences, understanding of societal contexts and the impact of making sense of this reality on them. A societal context which may influence this meaning-making is the understanding of gender norms and identity within society. The realist, objective reality side to this argument is that many people understand the existence of gender within a binary framework. This may influence how NHS therapists interact within appointments and how these interactions are understood by members of the trans community. Conversely, a critical stance would argue that gender only exists through societal understanding of gendered acts (Butler, 1990). Queer theory suggests that "…gender is fluid, flexible and subject to change", again influencing both the NHS therapist understanding and the trans person who may then participate in this research (Browne, 2019).

2.3 Design

When approaching empirical research, a 'fit' between philosophical stance, theory, method, and research question needs to be established (Zilber & Meyer, 2022). A qualitative approach to this research was adopted as it aims to explore the experiences of the trans community when accessing NHS mental health services, rather than trying to establish an 'absolute truth' (Sullivan & Sargeant, 2011).

A further distinction is made when conducting qualitative research between 'Big Q' and 'small q' approaches (Terry et al., 2017). 'Big Q' research sits fully within a qualitative, interpretivist paradigm, whereas 'small q' sees qualitative tools being used within a quantitative, positivist paradigm (Campbell et al., 2021; Kidder & Fine, 1987). A 'Big Q' approach fits well with this research as it is "fully qualitative", not only using qualitative techniques but also sitting within qualitative values (Braun & Clarke, 2021a). Although qualitative values have no explicit definition, two key values relevant to this research are the use of researcher subjectivity as an asset to the research and the understanding of knowledge as individualised and contextual (Braun & Clarke, 2013).

Finally, when designing this research, the method of data collection was considered in depth. Semi-structured interviews were felt to be most appropriate due to their main purpose being gathering individual views relating to an experience which is relevant to the research question. They are not tied to any philosophical stance, and can be considered to reflect political engagement, empathy, and critical, feminist, and queer theories (McIntosh & Morse, 2015). Focus groups were considered to collect data, but it was felt that trans people may not feel comfortable discussing personal experiences relating to their mental health in a group setting (Jamshed, 2014). Similarly, online written surveys were considered but, as the researcher cannot probe for further information, it was felt this could limit the richness of the data (Safdar et al., 2016).

2.3.1 Justification for Thematic Analysis

Thematic analysis is a qualitative method used for "…identifying, analysing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79).
It is considered a flexible method, practice, or tool (rather than methodology), which is not tied to any epistemological or theoretical approach (Chawla & Wood, 2021; Maguire & Delahunt, 2017). Braun and Clarke (2006) further distinguished this technique with its independence from epistemological stances and coined the idea of reflexive thematic analysis (RTA). This allows the researcher to consider how, rather than if, their beliefs, values, knowledge, and experience can contribute when interpreting data and generating themes, and views this as an integral part of the analytic process, encouraging the researcher to utilise their own position by embracing "...reflexivity, subjectivity and creativity as assets in knowledge production" (Byrne, 2021, p. 1393; Campbell et al., 2021; Devine, 2021).

The flexibility of thematic analysis does not mean that epistemology can be ignored, rather that the researcher must ensure it is appropriate for their desired approach (Campbell et al., 2021). It fits well with a critical realist approach, as used in this research, as it acknowledges that people make meaning from their experiences. While these experiences sit within limits of an objective reality, which is accepted to exist but cannot be seen or observed, they are more impacted by individual and social context, experiences, values, and knowledge (Braun & Clarke, 2006; Stutchbury, 2021).

RTA was chosen rather than discourse analysis (DA) or interpretative phenomenological analysis (IPA) as the research was keen to understand overarching themes or patterns across the data rather than a hyper-focus on individual discursive interactions or experiences (Thomas, 2006). That is not to exclude or diminish individual experiences but to focus on understanding them as part of a wider, more systemic context. Again, RTA was chosen as it can be, and in this research needs to be, used comfortably to include critical discussion of the specific contexts and discourses within which the research is situated (Finlay, 2021).

2.4 Ethical Considerations

2.4.1 Ethical Approval

Ethical approval was sought from the University of East London (UEL) School of Psychology Ethics Committee (see Appendix E). This was granted subject to minor amendments. All amendments were made except for two, and commentary on these decisions can be seen on the final signed ethics form (see Appendix F). A title change request was approved in April 2024 and a copy of the approval letter can be seen in Appendix G.

2.4.2 Informed Consent

Several processes were followed to ensure that consent was voluntary, specific and from a “competent person” (Wallace, 2001). The participant information sheet (PIS) was available to access as a Google Drive file via a QR Code on the recruitment poster (see Appendices H and I respectively). All potential participants could choose to access this if they wished. When a potential participant reached out via email, the PIS was shared again.

The PIS included details about the researcher, the purpose of the research, confidentiality assurances, plans for disseminating the results and contact information. It also covered what would happen if a person agreed to participate, as well as potential benefits and disadvantages of taking part, and how to withdraw. Once agreeing to participate in the research, participants were asked to sign a consent form (see Appendix J).

2.4.3 Remuneration

Although remuneration, usually financial, is considered commonplace when people are giving time to participate in research, this was not possible for this research (Largent & Fernandez Lynch, 2017). The only option for remuneration was to offer the chance to be entered into a prize draw to win a shopping voucher, for which participants would have to provide further personal information including a postal address. Both the researcher and Director of Studies (DoS) agreed that asking any participant for this information felt inappropriate, but especially when the participant pool involves members of the trans community who are already marginalised and potentially vulnerable within society.

The researcher took time to explain this decision at the end of each interview and all participants confirmed they had agreed to take part to benefit the research field. They all agreed that providing further personal information would not have been comfortable. Their hope was that, as an ‘in kind’ remuneration, the researcher would commit to disseminating the research findings to increase support for the trans community, particularly within NHS services (London School of Economics Research Ethics Committee, 2022).

2.4.4 Confidentiality and Anonymity

The PIS explained how all potentially identifiable information would be kept confidential, with only the researcher having access to the participants’ name, email address and full interview recordings and transcriptions. It also explained how data would be anonymised by allocating codes and pseudonyms. The PIS informed participants how all data would be processed in line with the Data Protection Act and General Data Protection Regulation (GDPR) (HM Government, 2018).

2.4.5 Managing Potential Distress

The PIS explained that, although there were no risks anticipated within the research, due to the nature of personal conversations, participants may experience strong emotions and potential distress. It was reiterated at the start of each interview that participants could decline to answer questions, take breaks, and end the interview at any time. The Process Consent Model was considered by the researcher during the interviews to monitor consent continually, revisiting and re-establishing when required (Dewing, 2008). Contact details for support organisations were provided on the debrief sheet.

2.4.6 Debrief

After each interview, once the transcription was ended, the researcher took time to thank each participant and check in with how they had experienced the interview. It was explained who the participants could contact if they required further support. Each participant was sent a debrief sheet (see Appendix K) via email after the end of the interview which explained how their data and interview content would be used and managed, as well as how the results would be shared. A full list of contact details for organisations offering support if needed was included alongside contact information for the researcher, DoS and the Chair of School Ethics Committee.

2.5 Participants

2.5.1 Inclusion Criteria

Inclusion criteria for participants:

- Adult aged over 18
- Trans
- Had an appointment with an NHS therapist lasting at least 30 minutes
- Appointment not as part of a gender identity service
- UK based
- English speaking

2.5.2 Exclusion Criteria

Exclusion criteria for participants:

- Communication needs not supported by Augmentative and Alternative Communication (AAC)
- Personal or professional connection to researcher (for interviews)

2.5.3 Participant Demographics

Eight participants took part in the research. Demographic information was discussed as part of the interview rather than being sent as a form via email. This was to ensure that confidentiality and anonymity could be fully discussed with each participant. One of the demographic questions also involved asking each participant to define or describe their gender identity. This was felt important in order to consider the different experiences *within* a broad umbrella term used to 'define' a community. This was explained to each participant when the question was asked.

The demographic information for the eight participants can be seen in Table 1. To minimise any demographic information being used to identify participants, pseudonyms have been used and ages are presented in five-year brackets. Each pseudonym was considered in relation to the participants gender identity (i.e. gender-neutral names where appropriate).

Table 1

Participant Demographic Information

Pseudonym	Age	Ethnicity	Gender Identity	Pronouns
Eddie	25-29	White Caucasian	Trans Man	He/Him
Ollie	25-29	White British	Trans Male	He/Him
Alex	25-29	White British	Non-Binary	They/Them
Hallie	20-24	White British	Non-Binary - Trans Feminine	She/They
Ashley	30-34	White British	Non-Binary - Trans Feminine	She/They
Rob	25-29	White British	Binary Trans Man	He/Him
Diana	20-24	White	Trans Woman	She/Her
Blake	30-34	White British	Non-Binary - Trans Masculine	They/Them

The participant ages ranged from 21-32 and all participants identified as white. Although not asked, one participant asked that the researcher include that they are disabled, with diagnoses of a chronic health condition, attention deficit hyperactivity disorder (ADHD) and Autism. They felt this intersectionality was an important part of their identity.

Participants were also asked their rough geographic location and the following locations were identified with the number of participants shown in brackets: London (2), Norwich (1), Manchester (2), Lincoln (1), Brighton (2), Bedfordshire (1), Yorkshire (1). Two participants shared two locations as they had moved but discussed experiences in both localities.

With regards to gender identity, participants were asked how they would each individually describe or define this. An internet search produced websites, blogs and articles which suggest there are up to 107 gender identity labels (Sexual Diversity, 2022). Considering this, only two of the eight participants offered an identical gender identity label (Non-Binary – Trans Feminine). The participants provided equal numbers of non-binary (n=4) and binary (n=4) gender labels.

2.6 Living / Lived Experience Consultants

In recent years, it has been viewed that good practice in psychology and mental health research includes involving the public and people with lived experience (Owen et al., 2022). The NHS Health Research Authority (2024) states that health research should be undertaken "…'with' or 'by' the public, not 'to', 'about' or 'for' them". This idea links closely to the National Service User Network (NSUN) ethos of "nothing about us without us" which supports involvement and partnership working between service users and mental health services or professionals (National Service User Network, 2015).

Given that the researcher is not a member of the trans community, and the research involves trans people who have accessed mental health services, it felt important to include the views of individuals and organisations with living or lived experience. Participant involvement can include consultation, collaboration, and patient-controlled initiatives (Patel et al., 2018). Owing to constraints mostly around the possibility of remuneration for participant involvement, the focus for this research was on consultation in the development stage with a particular emphasis on design, aims, research questions and methodology. The researcher made contact via email and social media to possible consultants who were identified from personal and professional connections. Three people offered consultancy at the research development stage. This is discussed in more detail in Appendix L; organisation names have been included but the individuals' names have been anonymised with pseudonyms to reduce the possibility of identification.

2.6.1 Developments From Consultancy

Following the consultation, several decisions about the design of the research were made:

- Change of wording for exclusion criterion from 'Learning Disability or communication needs' to 'Communication needs not supported by Augmentative and Alternative Communication (AAC)'
- Initially recruiting for face-to-face interviews with a 'back-up' option of adding in written surveys if required
- Inclusion of an interview question focusing on gender identity and mental health difficulties being conflated

2.7 Materials & Procedure

2.7.1 Developing an Interview Schedule

The interview schedule was created and developed from conversations in supervision with the DoS and from suggestions made by lived/living experience consultants.

A final interview schedule was developed alongside a thorough prompt sheet for the researcher to use during the interviews (see Appendices M and N respectively).

2.7.2 Recruitment

A recruitment poster (see Appendix I) advertising the study was shared via personal and professional connections. This included on social media and via email to LGBTQ+ networks within NHS Trusts. An Instagram account (see

Appendix O) was also created to separate from the researcher's personal account.

The researcher had an aim for 12 interviews in mind. Although it is suggested this allows for 'saturation' of codes and themes, it is also argued that the values of RTA inherently lead to a more flexible and subjective approach to data collection, meaning it cannot be entirely determined in advance (Ando et al., 2014; Braun & Clarke, 2019).

2.7.3 Initial Contact

When a potential participant reached out via social media, they were provided with the researcher's UEL email address to make contact. A copy of the PIS was sent to them, which asked them to confirm they met the inclusion and exclusion criteria and offered an initial phone call to discuss further if required. Once written confirmation was received, a mutually convenient time for a video call was arranged. A calendar invitation was sent via email for a Microsoft Teams Meeting with the informed consent form attached.

2.7.4 Semi-Structured Interview

The finalised interview schedule and prompt sheets were used to facilitate each interview. The interviews took place via video call using Microsoft Teams and lasted between 40-60 minutes. Each interview began with a brief check in, administrative information relating to the interview process and an introduction from the researcher, including their position as a cis woman entering this space. All participants were given the chance to ask any questions before the interview began. The interviews were then recorded using the transcription feature built into Microsoft Teams. Verbal consent to the recording was obtained.

2.7.5 Data Governance

As outlined in the PIS, all data was gathered, recorded, and stored in accordance with the legal requirements of the Data Protection Act (HM Government, 2018). All files which contain any identifiable information, consent forms, raw interview transcripts and audio recordings were stored separately with password protection using the UEL One Drive. Transcripts were then reviewed manually, and all identifiable information was removed, for example, participant names, NHS trust and service names were redacted using pseudonyms and generic descriptive terms (UK Data Service, 2024). Only the researcher, DoS and the examiner, if necessary, would have access to the secure files. All files which contain identifiable information will be destroyed following the research being examined. Anonymised data will be stored securely by the DoS for three years following examination and will then be permanently erased.

2.7.6 Appointment Information

It is of note to briefly mention the variety of appointments discussed by the participants. Although all NHS mental health services, there was variation in the specific types of services accessed. Appointments also varied in type, from one-off assessments up to 10 sessions of therapy, including face-to-face, video, and telephone appointments. The professional background of the therapists also varied greatly, and this is outlined in Table 2 below.

Table 2

Professions of Therapists

Profession	Frequency
Psychiatrist	4
Psychologist	2
Counsellor	3
CBT Therapist	2
Mental Health Employment Specialist	1
Mental Health Nurse	2
A&E Psychiatric Liaison Nurse	1
GP	1

2.7.7 Transcription

Braun and Clarke (2006) state that transcription is an active process which acts as the first stage of thematic analysis, in that the researcher is becoming familiar with the data. This process is considered transformative rather than acting to replicate, taking the data from its ‘raw’ state as audio recordings to a ‘partially cooked’ state as transcribed interviews (Sandelowski, 1994).

The level of detail which should be included when transcribing interviews has been debated; this decision should be based on the design and purpose of the research. Jeffersonian transcription is considered a useful tool for full conversational analysis which captures features of speech such as gaze, facial expression, pitch, tone, and non-speech sounds (Park & Hepburn, 2022). It is a thorough and extensive method, but yields no benefit for thematic analysis (Howitt, 2019).

Conversely, others argue that the transcript should be written in a formal style that reads coherently (Kvale, 2007). For thematic analysis, an orthographic approach is often considered most appropriate, which focuses on what was said verbatim (Trippas et al., 2017). Features of speech such as “…emphasis, speed, tone of voice, timing and pauses” can be included to add context (Bailey, 2008, p. 128). The orthographic method used involved not ‘sanitising’ any elements of speech (slang, abbreviations etc.), removing identifiable information, transcribing verbal utterances, and using symbols to represent meaning-making and uncertainty (Guendouzi & Müller, 2005). The transcriptions used [ ] to represent redacted identifiable information, ellipses to show pauses in speech and < > for non-speech utterances.

2.8 Analytic Approach

Braun and Clarke (2006) outline four domains when approaching RTA and this research considers its position in each domain as:

Orientation to data

An inductive orientation, allowing the themes to be generated from within the raw data, as opposed to fitting ideas into predetermined or preconceived ideas and theories (Nowell et al., 2017). Braun and Clarke (2021b) do, however, acknowledge that all researchers are “...theoretically embedded and socially positioned” (p. 56), meaning TA can never be entirely inductive.

Focus of Meaning

A latent analysis which considers underlying and implicit meaning within the data rather than simply what is being said at a descriptive level (Braun & Clarke, 2006). The researcher's position is utilised in this type of analysis as they are drawing on their own knowledge and experience (Braun & Clarke, 2021b).

Qualitative Framework

An experiential approach which captures and grounds the research in the accounts given by participants and considers their language as reflective of "internal categories of understanding" (Clarke & Braun, 2014; Reicher, 2000, p. 3).

Theoretical framework

Although placed within a critical realist epistemology, the research aligns with a relativist, constructionist approach in that it is not seeking to find an objective reality, but rather a social construction of reality as perceived and expressed by the participants (Braun & Clarke, 2021b).

2.8.1 Analytic and Interpretive Process

Braun and Clarke (2006) outlined six phases of TA which guided the analytic process in this research. These phases are seen as a guide rather than strict rules and, if they are roughly followed, they can be adapted and used flexibly to suit the data (Patton, 1990). The process is also not a linear one, but rather the analysis can move back and forth through the stages as needed (Braun & Clarke, 2006).

2.8.1.1 Familiarisation with the dataset: At this stage, the researcher read and re-read the interviews. A significant part of this process is ensuring the transcripts are correct and formatted clearly. Reading the written transcripts making corrections allows familiarisation with each interview. During this process the researcher allowed their thoughts and critical reflections to flow freely, making brief written notes of these.

2.8.1.2 Coding: During the coding stage, the researcher opted to code the data manually rather than using software such as NVivo. The researcher went through each interview line by line and considered what the participant was saying, any relevant and through provoking words or sentences and how these relate back to the research question (Braun & Clarke, 2021b). The researcher made handwritten notes on the interviews in pencil which can be seen on the transcript excerpt in Appendix P. During this process the researcher continually reflected on their own position and the position of the research within the four domains of TA (Braun & Clarke, 2021b).

2.8.1.3 Generating initial themes: The codes were then compiled into related topics which generated the initial themes. An initial thematic map was drawn up which helped to link ideas and concepts together, this contains many ideas and can be seen in Appendix Q.

2.8.1.4. Developing and reviewing themes: The themes were then further reviewed and reduced into more concise categories. A second thematic map was created as the initial codes and themes displayed too much breadth and depth to accurately represent deeper meaning of the data. This can be seen in Appendix R.

2.8.1.5 Refining, defining and naming themes: These themes were then further analysed to condense any overlaps and clearly define four themes and five subthemes. A final thematic map was drawn up with colours assigned to identify segments of text (see Appendix S). Two pages of completed analysis are included in Appendix T showing all stages of the analysis. Themes were given clear and concise names, which accurately reflect what they are trying to convey.

2.8.1.6 Write-up: The write-up of themes should display a 50:50 ratio of data extracts and analysis to both keep the reader engaged whilst demonstrating the validity of the argument that the researcher is proposing (Braun & Clarke, 2021b). The narrative which demonstrates the themes needs to be coherent and connect each theme, meaning a thread runs between them. The extracts included need to be rich, engaging, representative, and accurate (Braun & Clarke, 2021b). Extracts were not paraphrased, but quotes were edited for readability to remove superfluous text and verbal mistakes / habits (e.g. “like”, “you know”) which don’t have semantic impact on the content. American Psychological Association (APA) formatting guidelines were followed to present quotes either within the text or as indented text blocks if over 40 words (American Psychological Association, 2020).

2.8.2 Researchers Position: Reflexivity

Reflexive practice and acknowledging the researcher subjectivity and position is considered a vital part of conducting a *reflexive* thematic analysis (RTA) (Braun & Clarke, 2022). In being reflexive in their practice, researchers are encouraged to hold a position of ‘knowing’, in that they consider their own perspectives, how this may impact their position when analysing data and consider all decisions with this in mind (Braun & Clarke, 2022; Elliott et al., 1999). Holding a reflexive position is also compatible with a critical realist epistemological stance, particularly when the researcher has a social focus (Vincent & O’Mahoney, 2018).

It is vital for the researcher both to understand their own positions of privilege and marginalised identities, and how these intersect, known as personal reflexivity and understand the impact of training and research experiences, known as functional and disciplinary reflexivity (Wilkinson, 1988). Transparency about these positions and any biases or assumptions they may produce must be applied when analysing and therefore judging qualitative accounts of others’ real-life experiences (Reid et al., 2018).

Folkes (2022), however, states the importance in RTA of not just producing a ‘shopping list’ of identities and positions. Within RTA, researchers should be using their understanding of their own personal position to consider “…*how* researchers engaged in reflexivity, and *how* this shaped the analysis they produced” (Braun & Clarke, 2022, p. 3).

Below is a summary of the researcher’s personal, functional, and disciplinary reflexive positions and aspects of their identity. These are relevant to the research topic and, although laid out in this format to form an ‘identity shopping list’, the researcher has continued to reflect on during the research process and continue to reflect in their practice:

- White British, non-disabled and from a middle-class background, holding certain socially privileged positions because of this.
- Cis woman using she/her pronouns, entering a space made up of and for queer people, namely members of the trans community. The researcher wanted this position to be stated explicitly and acknowledge their lack of lived experience.
- Holds left-wing political views and is training as a clinical psychologist at UEL, drawing the researcher to be critical of current government positions, particularly in relation to healthcare policy and the trans community. This has also drawn the researcher to critical research methods and practice, and focusing on research which prioritises marginalised voices.
- Previous experience of working within NHS mental health services, witnessing positive, negative, and neutral experiences of staff interacting with and discussing work with trans people.
- Holding voluntary leadership positions within NHS LGBTQ+ networks as an ally. These roles have included writing policy and offering situation-specific guidance to support trans staff and service users, introducing the use of pronouns and rainbow lanyards, and delivering training.
- Receiving training written and delivered by trans people, including recognition as an ‘ally trans ambassador’ and attending training delivered by organisations such as Stonewall and the Gender Identity Research and Education Society (GIRES).

The researcher did not explicitly state any of their intersecting social positions to the participants other than their position as a cis woman. It was felt important to disclose this as it positions the researcher as an ‘outsider’, entering a space and conducting research with a group they do not belong to (Braun & Clarke, 2013). The researcher briefly explained their reasons and rationale for wanting to undertake this research, having seen a lack of trans voices informing NHS policy and procedure. They readily acknowledged their position as an ally and wanting to use their positions of privilege to champion trans voices without speaking for a community that is not theirs, following the allyship principle of ‘speaking up, not over’ (Stonewall, 2022a).

3. ANALYSIS

3.1 Chapter Overview

This chapter presents the results of the thematic analysis. The final themes are represented in a thematic map. Each theme and subtheme are discussed in detail, illustrated with quotes extracted from the interview data.

3.2 Themes

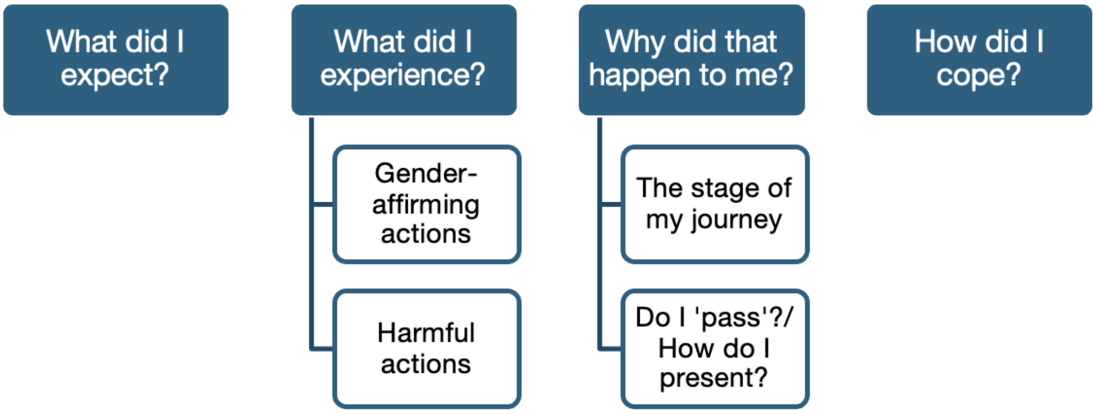
The analysis yielded four superordinate and four subordinate themes from the data. Participants each shared a ‘story’ of their experience when accessing NHS mental health services. Although not necessarily discussed chronologically in the interviews, the researcher was able to make sense of each person’s journey by mapping these out from prior to the appointment(s), during and afterwards, framing them as questions as if in the words of participants. These questions relate closely to the original research questions, but it felt important to preserve the participant’s voices within the themes and to understand the research questions as if asking them directly to the participants.

Their journeys started with the first superordinate theme, ‘what did I expect?’. The second superordinate theme, ‘what did I experience?’, contained subordinate themes of ‘gender-affirming actions’ and ‘harmful actions’. The third, ‘why did this happen to me?’, contained ‘the stage of my journey’ and ‘do I ‘pass’? / how do I present?’. Finally, the fourth superordinate theme, ‘how did I cope?’, considered the end of each participant’s journey.

The final thematic map is shown below in Figure 1.

Figure 1

Thematic Map



3.2.1 What did I expect?

All participants acknowledged that they went into their appointments with expectations of what their therapist and their experience might be like, which generated the first theme. The reason for having these expectations stem from three prominent areas: personal, community, and professional experiences.

Firstly, all participants had previous, personal experiences of accessing mental health services, and what they had come to expect because of these. Largely, participants went into their appointments with low expectations, from previous negative experiences. Both Blake and Ashley shared this explicitly: *“The reason that I feel the way I do about it is because I've had such terrible experiences”* (Blake); *“I have had a long experience with mental health teams. Very mixed. So I guess I did go in with low expectations”* (Ashley).

Previous experiences also led to expectations of the therapists, often based on a first impression. Several participants described their therapist as appearing as a member of the ‘old boys club’, a term coined to describe the British public-schooled elite, but now more generally used to describe white, cis/het men in a position of privilege. Eddie described his therapist in this way *“It was with a counsellor whose name was a very generic white man name. That I can't remember. And that appointment was a write off from the start”*. As did Ollie: *“He gave the impression of being a member of the ‘old boys club’, very traditional in his views of what psychiatry is and psychiatrists would do”.* Participants felt that a therapist who fit this stereotype would not have an understanding, let alone an experience, of what it means to be trans, so would not be able to offer useful support.

Secondly, community experiences and negative stories shared by friends and other members of the trans community led to low expectations heading into the appointments. *“I was worried because I've heard so many horror stories of people just not being interested in helping trans people because their mental health is too complex for them”* (Rob). Ollie acknowledged the low expectations this gave him:

> *I was also quite immersed in the world of mental health and trans people's experiences; I think I did go in with some preconceived ideas that this is just going to be horrific. Because there's just no positive experiences out there, there's none.*

Finally, professional experiences, with five out of the eight participants being current or ex-NHS employees. Having knowledge of what is offered to staff further led to low expectations heading into these appointments.
This was often related to the training available to NHS employees: *“I mean I've seen some of the NHS training that they do on equality and diversity. And there's not a lot of trans stuff mentioned in it”* (Eddie); *“I know what the mandatory training is, right? So, I know that they will have done some mandatory training on trans awareness, but very little… maybe an hour online”* (Blake).
Both participants therefore went into their appointments believing their therapist would lack the knowledge required to support them adequately as a trans person.

Diana also applied her experience as an NHS professional, expecting the professional to lack knowledge: *“I can kind of understand from like a practitioner level like how much you need to know”.*

Interestingly, Rob felt that his low expectations differed from that of other trans people, when in fact were very representative:

> *I've never expected anything from anyone really. Other than trying. So I think that, maybe my expectations would differ or definitely do differ from another trans person. Because I went into it with the expectation that they wouldn't know anything. And then if they if they did, then that would be great.*

Rob also clearly describes here that going in with these low expectations allows for a higher chance of leaving the appointment feeling it had gone well. If participants go in expecting very little, or even nothing, then anything above that which isn’t actively harmful can be seen as a positive.

Although more specific experiences within the appointments will be shared within the next theme, low expectations going into the appointments left some participants feeling pleasantly surprised when coming out: *“I felt a bit surprised that it had gone so smoothly, that it was going so smoothly. A little bit like waiting for the fuck up to happen. I guess disbelief that it could go smoothly”* (Ollie).

> *It wasn't that bad, I’ve definitely had worse. From other healthcare settings that aren’t mental health. And I think overall I would say I was probably pleasantly surprised. From a gender point of view. I would love it if I could be like, “oh, do you know what he actually got this one thing wrong and I'm really pissed off, that's really awful”. But the fact that I wasn't actively hate crimed in the appointment is like a huge plus. That’s the level that I'm at with it.*

(Blake)

3.2.2 What did I experience?

The second theme relates to what participants experienced within their appointments. The questions focused participants' attention onto the interaction with the therapist, so their experiences are described considering the therapists behaviours and actions within the appointments. Generally, these actions were experienced and then described as either positive or negative.

There were several descriptions of seemingly neutral actions which were instead experienced as positive. As above, low expectations going into the appointments were common, meaning the feeling of being 'pleasantly surprised' will have impacted how these actions were ultimately experienced by the participants.

Blake was the only participant who named this: *"I felt he did a fairly neutral job, and I didn't feel like he did particularly treat me one or the other that much. And he got my pronouns right. So that was, like I said, pleasantly surprising".*

Whereas other neutral actions experienced as positive were not explicitly labelled, just discussed in a positive way. Firstly, preparing for sessions, Ollie *"got a sense that he had properly read the notes...he'd taken the time to prepare himself before each appointment, he'd given himself the time".*

Secondly, the importance of asking 'simple' questions, Hallie said "...*it's always. 'How's your day been?' It's 'what are you doing afterwards?'"*. Similarly, Diana shared *"...he would start off a conversation by talking about how I was in general".* Finally, Hallie explained *"...it's really, really nice to have a counsellor that I can speak so freely about my gender issues and things like that... you can say whatever the hell you want here, you could be yourself".* This allowed them to feel like an individual, and not just a 'tick box', reducing the medicalised feeling of the appointments.

One action experienced differently between participants was how the therapists approached their lack of knowledge and whether asking trans people to educate them on trans issues was acceptable or not. Diana felt comfortable with this:

> *So I think it's important to have people be educated, so for example, my mental health practitioner asked me to educate him and the same with my mental health employment specialist asked me to educate him. And I think that's really good.*

Whereas Blake did not: "*...he didn't, try and get me to educate him about gender, which is also great"*. There was, however, a shared feeling that therapists owning this lack of knowledge in some way was an acceptable approach, with Blake saying:

> *The best possible experience from a cis person would have been kind of saying something to own their lack of knowledge... To say I'm cisgender myself, and I've had some training on this, but it's not in my lived or my personal experience. So, forgive me if I might make mistakes...*

3.2.2.1 Gender-affirming actions: The first sub-theme, mentioned by all eight participants, was examples of gender-affirming actions. Positive actions where therapists had recognised, acknowledged, supported, and affirmed an individual's gender. Each person shared at least one example where they had experienced an affirming action from their therapist. This level of inclusivity in trans healthcare is vital as it has been shown to significantly increase quality of life, health outcomes and patient experiences.

"Using the correct pronouns" (Rob) and "...*when she did get them wrong, she recognised it"* (Alex) were common examples of gender-affirming actions. Participants also stated the importance of their therapist *genuinely* seeing them as their gender and respecting their truth. There were several examples of this: *"She just spoke to me like I was any other guy"* (Rob); *"...he did like describe my appearance as a 'woman in her mid-30s'"* (Ashley); "...*her kind of acceptance that if I just said something that was what it was"* (Alex); *"It was sort of just an understanding of the fact that that's the way I am"* (Hallie).

Hallie also felt their therapist had taken the time to understand and therefore was able to affirm:

> *They were able to almost understand things within a context of, I guess being LGBT plus. And it made me feel like I wasn't talking to just somebody who's read a checklist about what they're supposed to understand. It felt like I was talking to somebody who personally had put time and effort into understanding issues.*

Eddie explained how he found privacy and discretion an important gender-affirming action:

> *So she made sure you know the door was shut. We'd gone to the other side of the room... Very discreet in the sense of, "hey, we can't find you under Eddie here. What other name might we be able to find you under". Away from everyone, away from him, just in case he didn't know. I appreciate this. This is great. Thanks.*

It is of note that where therapists' actions were experienced as positive and gender-affirming, their knowledge was attributed to and somewhat outweighed by personal qualities of that individual therapist. Participants seemed to value experiences where they could just 'get on' with someone as a human with little emphasis put on formal training, knowledge, or experience.

These qualities varied but positive experiences occurred when "*... they were sympathetic and they were kind"* (Blake), *"he gave a shit...he actually cared about the person who was sat in front of him"* (Ollie) and *"my counsellor treats me like a person and not just a client...actually takes time to know me as an individual"* (Hallie).

Several participants also named how important it was that even if their therapist didn’t understand trans identities, they were still respectful, which was experienced as gender-affirming. Alex found their therapist did this: *“Yeah, it was very much a… I don't know much about it, but I fully accept your experience and I will not question it kind of thing”*. As did Eddie: *“And I think you know the fact that I don't understand why this person is trans, but I can understand that they’re a person who's distressed and needs help”*.

3.2.2.2 Harmful Actions: Each participant in the research was also able to identify at least one occasion where the actions of a therapist had been harmful, giving the second sub-theme. This centred around the use of language: ”*God it's amazing that you interact with people who are, you know, non-cisgender because some of the terminology you use is, you know, 50 years old”* (Hallie). Offensive language was used by some therapists as Blake described: “*Yeah. So also in the letter, they described my surgery as gender reassignment surgery. Which is quite an offensive term, and my gender was not reassigned. I had gender affirming surgery”*. These actions left participants feeling dismissed, isolated, unsupported, and uncared for.

There were also several experiences of being overtly misgendered and deadnamed. Eddie described his experience, where the therapist also did not respond to being corrected:

> *I walk into the room. He introduces himself and he's like, “OK for the paperwork. Is it Miss or Mrs?” And I'm like, “it's Mr. I've got a deed poll. Where my name is legally Mr [Surname]”. Did not matter to him. In the slightest. So, I said, “it’s Mr”. He was like, “well, that wasn't an option I gave you, was it?” And I was like. “OK, wow. No, but it's what you're gonna write down”. He did not, he wrote Miss on the paperwork that I got back. He also wrote my deadname down. And put [Eddie] in brackets.*

Several of these harmful actions occurred in assessment letters or other written correspondence received after the appointments, *“So he called me [Blake]. I emailed back as [Blake] the next day and then the day after he emailed me with my deadname”*.

Another harmful and shared experience was the therapist pathologising or conflating their trans identity with mental health difficulties. Participants did acknowledge there sometimes being a connection between their gender identity or transition and their mental health, but therapists *blaming* mental health difficulties on their transition was a difficult experience. *“So initially on the first phone call, he was like, “oh, you're, you're trans and you know, you're probably going through a lot with stuff like that, so it could be to do with that””* (Diana); *“...he’s trans, he’s in distress, he’s in distress because he’s trans”* (Eddie). Eddie also experienced a therapist telling him to stop his transition:

> *Then got to the gender stuff. And it was all the fault of the transition...It was all the fault of the gender stuff and I should stop... The family issues are affecting you a lot and the family issues wouldn't affect you a lot if you didn't transition.*

Other participants experienced their therapist overly separating the two things, dismissing the connection, and not wanting to support with mental health as it was related to their gender identity or transition: *“...well can this stuff not be discussed at the gender clinic? Is this not a ‘gender thing?’”* (Ollie). This gave a sense that some therapists did not see challenges stemming from gender identity or transition as part of their role.

3.2.3 Why did that happen to me?

The third theme relates to the participants trying to make sense of their experiences, mostly when they had been negative, “*because looking back, there's no way in hell that I should have been treated like that*” (Eddie). Ashley shared a poignant quote of trying to understand her experiences:

> *I try not to just say that sometimes it's transphobia, but I think genuinely it might actually be that sometimes. Just come away from feeling like is that the reason? Is that why they're being horrible to me is, is that why? And sometimes, maybe it's just that, maybe that is the reason.*

One way that participants tried to understand their negative experiences was to consider the therapist's actions in the context of them having a lack of knowledge. Ashley understood her experience in this context:

> *Or just lack of knowledge. Most common I'd say is just lack of knowledge. I think most of the time it's lack of knowledge and training. I'd give most people the benefit of the doubt. It just feels like a lack of knowledge or lack of compassion... you don't even know what Section 28 is or was... and just aren't informed around any like trans issues or any like queer stuff at all.*

Blake understood their therapist avoiding certain topics within the context of them having a lack of knowledge: *"I think I got the feeling that he was a bit nervous to ask me any details about my surgery because of being nervous of saying the wrong thing".* Meanwhile, Diana made sense of her experience by recognising the lack of knowledge whilst hoping for improvements in the future:

> *So it's nice to see those things kind of come into place and I think that's… As long as that basical (sic) level of understanding is kind of coming in... Obviously there's bits to be improved everywhere, not everybody's perfect.*

A lack of lived experience of the therapists helped Eddie to make sense of his experience: *"I don't think any of them have any lived experience and I think for some of the mental health professionals especially. If they did, it would have been such a difference".*

In contrast to this, Hallie was able to make sense of her more positive experience by considering the therapist's experience of working with trans people on a regular basis, which they displayed during her appointment:

> *I genuinely think it's because they interact with people like me all the time. And I feel that like when you, how do I word it? When you put yourself in a community, you almost have an obligation to learn about it. And I feel that's probably their experience.*

Some of the ways participants made sense of their experiences posed the question whether these were explanations or excuses. Were the participants justifying and understanding experiences or were they simply excusing negative behaviour to protect themselves from having to acknowledge a more harmful truth?

Several participants explained their experiences by considering their therapist within a wider systemic context of the NHS being underfunded:

> *I'd say like a mix of… them being overworked. And I guess it is like lack of resources, lack of funding and… lack of information, like a lot of them, and especially I come across this with like my GP, just have no fucking clue how to deal with trans people.*

(Ashley)

Other explanations which came across as excusing the therapists' actions included geographical location, "*But I wasn't in London then either. I was like back home in the north, erm, maybe different resources"* (Ashley); changes in practice, *"since COVID there's been a real push on trying to save time and it's not for hygiene reasons now. It is purely to save time"* (Ollie), and workload, "*So I think I was always quite conscious that like she was really busy. So I couldn't expect her to do it. She might have been willing. But I think she was really busy"* (Alex).

Rob accessed mental health support when he was pregnant with his first child, and he understood some of his experiences in the context of what NHS professionals will ‘normally’ encounter when supporting people giving birth. He shared an example of language use from his midwives (not a mental health therapist) but explained this represented several instances of this type of action, and the below quote demonstrates how he appears to excuse these mistakes:

> *When I was pregnant, the midwives…When they'd come and, like, visit me, they'd be like, “oh, when I see my other women”, “but the other women”. I'm not a woman but they knew that and like they didn't mean it like that. It's just in their brain when they see the other women because they only see other women. I think that's it's like that kind of turn of phrase.*

3.2.3.1 The stage of my journey: Several of the participants had made sense of their experience in relation to their own relationship or position with their trans identity at the time of the appointment. Hallie said: “*coming out and just immediately becoming yourself is incredibly difficult. It felt awful because it felt like I was being judged. I'm not gonna be the embodiment of who I want to be immediately”.*

Alex accessed mental health support soon after coming out as non-binary and felt their expectations of the therapist and the support would be much different now:

> *But, it ended up kind of helping me because it also helped me learn...I think if it was to happen now, I'd find it a bit frustrating now that I am more secure in my identity... And I think because my knowledge of myself wasn't that strong, actually it felt like we were both coming from a similar angle of knowing the terms, but not knowing how that fits for me. And I think that's why I see it as quite positive is because in that moment what I did need to do was just talk*

> *out how I was feeling, what was going on with me. And I think now I would want more of that acknowledgement and understanding.*

3.2.3.2 Do I 'pass'? / How do I present?: 'Passing' is a complex and controversial term within the trans community. It essentially describes society's expectations of trans people to 'look a certain way', for them to conform visually with their affirmed gender. Although a term not endorsed by the researcher or many of the participants, it was used explicitly several times during the interviews, so the researcher has opted to preserve this language choice in the analysis.

Several of the participants made sense of their experience in the context of how much their therapist considered them to 'pass': *"Very early on when yeah, I looked like a man… that's what they'll have seen"* (Ashley). Hallie felt their therapist acted the way they did, as they had an expectation of her to look and present a certain way: "*And I remember that counsellor sort of getting quite angry that I was, well, not angry, sort of almost disappointed that I was dressed masculine. And I was like, it's just clothes".*

Blake felt their experience would have been much different if their therapist didn't consider them to 'pass' as male. "*Prior to top surgery, I would have had a very, very different experience of that appointment. I think it's very likely that I would have been misgendered".* They identify as non-binary, and feel generally they are viewed as male which, although more gender-affirming than being seen as female, they were left with positive feelings that their therapist in this instance affirmed them as non-binary:

> *But given that I do mostly 'pass' male at the moment, I was pleasantly surprised that they didn't misgender me as he because... I get that most of the time now and in the past, people always misgender me as she instead of they, and that was really, really distressing. Whereas now when people misgender me as he, I often don't bother to correct them. It doesn't bother me as much and it's not because that's the right pronoun for me, it's because I*

> *would rather that somebody misgender… sees me as a man, and is wrong, than sees me as a woman and is wrong.*

Alex and Ollie both considered that their appointment had been over the phone, so the therapist could not see them. For Ollie, who explained he still experiences some dysphoria around his voice, he felt this contributed to his worries: "*Well, I like to think I wouldn't have been misgendered if this person was looking at my face".* Whereas for Alex, this was a positive thing, as they did not feel they had to present a certain way:

> *I just have all the clothes that I wore when I was a woman and know how I present, quite quickly. So the fact that it was over the phone meant that I didn't have to look a certain way or feel like I needed to express myself in that way.*

3.2.4 How did I cope?

The final theme identified centres around the participants sharing how they coped with the experiences they had. Participants shared a variety of coping strategies, which allowed them not only to manage difficult emotions triggered by negative experiences, but also more generally to support themselves through accessing NHS services.

Ollie felt the only way for him to manage the feelings of anger was to leave the appointment: "*And that was at the point where I kind of erm, terminated the call. I was like well clearly this isn't going any further and this isn't helping".*

Eddie shared the importance of humour when engaged with psychiatric liaison nurses, and how he used this as a coping mechanism during a difficult time: "*I'm just sad and I have a really dark sense of humour and they enjoyed that... The nurses had a bit of dark humour. It was great".*

Diana shared that she has been supporting herself to understand her own mental health: *“And I feel like I'm having to do more my own research and own understanding of mental health to actually benefit me”.*

Hallie felt that she has managed appointments in the past by carefully choosing what to share, to ‘fit’ with what the NHS can offer and reduce the risk of negative experiences occurring:

> *I wasn't sure whether it was going to be the type of counselling where I have to censor myself, but almost do it in a way to, this sounds awful. to appease the NHS. Because I've, I've had to do that a few times before and I thought, oh God, it's an NHS service that's run through my gender clinic. I'm going to have to be, like really censored about what I say.*

Almost all participants shared how they advocated for themselves during their appointments. Although this position as a personal advocate can be seen as a burden, participants described how they found this a useful tool to defend and affirm their own position.

Blake felt that had they not done this, their experience would have turned out very differently: “*And I do also think that it was made better by how much I advocated for myself and was quite strident, both like in my referral and in the appointment about like this is my gender”.*

Alex shared how they advocated for themselves by being the person who raised gender within the appointments: *“Oftentimes it would be that I would bring it up because it was important to the situation and then it would be considered”.* Ollie *“had corrected them and got a bit shirty with them”* when he experienced mistakes during the appointment.

Both Rob and Blake felt they ‘set out their stall’ at the start of their appointments. Rob clearly stated his concerns around his voice to the therapist and explicitly stated his trans identity: *“I probably like just explained it very well. I told her that I* *was trans and that like ‘cause my voice was very high, I was worried about being misgendered”.*

Blake did the same, explicitly stating their name and pronouns:

> *But also I think knowing me, I was, I would have been very… I would have started the appointment being very like, “these are my pronouns”. So, I think I'd already been quite strident before the appointment about… erm I probably said at the start of the appointment that, you know… I’m Blake, I use they/them pronouns. Like you know, I would have been quite clear about that.*

Ollie and Ashley shared their experience of advocating for themselves during the appointments, which involved more specifically providing education or information to the therapist that may support them to understand the experiences of the trans community when accessing mental health support.

> *And just a complete, like, trying to explain to him the reasons I was accessing mental health services at that time wasn't gender related, but also it felt like I was trying to educate him like you do you understand that being a trans person and having that diagnosis of gender dysphoria isn't the be all and all of mental illness. And I can access services for alternative reasons.*

(Ollie)

> *Here's what you have to do. Here's why. Here's the information explaining why and now it's just part of the process. Like literally every time I come in, I'll have my like, PDFs and letters. Just say here's why you have to do this… And here's some stuff to read in case you don't fucking know why you have to do this or what it's done for.*

(Ashley)

Although they were able to share concrete examples of how and where they have advocated for themselves, Ashley was the only participant who questioned how effective this approach is: “*And why would they listen to you? You're just a crazy trans person”.*

4. DISCUSSION

4.1 Chapter Overview

This final chapter summarises the main findings, relating the themes to the initial research questions and existing literature. Clinical, training and policy implications for the NHS are considered, alongside possible implications and suggestions for future research. A critical review of the research will consider more formal quality assurance, followed by general considerations, and both strengths and limitations of the research. Finally, researcher reflexivity will be discussed, including reflections raised by participants' queries, before conclusions are presented.

4.2 Summary of Findings in Relation to Research Questions

This research had an overarching aim to address the gap in literature relating to the trans community and their experiences of accessing NHS mental health services. The summary of findings will explore, in relation to existing literature, what trans people experienced during their appointments with NHS therapists, how these experiences were understood, and how trans people manage these experiences.

It is of note that, as was the case in the scoping literature review, there were surprisingly more positive experiences shared in the interviews than anticipated by the researcher. Some possible reasons for this and further consideration is made in section 4.4.3.

4.2.1 What experiences do trans people report?

4.2.1.1 What did I experience? As the research has its epistemological stance rooted in critical realism, and a research question focused on experiences, it is unsurprising this swiftly emerged as a superordinate theme. There was also a direct question asking the participants what their experience of the appointment was. This focused participants' attention to describing the interactions with the therapists. How did the therapist act, behave and relate to them?

Participants described feeling neutral towards several experiences in their appointments. It is often considered that experiences cannot be perceived as neutral as people are always feeling ‘something’ (Izard, 2007). This view has been challenged to suggest that neutral feelings are not the absence of any feelings at all, but the presence of actual neutral feelings about something (Gasper et al., 2019). Several participants suggested that, although their therapist didn’t seem to go above and beyond, they weren’t overtly knowledgeable in gender-affirming care, equally they were not overly transphobic. It is therefore understandable that participants could feel neutral about those actions they described.

It is also of note that several actions which participants perceived their therapist to engage in, could be considered neutral or ‘simple’ from the outside but were experienced very positively by participants. Two explicitly mentioned feeling that the therapist had prepared before the appointment and that they asked ‘simple’ questions, such as how someone’s day was going. These ‘small things’ have been shown in a range of research studies to have a big impact on not only the therapeutic relationship, but also relationship to help and processes of change (Alessandrini, 2023). Often these ‘small things’ that people experience cannot be operationalised, they therefore cannot be trained or taught. Sometimes it is even difficult to describe them as something more than a good feeling or the therapist being a ‘good person’ (Bertelsen & Bøe, 2016). These ‘small things’ have also been shown to be important to healthcare professionals, from a study in the NHS, where they were identified as central to providing person-centred, sensitive, empathetic, and dignified care to older people (Williams et al., 2016).

One action which participants experienced differently was whether therapists asking for education on trans issues from the person sat in front of them was acceptable or not. One participant felt this was appropriate, as the importance of therapists being educated outweighed their feelings on being the educator. Other participants felt this was not an appropriate action and perceived this as a negative experience. Although no empirical research on these views could be found by the researcher, there are several blogs and allyship ‘guides’ such as that by Molloy (2014) which state that it is not the responsibility of trans people to educate other people or allies about trans issues. Participants felt that therapists ‘owning’ their lack of knowledge, intersectional position, and blind spots goes most of the way to accounting for, and in some cases, allowing mistakes and the need for education. ‘Naming’ one’s own position, alongside an understanding of oppression and injustice, gives a common language and can demonstrate a position of allyship. This can foster a relationship based on authenticity and can reduce feelings of doubt for the person in the marginalised position, allowing their experiences to be validated (Chin et al., 2022).

4.2.1.2 Gender affirming actions: Gender affirming care is often considered in the context of supporting trans people in their social and medical transition, such as hormone therapy and surgical intervention. Gender-affirming care indeed begins from the first interaction, and includes actions which recognise, acknowledge, support, and affirm an individual’s gender identity (Hana et al., 2021). Therefore, in this research, gender-affirming care was considered to include any actions by the therapists which affirmed the participant’s gender identity, including the correct use of names, pronouns, and trans-inclusive language. This level of inclusivity in trans healthcare is vital as it has been shown to increase quality of life significantly, health outcomes and patient experiences (Bhatt et al., 2022).

Working in a gender-affirming way requires conscious and active processes, and includes actions such as not assuming gender, using your own and asking for others’ pronouns, using gender neutral language, and reflecting someone’s gender back to them in a respectful way (Mental Health America, 2022). All participants shared examples of these actions and how much they contributed to leaving the appointments with positive thoughts and feelings.

As discussed previously, at the time of writing, there is very little formal guidance for NHS therapists on supporting trans people in a gender-affirming way. Professional and regulatory body guidance is largely outdated, with most guidance from between 2016-2020 (Trans Actual, 2023). The BPS guidance is relatively brief: 20 pages where gender diversity is grouped with sexual and relationship diversity. This document lacks clear direction for providing gender-affirming care, leaving professionals to rely largely on their own knowledge and understanding.

Participants shared that sometimes these overt gender-affirming actions were outweighed by the personal qualities of the therapist. They mentioned specific qualities such as kindness, warmth, sympathy and treating the participant as an individual. They also highlighted the importance of feeling respected, even if it was evident the therapist had little knowledge or experience. These are core components of Rogerian ideas, offering unconditional positive regard to build and maintain a therapeutic alliance based on reciprocal positive feelings and a personal bond (Ardito & Rabellino, 2011; Rogers, 1951).

4.2.1.3 Harmful actions: All participants also named multiple actions which were experienced as harmful or transphobic. A cross-party governmental report in London found as many as 70% of trans people have reported experiencing transphobia when accessing primary care (such as GP practices). This included being misgendered, deadnaming, use of incorrect pronouns and microaggressions (London Assembly Health Committee, 2022). Participants in the current study named examples of all these actions. Transphobia and harmful actions have been shown to be a key barrier for trans people when accessing healthcare in both the USA and the UK, despite the very different healthcare systems and structures (Safer et al., 2016; Stonewall, 2018b).
In the UK, the NHS is seen as largely anti-trans, especially in the context of the recently published Cass Review (2024) which recommends gender identity services for young people to move away from gender-affirming models and more toward models of psychoeducation and therapy (Block, 2024; Horton, 2024).

Another harmful, transphobic experience, which was shared by several participants, was the therapist pathologising or conflating their trans identity with mental health difficulties. Pathologising is “to unfairly or wrongly consider something or someone as a problem, especially a medical problem” (Cambridge Dictionary, 2023). This was experienced as therapists blaming their mental health difficulties on their transition and, in some instances, suggesting they stop their transition completely. This reflects the medical view that being trans is a diagnosable mental health ‘disorder’. In 2019 the WHO acknowledged the stigma caused by this pathologising of trans identities and, in 2022, these came into fruition in the tenth edition of the ICD (ICD-10). Outdated terms such as ‘transsexualism’ were replaced with ‘gender incongruence’ and moved from being considered as a ‘mental and behavioural disorder’ to a ‘condition related to sexual health’ (World Health Organization, 2023). This change mirrors that made in 1973 to remove homosexuality from the DSM-2 to depathologise it. However, it was only in DSM-5, published in 2013, that the final traces of homosexuality were truly removed (McHenry, 2022). Given that the DSM-5 still includes the diagnosis of ‘Gender Dysphoria’ and is more commonly referenced in the UK, there is expected to be a legacy of these views for years to come (Horton, 2022).

Trans people should be legally safeguarded against any form of discrimination as per the Equality Act (2010). As in section 1.3.2, gender reassignment is a ‘protected characteristic’, and trans people should be recognised as their affirmed gender without the need for any affirming treatments. Within the NHS, the values of the constitution recognise respect, dignity, and compassion as values which all staff employed are expected to demonstrate (NHS, 2015).

4.2.2 How are these experiences understood?

4.2.2.1 What did I expect? The expectations of participants going into their appointments were low based on previous personal, community, and professional experiences. This is in line with several studies which show that trans people often delay accessing healthcare services due to fear of discrimination, with Kcomt et al. (2020) finding that 23% of their sample of over 19,000 trans people had avoided healthcare completely due to this fear. Seelman et al. (2017) found that almost 72% of the 417 trans people they asked had delayed attending any healthcare appointments and had not engaged with a routine check-up for two years due to a fear of being discriminated against. These low expectations show the awareness that trans people have that they are accessing a healthcare system not designed with them in mind.

Although some participants did personalise their experience, for example by considering that the professional ‘just didn’t like them’, all participants considered their experiences within a wider systemic context, either by considering shared negative experiences from friends and other members of the trans community or through their knowledge as a current or ex-NHS professional. There is little literature on the relevance of these processes at a within-group level, and how these may impact on the perceived experiences but, at an intergroup level, shared experiences are thought to increase solidarity (Cortland et al., 2017). It may be that participants were leaning on shared experiences to contextualise and not feel so alone in what happened to them. This lends itself to the application of community psychology theories to address these expectations. It is recommended that clinicians aim to understand how wider systemic issues are in play for trans people even before accessing services (American Psychological Association, 2021). Social capital, the quantity and quality of social connections, which generate both individual and wider systemic benefits, is often vital to marginalised communities (Siegler, 2014). Using ideas from community health psychology, professionals can endeavour to move away from an individualised understanding of expectations of and barriers to healthcare. Systems and services can then begin to be embedded in communities, ensuring these expectations are part of an open discourse to better inform practice (Campbell, 2019).

4.2.2.2 Why did that happen to me? Given the critical realist epistemological stance of the current research, it was unsurprising that participants' meaning-making of their experiences emerged as a superordinate theme. This theme connects to the idea of sense-making, a term coined by Karl Weick (1995) to describe the retrospective process of organisation and understanding aiming to rationalise the behaviour of others (Weick et al., 2005). This model was developed to understand how individuals and organisations make sense of and navigate the systems in which they exist and has been criticised for not considering power and context. A development of this idea is that of critical sense-making, which considers how people make sense of the experiences that happen to them on an individual level but locate this meaning within broader contexts and understandings of power and privilege (Helms Mills et al., 2010). This is more applicable to this study's participants understanding their experiences, demonstrated by examples shared applying the context of therapists' lack of knowledge and lived experience.

This also links to Leon Festinger's (1957) Cognitive Dissonance Theory which may suggest why some of the sense-making shared by participants led the researcher to question if these were in fact explanations or rather excuses.

Cognitive dissonance suggests that, when people hold conflicting beliefs, values, or attitudes, this causes a level of emotional or mental discomfort. People will engage in behaviours to minimise these feelings, such as justifying or rationalising behaviour (Harmon-Jones & Mills, 2019). It is plausible that participants over-justified some of the actions they experienced, to reduce the emotional discomfort of these negative and harmful actions. Not only from the actions themselves but also how these are at odds with their own values and beliefs on how trans people should be treated when accessing NHS mental health services.

One participant did acknowledge this during their interview, by reflecting that they try not to hold the belief that all experiences are due to transphobia, as this leads to a lack of trust, but rather try to *hope* that people are doing their best. Snyder's (2002) cognitive model of hope suggests that the ability to have and hold onto hope sits somewhere between a mindset and skill set. Having hope has been shown to reduce psychological distress including depression and anxiety, particularly when hoping for societal improvement, as well as improve quality of life, coping and overall wellbeing (Laranjeira & Querido, 2022; Smithson et al., 2022).

4.2.2.4 The stage of my journey and Do I 'pass'? / How do I present? Although separated as subordinate themes, to allow full understanding and appreciation of the interview data, there is overlap in the understanding of these two ideas. The preservation of this terminology within the analysis is discussed further in section 4.4.1. For expansion on this idea, the language will be converted to 'visual conformity with affirmed gender' (VCAG).

How trans people perceive their own VCAG and anticipate being treated by others is a significant predictive factor for delaying or avoiding access to healthcare services (Kcomt et al., 2020). Given that non-VCAG has been shown to increase instances of victimisation and even violence (not within healthcare services), it is unsurprising that this perceived discrimination by healthcare professionals is a shared and common belief (Bratton, 2021).

These outcomes are worse for trans people of colour, as the intersection of racism and transphobia further increases the likelihood of discrimination (Kattari et al., 2015; Muhigaba, 2023).

The intersection of these two themes is the idea of a person's own sense and self-acceptance of how their outward gender presentation (VCAG) is 'congruent' with their inner sense of their affirmed gender. The participants shared that they felt their experiences were better when the therapist perceived them as VCAG, and it also reduced some of their own anxiety around how they would be perceived or treated. Similarly, the further along participants were in their own journey of transition, coming out, or gender exploration, they felt that had not only different expectations, but understood their experiences differently.
It is of note that participants who did mention the relevance of VCAG did this in a binary way, noting that being perceived as either male or female was useful to reduce negative experiences. This opens the opportunity for further exploration of non-binary identities and the experiences of those who are gender fluid. It may be that participants did not explore ideas outside of cisnormativity given the researcher's position as a cis woman.

This can create a reciprocal sequence of cause and effect known as a vicious circle (Wender, 1968). Not feeling an inner sense of VCAG, or believing this is the perception of others, can increase depression and anxiety. It can then, in turn, lead to healthcare avoidance, so these difficulties can go unsupported (To et al., 2020). For this reason, trans people who visually conform may conceal their identity as a trans person and 'pass' as cis, to avoid discrimination. This can then lead to a lack of access to appropriate services to support trans-specific healthcare (White Hughto et al., 2015). Not accessing appropriate gender-affirming care can then lead back to increased mental health difficulties, and so the vicious circle continues (Tordoff et al., 2022).
This also closely links to the 'circles of fear' model, developed with black communities, which demonstrates how power operates within systems and institutions such as NHS mental health services (Keating et al., 2002). This power acts to oppress marginalised communities and can stop them from accessing services. In the original model, mental health services represent experiences of racism in wider society, and mirror other discriminatory systems such as

education or the police, so are often seen as a 'last resort' (Keating et al., 2002). For trans people, mental health services operate in similar ways, representing structures where they cannot authentically be themselves, leading to delayed access or avoidance, which, in turn, worsens mental health outcomes.

4.2.3 How are these experiences managed?

4.2.3.1 How did I cope? All participants shared examples of how they had 'coped' with the experiences in their appointments. 'Coping' is the thoughts and behaviours that an individual consciously employs to manage stressful situations and heightened emotions. People vary in their 'style' of coping (Algorani & Gupta, 2023)., and this was evident in the current research. A framework to understand styles of 'controlling', 'approaching', 'avoiding', and 'escaping' (Segerstrom & Smith, 2019) fits with the examples shared by participants.
'Escaping' differs slightly from 'avoidance'. Several participants shared examples of 'escaping', by leaving appointments or terminating calls when they encountered transphobic or harmful actions. One person did share that they had postponed their appointment several times, an example of 'avoidance' by not engaging with situations which may increase the chance of encountering stressful situations or emotions. Another person shared that they censored what they shared in their appointments to avoid misinterpretation or discrimination, in a bid to 'appease' and fit with the requirements of the NHS services. No clear examples of 'approaching' were shared, with the most common coping style being 'control'. Participants exhibited 'control' as a coping mechanism by using humour, engaging in their own research and, most notably, by advocating for themselves during and after appointments. Self-advocacy can be seen as a burden and can position individuals as 'reluctant educators', having to provide the correct information to ensure treatment is adequate and to reduce feelings of frustration (Ervasti, 2015; Willis et al., 2020).

Interestingly, no participants shared experiences of relying on social support or social coping to help them process and manage their experiences. This is generally a recognised and useful method of coping (Algorani & Gupta, 2023; Colori, 2021) and has been shown to develop coping mechanisms and emotional resilience within the trans community (Sherman et al., 2019). There are several possible reasons participants did not mention this. Firstly, at a societal level, the

UK has long been considered one of the most individualist societies in the world, valuing independence and a self-determination over considerations of community (Hofstede, 1980). Secondly, at a group level, the lack of trust towards the researcher as a cis woman and outsider when it comes to accessing social capital and community support (Szkudlarek & Biglieri, 2016). It could also be that health care and access to mental health services is a private topic, and generally not discussed openly in the UK due to stigma (Mind, 2023).

Again, this points toward the value of social capital, and clinicians leaning on community psychology theories and methods to understand the experiences and coping strategies of trans people accessing healthcare, to improve practice and health outcomes (Campbell, 2019).

4.3 Critical Review

4.3.1 Quality Assurance

Quality assurance in qualitative research is a growing area of research and debate, comprising checks and practices undertaken throughout the research process (Reynolds et al., 2013). From a critical realist perspective, as qualitative research does not aim to find a single and measurable truth, traditional quality assurance measures cannot be utilised. Those relied on for assessing quality in quantitative research, such as reliability, validity, and generalisability, need to be reconsidered and re-operationalised (Mays & Pope, 2000).
Spencer and Ritchie (2012) suggest three principles that can be applied to qualitative research to assess quality: contribution, credibility, and rigour.

4.3.1.1 Contribution: The contribution of the research considers its “value and relevance” (Spencer & Ritchie, 2012, p. 229). As shown in the literature review, there is a significant gap in this area. Very little research relates to how trans people experience mental health services, specifically in the UK and using the NHS. For that reason, this research is a vital contribution to the field, which aims to begin addressing this gap. It is hoped that further research can be conducted, thus increasing the value and relevance. The researcher plans to submit the research to peer-reviewed journals to disseminate the findings on a national level. The researcher also aims to contact NHS trusts and/or NHS England to share the research findings and clinical implications with a long-term goal to inform training, policy and practice.

4.3.1.2 Credibility: The credibility of the research considers the “defensibility and plausibility of the claims made” (Spencer & Ritchie, 2012, p. 230). It is concerned not only with the claims made, and how believable these are, but how these claims have been derived from the data provided by participants. The researcher followed the reflexive TA methodology (see section 2.8), including a process of immersion in the data to generate themes that directly linked to the words and experiences of participants. The credibility of the analytical process is evidenced through presentation of key quotes from interviews within the results section.

However, an element of credibility is lacking from the current research given the minimal input from living/lived experience consultants. Although there was contribution to the study design, the analysis of results and discussion stemming from this was undertaken solely by the researcher. This only provides one viewpoint from someone with no lived experience of being trans. Although not feasible given the time restrictions, having at least one consultant involved in analysing the raw interview data would have significantly bolstered the credibility of this research.

4.3.1.3 Rigour: Rigour considers the validity of the research by assessing the “...transparency of research processes, defensibility of decisions and thoroughness of conduct” (Spencer & Ritchie, 2012, p. 236). A detailed rationale for the methodological decisions and a thorough description of the analytic process were outlined in the methods chapter.

The researcher’s understanding of and journey through the data was discussed in supervision which supported with refining the themes. As this research used reflexive TA, the opportunity to reflect outwardly to the supervisor as well as inwardly using reflective logs was beneficial to consider the research process, the impact of the researcher’s position, and how this guided their decision-making (Spencer & Ritchie, 2012). Excerpts of transcripts and the analysis process are provided to further demonstrate the movement of information from raw data to codes, themes, and superordinate themes. Appendices O-R also outline the analytic process including interview extracts showing coding and analysis, and several thematic maps from development to refined, final themes.

4.3.2 Strengths and Limitations

Although there are limitations to the research, there are also strengths which demonstrate that the research did generate rich data and address a gap in the literature.

4.3.2.1 Research Design: Two consultants offered suggestions that people may prefer written surveys to face to face interviews, or for written surveys with the option for the participant to consent to a follow-up face-to-face interview if required. Due to the time constraints of conducting this research as part of a professional doctorate, and the aims of the research, the researcher and supervisor felt this could make it difficult to track the participants accurately and ensure data was not replicated. The decision was made to focus on face-to-face interviews but, if there was no uptake, there was a ‘back-up’ of offering written surveys to increase participation.

Limitations of only offering face to face interviews include a reduction of anonymity and accessibility (Braun et al., 2020). They also require more time commitment from both researcher and participants. However, interviews generally yield richer data, as people can more fully engage with the researcher, offering the change to develop a rapport and ask follow-up questions (Archibald et al., 2019; Oliffe et al., 2021). Feedback from the UEL People’s Committee was that written questions may go unanswered if they are not understood, with limited scope to gather meaningful data if such a scenario were to occur.

4.3.2.2 Analysis: One of the key limitations of the study was the lack of trans voices in the research process, other than as participants. Despite reaching out to multiple organisations and individuals, the researcher only received replies from three people who acted as consultants during the development stage. This means that trans voices were not as centred as the researcher would have liked when developing and conducting the research. Owing to this, the previously mentioned time constraints, and the inability to pay a co-researcher, no lived experience consultants were involved during the analysis phase.

It is rare for lived experience co-researchers to be involved at this stage, but it has been shown to benefit research by providing different lines of enquiry, alternative perspectives, and different interpretations. It can also reduce bias and remove the academic ‘lens’ which researchers can apply when studying a field not representing their own lived or living experiences (Hemming et al., 2021).

Having an awareness of these limitations allowed the researcher to make some efforts to counteract them. The researcher was able to immerse themselves fully into the data, spending several months collecting, transcribing, and analysing interview data, ensuring the themes were generated from what the participants said. The researcher also drew on personal connections within the trans and queer community to informally discuss their understanding and reflections of the data.

4.3.2.3 Study Materials: Prior to interview, several participants reached out via email to fully understand whether their experience would be included within the scope of the research, suggesting a limitation in the wording of some of the materials.

Firstly, inclusion criteria raised questions as to what counted as an NHS therapist, and there was suggestion that this could be rephrased as few appointments in mental health services are with therapy staff. As the researcher had an existing definition of ‘NHS therapist’ for administrative purposes, included in section 1.2.2 it could have been useful to include this on the PIS.

Secondly, participants raised whether they had to identify as trans as the time of the appointment. Again, the wording in the PIS could have been expanded on to include the below definition which was shared via email when required:

> *At the time of the appointment, the person identified as trans, and most notably that the professional was aware of this during the appointment. This does not have to be after social or medical transition.*

4.3.2.4 Sample: The study recruited eight participants, with the original aim being 12. Although there is contention about the use of 'saturation' in methodologies outside of Grounded Theory, Ando et al. (2014) suggest that 12 participants do allow for saturation in generation of codes and themes within TA. Due to the nature and aims of the research and of RTA, the purpose of the findings was not to generalise, but to produce rich data to explore and understand experiences, considering the implications of these within a wider systemic context (Braun & Clarke, 2021b). The sample represented a range of trans identities, as discussed in section 2.5.3.

However, it is of note also that all eight participants identified their ethnicity as White British, meaning the research did not consider any experiences of trans people from racialised backgrounds. Although people from a racialised background are over-represented in UK mental health services, this is more commonly seen in crisis or detention services. The racial disparities for primary and secondary care services are in fact often through underrepresentation, alongside poorer experiences and rates of recovery (Bansal et al., 2022; Thornton, 2020).

This may explain the lack of representation in this research, as all the experiences related to primary or secondary care non-crisis or detention services, although it is possible that the researcher's identity also contributed to this. The researcher considered her position as a cis woman entering trans spaces but did not overtly consider her position as a white cis woman. George et al. (2014) conducted a review, albeit in the USA, which showed racially marginalised people experience several barriers when accessing health-based research.
The researcher's position as a white woman, representing institutional systems of oppression and colonialism, could have acted as a barrier to trans people of colour reaching out. Given the intersection of racism and transphobia, often culminating in increased violence, particularly towards black, trans women, it would be pertinent to ensure these voices are heard in future research (Ellison et al., 2017; Jefferson et al., 2013).

Similarly, the sample only included participants aged between 21-32, meaning the voices of older trans people were not captured in the research. This could have been due to the online nature of the research advertisement, recruitment, and interviews. The ‘digital divide’ in the UK shows increasing age reduces internet access and usage, which has only worsened since the Covid-19 pandemic (Bozek et al., 2022). The socio-cultural views on trans identities have changed significantly during the life span of older adults (e.g., 50+), and they therefore may hold views about what a younger person may be able to understand and appreciate about their historical experiences (Siverskog, 2015). The researcher’s position as not only a younger person, but also a cis person, known from the research advert, may have stopped older adults reaching out. Given historical experiences and proven worse health outcomes, again it would be pertinent to include these voices in future research (Benbow & Kingston, 2022; Fredriksen-Goldsen et al., 2013).

4.3.2.5 Themes: As explained in section 3.2, the four themes are framed as questions and do closely relate to the original research questions. There are possible limitations here, in that it could be viewed that the themes did not emerge from the data, but rather the questions were mapped onto the data and it was made to fit a narrative.

All themes did emerge from the data, as mentioned in section 3.2 the journey of the participants through the appointments was central to understanding their experiences. Framing the themes as questions as if in the voices of participants to understand their experiences before, during and after the appointment allowed the voices to be preserved. The researcher not only wanted the themes to be worded as if from the participants, but wanted to ensure they captured their experiences and the understanding or explanations made for these experiences.

Four alternative themes were considered: therapist actions (including gender-affirming and harmful actions), therapist qualities, understanding of experiences (including expectations, stage of own journey and ‘passing’) and coping strategies. On reflection two of these focused too much on the therapist rather than the participant, and the headings seemed reductionist when considering such a personal and sometimes distressing experience.

4.3.2.6 Experiences of the public: It is of note that this study does not consider the general level of (dis)satisfaction and experiences with NHS services in the

UK. As previously mentioned, outcomes and experiences have been shown to be generally worse for the trans community as compared to their cis peers (Fish et al., 2021). However, the access to and experience of mental health services, especially negative experiences, are not exclusive to the trans community.

The overall satisfaction with the NHS reduced significantly from 60% in 2019 from to 24% in 2023 (Appleby et al., 2020; Jefferies et al., 2024). Kirkham et al. (2022) found that overall satisfaction was lower for mental health services than it was for physical health. Of their participants who had accessed mental health services (n=526), 48% were satisfied with their most recent contact with services. The NHS Patient Survey Programme carry out regular surveys to understand and assess the NHS' performance. They found in their 2023 survey that only 39% of almost 15,000 respondents had 'definitely' received the support they required at their last mental health appointment (NHS Patient Survey Programme, 2022). Although not entirely comparable to qualitative experiences explored in the current research, these findings suggest other marginalised and non-marginalised communities will experience services negatively and express a level of dissatisfaction. The experiences of the participants in this study and the trans community generally may be situated within a wider context of dissatisfaction perceived by any patient accessing mental health services and the researcher wanted to understand and recognise this, at least at a surface level.

4.4 Researcher Reflexivity

As discussed in section 2.8.2, I was drawn to this research topic given previous professional experiences supporting the LGBTQ+ and more specifically trans communities. This experience mostly occurred within an NHS trust in the south of England, as a member of the leadership team of the trust's LGBTQ+ network. This 'ally coordinator' position was a voluntary role which I undertook alongside my full-time, paid psychology role. I initially became involved with the network as an ally, growing up with several close friends who are members of the queer community, and seeing the lack of training and support offered within the healthcare professions. I gradually progressed into the role within the leadership team, taking responsibility for training and supporting allies.

As there were no ‘out’ trans members of staff in the trust, I then took on responsibility within the network for supporting trans people. This involved working with partner organisations to deliver training, writing policy, and introducing pronouns to email signatures. All of this work was undertaken alongside trans people accessing services and led to the Trust being recognised as a ‘Stonewall Top 100 Employer’ in 2022. This ignited my passion for supporting the trans community, and I knew entering onto doctoral training that this was the area of research I wanted to pursue.

I wanted to undertake research in this area not only due to this experience, but also experience as a clinician seeing the lack of knowledge in the teams I had worked in. I found myself often correcting pronoun use, calling out deadnaming or other transphobic actions and educating colleagues about terminology. This was further entrenched by the clinical systems we used not having options to easily identify someone as trans, or to change names, pronouns and titles leading to confusion and the occurrence of harmful actions. I felt that if I was observing these experiences as a staff member, what were trans people experiencing when attending appointments? I wanted to understand these experiences further, with the hope of being able to inform future research, policy, and training priorities for NHS services.

Given my previous experiences, I anticipated hearing an abundance of negative experiences from the participants. I was aware of this as early as the planning stage and raised it in supervisory discussions with my DoS. We worked together to ensure that my interview questions were broad enough to limit bias and not influence participants’ answers (Roberts, 2020). I didn’t want to impose my own perspectives during the interviews or analysis increasing the salience of negative experiences and meaning other experiences were lost within the interviews. This was also combatted by using semi-structured interviews which were asked in the same way to each participant, only adding in new lines of enquiry if relevant, not only to the answers being provided but the purpose and aims of the research (Bergelson et al., 2022).

During all stages of the research, I was also aware that being a cis woman positioned me as an ‘outsider researcher’, not belonging to the same group as the participants (Braun & Clarke, 2013). On one hand, this can be problematic, as outsider researchers can struggle to access participants, and those who they do reach can be unwilling to disclose honest answers (Borrill et al., 2012). Conversely, it can be seen as a strength, as outsider researchers can detach personal experiences and offer more balanced, neutral views (Finefter-Rosenbluh, 2017). I explored the idea of an 'indigenous outsider', owing to the likelihood of shared views, values, beliefs and most notably biases with the participants (Banks, 1998). This also acknowledged my position, possible shared experiences with all participants of being white. Also, my position as a current NHS professional, as with some of the participants, which may have contributed to a shared language and rapport building in the interviews.

Despite all of this, indigenous outsiders are still viewed as outsiders by people within the community, and shared positions do not always lead to shared understandings or more insight (Browne, 2023; Browne & Nash, 2016). Given my lack of lived experience of the specific marginalised experience of being trans, representing the institution which contributed to harm for some participants, and purely within the consideration of power in research such as this, I felt comfortable within my position as an outsider, and named this to participants. This also made me aware of the 'interviewer effect' when considering my position within the interviews (Denscombe, 2014). Namely how relevant the participants' perceptions and views of me as an outsider were as they approached discussing their experiences.

This linked closely to my reflections on the possible impact of power in the interviews (Fors, 2021). I represented not only the power disparities in therapeutic relationships but the clinical structures which the participants were discussing, which at times had been harmful. I wondered how comfortable participants would be discussing honest experiences of the NHS and mental health services. I tried to overcome the effects of both by explicitly naming my position as a cis woman and my rationale for undertaking the research.

4.4.1 Language / Terminology

There were several instances during the interviews where language preferences and choices were discussed. Firstly, asking each participant to describe/define their gender identity. The reason for the inclusion of this question was the assumption that all experiences would be different due to changes in legislation, i.e. the experience of a 60-year-old trans woman would likely be different to that of a 19-year-old non-binary person (Fairbairn et al., 2020). Asking people to label and define themselves 'neatly', when several of the participants said they did not agree with using labels or being 'put into boxes' made it feel as uncomfortable as it was important. That being said, all participants were comfortable in discussing this question, some in more detail than others, and to label their gender identity for the purpose of the research.

Secondly, the term 'passing', a controversial term that many trans people don't connect with or use. It describes a person's 'visual conformity' with their affirmed gender and societal expectations of gender identity and gender expression, (Anderson et al., 2019; To et al., 2020). I chose to retain this language use as it was consistently used by participants who raised this as an area of importance but, as they all used visual 'air quotes', the term remained in quotation marks during the analysis.

4.4.2 Intersectionality

One of the participants raised the relevance of intersectionality. There were no questions when gathering demographic information about disability and/or neurodivergence. The participant who raised this highlighted the relevance of their chronic health condition and diagnosis of ADHD/Autism to their experience as a trans person. Not only is there an overlap, with the prevalence of neurodivergence higher among the trans community, but this leads to issues around intersectional stigma (Maroney & Horne, 2022; Warrier et al., 2020).
I reflected on not asking this question, and that none of the other seven participants raised any questions or thoughts. Had people not raised it as it wasn't relevant or because it wasn't explicitly asked? Although difficult to answer with certainty, given that up to 1/4 of people in the UK wouldn't disclose a disability to a prospective employer, the latter seems more probable (Evenbreak,

2023). It is likely I did not include this question because it is not a part of my living/lived experience, therefore creating a blind spot (Totsuka, 2014).
As blind spots are often pointed out by others, as by this participant, rather than through introspection, future research could collaborate with trans people who represent other marginalised identities (e.g. disability, race, and religion) to ensure that any other blind spots were recognised and accounted for. I also reflected on the Social GGRRAAACCEEESSS, an acronym for: gender geography, race, religion, age, ability, appearance, culture, class/caste education, employment, ethnicity, spirituality, sexuality, and sexual orientation. These are used to describe personal and social aspects of one's identity which contribute to differing levels of privilege and power. Inclusion of these in in future research could ensure more representative and relevant demographic questions (Burnham, 2012; Fiarman, 2016).

4.4.3 Experience of Interviews

As part of the reflective process, I thought in depth about how I had experienced the interviews as the researcher holding a position of power. I experienced all eight interviews as a relational process, in that it wasn't just an inquiry led by me (Fujii, 2017). In reflecting on this, I came across the idea of 'teller-focused' interviews, and although I do not claim to have fully utilised this technique within my research, it felt comfortable to align with this idea to understand the experience of the interviews. It has its roots within dialectical thinking, which likely closely aligns with my clinical experiences of working within a Dialectical Behaviour Therapy (DBT) model. In line with this, it felt like the participant and I were 'partners' in the process, with a "...mutual desire to gain an understanding of the research issues" (Hydén, 2014, p. 796).

Each interview was unique and not only due to the individual stories being shared, but also how the participant utilised the space to share their particular story. Some participants used the space to 'vent' their frustrations and negative experiences, feeling like a therapeutic session in some ways. Other participants held a much more sympathetic and understanding position with regards to both positive and negative experiences they had encountered. They were sympathetic toward the therapist they had encountered and spent time in the interview trying to not only make sense of their experience, but to validate and understand the experience from the point of view of the therapist.

I understood the surprisingly positive experiences shared in the interviews not only in the context of low expectations as discussed in section 4.2.2.1 but also in the context of this position of sympathy and understanding.

4.5 Implications

There are several implications to this study, from an individual practitioner to a wider-systemic level. These are most relevant to the NHS, as the research focused on experiences within NHS mental health services but can likely be applied to wider healthcare settings.

As this is an ever-evolving area of knowledge with a direct impact on discrimination of a marginalised group, it is hoped the clinical implications will support individual practitioners working with the trans community, whilst the research implications will suggest future research priorities. The training and policy implications will address systemic and institutional needs within the NHS, in line with and expanding on the National LGBT+ Action Plan (NHS England, 2018).

4.5.1 Training and Policy

As previously mentioned, there is no publicly available information relating to mandatory training requirements for NHS professionals. From the researcher's own electronic staff record (ESR), 25 mandatory training courses are required to undertake their clinical role. None of these courses relate specifically to supporting the trans community, and a search of the online training catalogue available to NHS staff yielded no results for 'trans', 'transgender' or 'LGBT' (ESR Support, 2024). This was raised by several participants who are also NHS professionals, as they were aware of the lack of training relating to working with the LGBTQ+ community let alone trans specific issues or awareness. The generic Equality and Diversity online training includes at most two slides or scenarios relating to the needs of LGBTQ+ people when accessing or working for NHS services. The NHS Equality, Diversity, and Inclusion Improvement Plan

(NHS England, 2023c) only focuses on the protected characteristic of gender reassignment and does not accurately reflect the needs of the trans community. This suggests there is no planning or policy within the NHS to introduce more specific training programmes and address how to best support trans people.

In 2020, NHS Wales did introduce two voluntary training modules relating to gender diversity and trans health (Health Education and Improvement Wales, 2020) and, given all eight participants acknowledged the therapist they met with demonstrated a lack of training and knowledge, it is recommended that NHS England follow suit. Initially, for similar specific modules to be available through NHS training, with a future goal of mandatory training to include LGBTQ+ awareness, including a dedicated section focusing on the needs of the trans community, and how best they can be supported when accessing services. It is advised that this is developed in conjunction with organisations run by and for the trans community such as Stonewall, Mermaids and GIRES. Initially, this training should be a ‘basic’ awareness level training including information on the history and context of trans identities, terminology, and best practice. The training should be ongoing, experiential, and continually reviewed (CIPD, 2019). It is hoped that if this was developed and expanded across the NHS as a mandatory training, there could then be introduction of a ‘higher-level’ training for staff with a keen interest who could then act as ‘ambassadors’ or ‘leads’. This could follow previous training packages which have applied a similar model such as Infection Prevention and Control (NHS Suffolk and North East Essex, 2023).

There are currently 229 NHS trusts in the UK, 50 of which are designated mental health trusts (NHS England, 2023d). There is no definitive way to confirm how many currently have specific policies about working with and supporting trans people. If future research is conducted, a useful preparatory task would be to carry out an in-depth search of publicly available policies or submitting Freedom of Information (FOI) requests to each trust. This would allow research to be conducted with accurate context of how many trusts have updated policies in place. Again, anecdotally, from the researcher’s previous experience working with an NHS trust in the south of England, the organisation had no policy or guidance in place for supporting trans people until 2021. It was then written by the researcher in conjunction with the LGBTQ+ network, Stonewall, and trans service users.

Based on the varied experiences of the people who participated in this research, it is recommended that all NHS trusts, especially those with a focus on mental health, have regularly reviewed policies. These policies should be co-produced, not only with relevant stakeholders and organisations, but also with trans staff members and people accessing services. This would be in line with existing NHS frameworks to ensure policies centre public voices and ensure effective, consistent, and safe care for all (Boudioni et al., 2017). Several of the existing policies, including that written by the researcher, address the needs of staff and people using services in one policy. It is recommended that these are separated, as the needs of staff and advice from an employment law perspective will differ from the needs of people accessing healthcare, and the advice given to professionals supporting them. The policy for staff should include legal information for employers to best support trans staff at work relating to areas such as leave, change of names and pronouns and any possible implications to their role. It should also detail information relevant to the recruitment and selection process for potential employees for example use of gender-neutral language in job adverts and how all suitable candidates will be considered equally. The policy for people using services should provide a framework for professionals working in inpatient, community, and residential services. This should closely link to the training packages available and offer guidance on how to approach potentially sensitive or difficult situations or conversations. Both policies should take a holistic view of diversity, with specific considerations on intersectionality.

It would be expected, or at least hoped, that introduction of consistent, mandatory training and policy would ensure that staff within the NHS are accountable for their own knowledge about working with trans people. A baseline level of knowledge would hopefully allow for more open discussion within teams and overall increase the positive experiences encountered by the trans community when accessing NHS services. Training and development are considered to be an important first step towards creating and implementing positive change in organisations (Balogun et al., 2016). To fully ensure positive outcomes for both trans employees and particularly people accessing services, NHS trusts need to ensure a level of cultural competency amongst their workforces. The introduction of training and policy alone are not enough to ensure an impact, there needs to be a positive ‘inclusion climate’ which is both bottom-up, from clinical staff on the ground, and top-down from senior management who encourage and promote inclusion and equity for all CIPD (2018).

4.5.2 Clinical

At an individual level, there are several recommendations for how therapists and professionals working in NHS mental health services can better support the trans community.

Firstly, for NHS staff to engage in learning and training in a voluntary way. Findings from the Stonewall (2018b) trans report found that 41% of trans people felt healthcare staff lacked understanding and knowledge relating to trans people’s needs. Although the findings in the Stonewall report related to general healthcare services, all participants interviewed in this research felt that the NHS therapist(s) in mental health services they met with demonstrated a lack of knowledge. Owing to the lack of mandatory training as outlined above, NHS staff are voluntarily seeking information to increase their knowledge. A study conducted in Europe, which did not include the UK but still holds relevance, showed that almost 60% of healthcare professionals who participated had gained information through their own initiative. Almost 60% of the same group of staff favoured training focusing on trans needs as part of their mandatory continuing professional development (CPD) and wanted this delivered by organisations specialising in trans or LGBTQ+ needs (Burgwal et al., 2021). Undertaking training relating to trans issues and/or gender identity can greatly improve the experiences of trans people accessing healthcare services (Willo, 2021). Within the UK, there are multiple online and in-person training packages available, delivered by charities or individuals and, until this is mandated, it is recommended that NHS professionals endeavour to engage in these.

Secondly, the importance of personal qualities and attributes, and the need to reflect on and develop these. Having the desire to engage in voluntary training, or increase knowledge to better support trans people, in some ways mirrors the importance that participants attributed to personal qualities of individual therapists. Although participants said this often outweighed the value of formal training and knowledge, it is more likely that therapists who display some of the positive personal qualities mentioned will seek out information and experiences to increase their knowledge base. Hendricks and Testa (2012) found that clinicians who felt most competent in supporting trans people showed higher levels of self-awareness, insight, and reflection, particularly into their own biases.

It is therefore recommended that NHS staff use supervision spaces to reflect on not only their skills and knowledge, but also their qualities and attributes which may allow them to offer a gender-affirming experience by building and maintaining a warm, respectful, and positive therapeutic relationship with trans people accessing services. This could be using a model such as the Social GGRRAAACCEEESSS (Burnham, 2012), to reflect on one's own identity and how this may contribute to acting out power and privilege within clinical spaces. A second useful model may be The Johari Window (Luft & Ingham, 1961) to understand one's own perception of self and how one is perceived by others using the below quadrants:

- Open Area: Known to self and others
- Blind Area: Unknown to self, known to others
- Hidden Area: Known to self, unknown to others
- Unknown Area: Unknown to self and others

By recognising these aspects of identity, professionals can name systems and structures which can cause oppression and which they represent. This then contributes to a shared understanding and awareness of trans people's expectations when approaching NHS mental health services. Once these are identified, efforts can be made my professionals to correct them and allow more welcoming, accepting and affirming services (Patin et al., 2021).

Finally, for staff to engage in staff LGBTQ+ networks to increase their learning and knowledge. Staff networks are seen as vital for reducing inequality, developing EDI plans and processes, and driving cultural change within NHS trusts (NHS England, 2023a). A survey showed that LGBTQ+ people and allies join staff networks to work alongside groups of like-minded people, meet people with shared identities, increase knowledge and awareness, and impact strategic and policy decisions (Einarsdóttir et al., 2020).

4.5.3 Research

It is hoped that this research will result in further studies which focus on the experiences and needs of the trans community within NHS and wider healthcare services. There are several recommendations for how to overcome limitations of the current research and increase the breadth of possible future research studies.

Future research could focus on increasing the reach and likelihood for people to participate, increasing the voices heard through interviews. It would be vital to include the voices of older trans people, and trans people of colour. Firstly, the research could be led by or involve co-researchers from the trans community. Secondly, the research could be developed, or even replicated, to use online written surveys. This increased anonymity may encourage more people, particularly those whose voices are less heard, to engage (Braun et al., 2020). Conducting this research outside the limitations of a doctoral thesis would allow future researchers the time and resources to conduct surveys and allow for the possibility of follow-up calls as suggested by the consultants. Thirdly, this would also allow for a longer consultation period, with more breadth. The researcher relied on existing personal and professional knowledge and connections to reach out to potential lived experience consultants. Since the time of project development, the researcher has been made aware of several more organisations who could have been contacted, particularly who support the black trans community.

There is possibility for a quantitative study to be conducted, looking at similar outcomes. Although the nuance and depth of people's experiences would not be understood, offering a Likert scale to rate the frequency and quality of experiences (positive and negative) would likely be well received by NHS trusts. Not only is quantitative data considered more reliable and generalisable, but it counteracts the time- and resource- intensive nature of collecting and analysing qualitative data (Verhoef & Casebeer, 1997). The option to complete a short online rating scale may increase participant numbers, and provide larger quantities of cross-sectional or longitudinal data, which could inform commissioning decisions in the hope of driving meaningful change.

It is of note that five out of the eight participants were currently or previously NHS professionals. Although discussing their experiences as people using services in this research, they did also include anecdotal experiences they have encountered in their roles. Owing to this, further research could focus on the experiences of staff who have direct experience of working with trans people in mental health services. This could involve a similar interview structure (either written or face to face) for NHS therapists working in these services and would allow researchers to understand how comfortable and confident NHS staff feel when engaged in this work. To the researcher's knowledge, at the time of writing, there are no UK studies which consider this. One study from Australia, based in paediatric oncology, found that, although staff felt comfortable working with trans people, they lacked confidence and knowledge (Ussher et al., 2022). Similarly, in the USA, mental health clinicians demonstrated unfamiliarity and a lack of training when supporting trans people (Whitman & Han, 2016). It is predicted, given the experiences shared by participants in the current research, that these results would be replicated and could offer further implications and recommendations to guide NHS training, policy, and practice priorities.

4.6 Conclusion

This thesis aimed to understand the experiences of the trans community when accessing NHS mental health services. Findings explored participants' journey through appointments, from the expectations pre-appointment to the experience during the appointment, through to the sense-making and coping relied upon post-appointment. There was a mixture of positive and negative experiences shared which is in line with the findings of Ellis et al. (2015).
Sadly, and unsurprisingly, all participants shared examples of harmful and transphobic actions they experienced. This only reinforces findings from Stonewall (2018b) that trans people in the UK face significant barriers to accessing healthcare. It is possible that this will only worsen considering the recent Cass Review (2024), further positioning the NHS as anti-trans.

The current research has several limitations. Firstly, the lack of trans voices as co-researchers in analysing the results, secondly, the constraints of the research as part of a professional doctorate, and, most notably, the sample. The sample was small (eight) and made up of only white British people aged between 21-32. This limits the understanding of the research from an intersectional perspective, particularly excluding the voices of trans people of colour, and older trans people.

Based on the findings of the current research, there are several implications and recommendations made for NHS training, policy and clinical practice, including:

- Introduction of voluntary training modules by NHS England
- Development of co-produced mandatory LGBTQ+ awareness training
- Continual review of trans inclusive policies across all NHS trusts
- NHS staff, particularly those in therapy-based roles, to engage in voluntary learning and training and ongoing reflection in supervision
- Increased visibility of and engagement with NHS LGBTQ+ network groups

It is recommended that further research focuses on increasing participation, particularly for trans people of colour and older trans people, and co-production with the trans community. It could also be developed to include written surveys to increase anonymity (Braun et al., 2020) or even collect quantitative data which is considered more generalisable (Verhoef & Casebeer, 1997). These may both increase participation but may also increase the potential impact in the hope of driving meaningful change for the trans community within the NHS.

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APPENDICES

APPENDIX A: SEARCH TERM GENERATOR

Worksheet: Search terms

Choose a research topic / title and enter it in the box below

Break your topic down into its key concepts and identify relevant keywords and synonyms.

Concept 1		**Concept 2**		**Concept 3**		**Concept 4**
Trans		**Experience**		**Mental Health Services**		**United Kingdom**
OR		OR		OR		OR
Transgender Non-Binary Gender Diverse Genderqueer TGNC	AND	View Perception	AND	~~Mental Health~~ ~~Appointment~~ ~~Healthcare~~	AND	~~UK~~ ~~Great Britain~~ ~~GB~~ ~~England~~ (Included by filtering rather than in the search terms)

APPENDIX B: SCOPING REVIEW STRATEGY

The guiding question in this literature review was the experiences of trans people within mental health services.

Search terms:

Different search terms were trialled, the final search terms were:
“Mental Health Services” AND (“Trans” OR “Transgender” OR “Non-Binary” OR “Gender Diverse” OR “Genderqueer” OR “TGNC”) AND (“Experience” OR “View” OR “Perception”)

Initially “NHS” was included in the search terms. This was then removed and replaced with (“United Kingdom” OR “UK” OR “Great Britain” OR “GB’). Again, this was removed and ‘geography’ or ‘country/territory’ filters were used on the relevant databases.

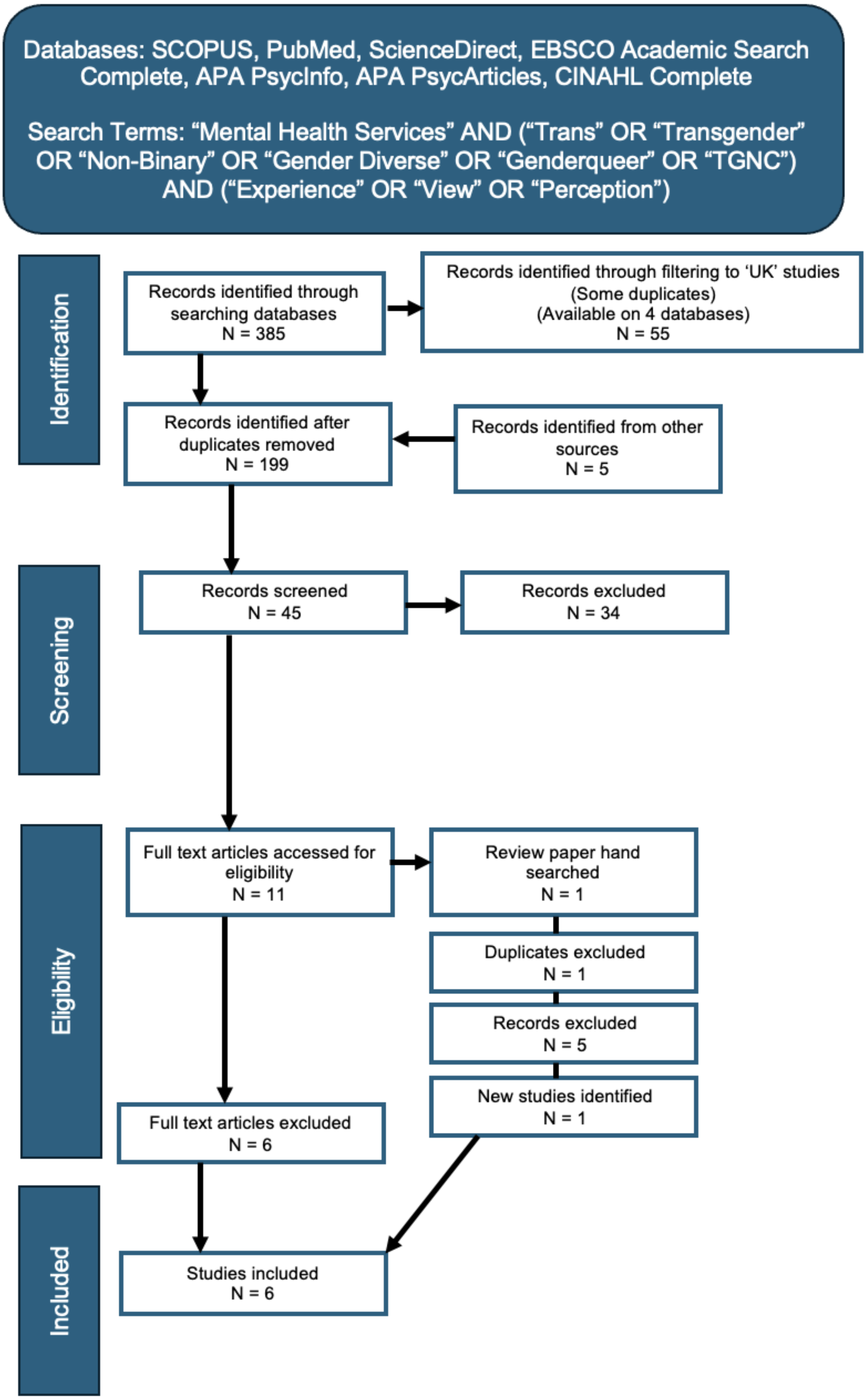
Inclusion criteria:

- Research focusing on experiences within mental health services.
- Qualitative or mixed-methods research.
- Participants are members of the trans community.
- Participants aged 18 or above.

Exclusion criteria:

- Full-text articles not available in English.
- Not complete academic articles (e.g., book chapters, personal commentaries etc.).
- Research focused on mental health outcomes.
- Research focused on general healthcare experiences.
- Quantitative research.
- Research focused on an intersectional identity *over* the trans identity of participants (e.g. homelessness, age, ethnicity, religion, disability).
- Research focused specifically on gender identity services or clinics (e.g. relating to surgery or hormones).
- Research focusing on the wider LGBTQ+ community.
- Review study

APPENDIX C: PREFERRED REPORTING ITEMS FOR SYSTEMATIC REVIEWS AND META-ANALYSES FLOW CHART (PRISMA; MOHER ET AL., 2010)



APPENDIX D: TABLE SUMMARY OF PAPERS

Goldberg et al. (2019)	USA	• Examine experiences with MH services • Focus on type of interaction, dynamics & assumptions	• 509 trans people • 403 completed qualitative answers • 82% white • Mean age 22	• Mixed methods • TA of qualitative data • Online written survey	2 themes: • Trans-positive experience - Affirmation - Education • Trans-negative experiences - Gender inflation - Assumptions	• Reflects a lack of training • Worse experiences for non-binary identities reflects binary idea of trans identities	• Location of care not specified • Specific to those attending higher education
Benson (2013)	USA	• Identify and recognise experiences • Inform and improve clinical practice • Promote social justice and foster change	• 7 trans people • 6 white, 1 latinx • Age 24-57	• Inductive TA • Semi-structured interview	3 themes: • Problems in practice • Therapist reputation • Trans affirmative therapy	• Medicalisation of gender • Need for affirmative training • Importance of experiences as an individual – not whole community • Acceptance and affirmation	• Limited representation of people from differing racial, educational, and socio-economic backgrounds
McCullogh et al. (2017)	USA	• Understand experiences so MHP's can connect and distinguish practice	• 13 trans people • 4 white, 4 black, 4 multiracial, 1 latinx • Age 21-54	• IPA • Semi-structured interview	4 themes: • MHP selection • Transaffirmative approach • Transnegative approach • Support systems beyond counselling	• Lack of intersectional understanding • Validation & affirmation • Lack of training •	• Small sample • Most pps identified on masculine spectrum • Higher education

APPENDIX E: UEL ETHICS APPLICATION

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2021)

FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form (please read carefully)

1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit 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 approvals that may be necessary (see section 7).

1.5	Research in the NHS: ▪ If your research 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, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites:

	https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ 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.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants ▪

Section 2 – Your Details

2.1	**Your name:**	**Ellis Hayes**
2.2	**Your supervisor's name:**	**Dr Navya Anand**
2.3	**Name(s) of additional UEL supervisors:**	**Dr Lorna Farquharson** 3rd supervisor (if applicable)

2.4	**Title of your programme:**	**Professional Doctorate in Clinical Psychology**
2.5	**UEL assignment submission date:**	**01/06/2024** Re-sit date (if applicable)

Section 3 – Project Details

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

3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	Understanding the experiences of the Trans community when accessing NHS Mental Health Services: A Thematic Analysis
3.2	**Summary of study background and aims (using lay language):**	Given that LGBT+ communities and more specifically trans people are at significant risk of mental health distress (Stonewall, 2018), there is a gap in the literature relating directly to the experiences of trans people accessing mental health services for support with this distress. Previous research has focused on survey data and/or review studies to provide mostly descriptive statistics relating to experiences within healthcare systems across Europe and the USA. Taking a critical realist stance, the proposed research aims to contribute to addressing this gap by collecting qualitative data from trans people aged over 18 who have accessed NHS mental health services to better understand their experiences. Data will be analysed using reflexive thematic analysis to discover common themes inform future research and NHS training priorities.
3.3	**Research question(s):**	The broad question is 'Exploring the experiences of trans people within NHS mental health services', underpinned by several driving questions: -What are the experiences of trans people? -What contributed to positive and negative experiences? -What could be done differently?
3.4	**Research design:**	Reflexive Thematic Analysis Qualitative Study

3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	Inclusion Criteria: Adult aged over 18 Trans Appointment with an NHS therapist lasting at least 30 minutes Appointment not as part of a gender identity service UK based English speaking Exclusion Criteria: Communication needs not supported by Augmentative and Alternative Communication (AAC) Personal connection to researcher	
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	A poster advertising the study will be shared via personal and professional connections, LGBTQ+ networks email lists and social media.	
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	Interview Schedule as created by researcher (Draft attached) UEL Microsoft Teams for Interviews	
3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	Data will be collected from interviews conducted using UEL Microsoft Teams. A maximum of 12 interviews lasting 60 minutes will be conducted, as it is suggested this figure allows for saturation to be reached in the generation of codes and themes (Ando et al., 2014).	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	If you selected yes, please provide more information here	
3.10	**Will participants be reimbursed?**	**YES** ☐	**NO** ☒

	If yes, please detail why it is necessary.	If you selected yes, please provide more information here
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	Please state the value of vouchers
3.11	**Data analysis:**	Interview data will be collected from individual participants via UEL Microsoft Teams. These will be video recorded and stored securely (encrypted with password). Attempts will be made to use the UEL Microsoft Teams transcription option, however these will be reviewed manually and amended accordingly. The data will either be exported to NVivo in a word file format and analysed using this software or analysed manually. Reflexive thematic analysis will be used to analyse the data. All data will be securely stored on the UEL One Drive for Business.

Section 4 – Confidentiality, Security and Data Retention

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.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.

4.1	**Will the participants be anonymised at source?**	**YES** ☐	**NO** ☒

	If yes, please provide details of how the data will be anonymised.	Personal data (name, email address, & signature) will be collected on the consent form. Demographic data will be requested from participants to allow for wider context to the data, they do not have to provide this to engage with the research: Age Gender identity Geographical location Ethnicity All responses will be stored as a word file which will be password protected. All names and identifiable data will be pseudonymised in the transcripts. The list of identifiers (pseudonyms) will be stored separately on the UEL OneDrive.	
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** ☒	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	To ensure confidentiality all identifiable data will be pseudonymised. There will be a document containing a key linking the participant's pseudonym and their identifying information to ensure that the correct data is withdrawn if the participant chooses to no longer participate. Participants will also be assigned a number to anonymize the data.	
4.3	**How will you ensure participant details will be kept confidential?**	Confidential and identifiable data will be obtained during the interviews and via email when participants send consent forms to the researcher's UEL email. Therefore, prior to transcription and analysis, all data will be pseudonymised in compliance with GDPR and all data will only be used for the purpose it was obtained. Indirect demographic information will be managed by using techniques including aggregating or reducing precision (recording age range rather than DOB).	
4.4	**How will data be securely stored and backed up**	UEL's OneDrive for Business is only accessible via the researcher's username and password. The laptop which will be used is personal, non-networked, with a password known only by the researcher. All documents (Word, PDF, Excel) will be	

	during the research? Please include details of how you will manage access, sharing and security	stored on the researcher's UEL OneDrive for Business. Data will be saved and organised using folders and subfolders. File naming conventions will be followed. The completed consent form documents (PDF) will be stored in a separate place away from the identifiable data, in a separate password protected file in OneDrive for business. The research supervisor will be provided with a copy of the anonymised interview transcripts (to be stored using their own secure UEL OneDrive account), to ensure there is a backup of this data. Each audio file will be named with the participant number. Pseudonymised transcripts of the interview will be stored in a password protected word file separate from the identifiable interview recording data. These files will be named using the given participant number. The list of identifiers (pseudonyms) will be stored separately on the UEL OneDrive Business.
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	Pseudonymised data (transcripts) will be stored separately from data that could reidentify someone (e.g., recordings of interview or personal data). They will be stored in separate files on the researcher's UEL OneDrive for Business which is secure and encrypted. Security will also be ensured by password protecting all documents and storing the data and meta data on UEL's OneDrive for Business which is secure and encrypted. The researcher will only share anonymised data (e.g., anonymised interview transcripts) with the research supervisor(s) and examiners. Data sharing with the research supervisor(s) will take place via UEL OneDrive (using OneDrive secure links) or UEL email.
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	Audio/Video recordings from MS Teams will be destroyed once transcribed in full. The thesis will use extracts of transcripts and be stored in the research open access repository (as outlined in the UEL Research Data Management Policy). All data stored on the UEL OneDrive for Business will be deleted by September 2024 as the thesis will have been submitted and the researcher will no longer have access to UEL systems once they complete the doctorate course. They will be sent to the research supervisor who will store them on their UEL OneDrive for Business for up to 3 years. This is for the case that the thesis may be required to be reviewed for publication. After 3 years, all data will be deleted.
4.7	**What is the long-term retention plan for this data?**	Audio/Video recordings from UEL Microsoft Teams will be destroyed once transcribed in full. The thesis will use extracts of transcripts and stored in the research open access repository (as outlined in the UEL Research Data Management Policy). All data stored on the UEL OneDrive for Business will be deleted by September 2024 as the thesis will have been submitted and the researcher will no longer have access to UEL systems once they

		complete the doctorate course. They will be sent to the research supervisor who will store them on their UEL OneDrive for Business for up to 3 years. This is for the case that the thesis may be required to be reviewed for publication. After 3 years, all data will be deleted.	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
Section 5 – Risk Assessment			
If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with 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.			
5.1	**Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort,	**YES** ☒	**NO** ☐

	emotional distress, intrusion, etc.)		
	If yes, what are these, and how will they be minimised?	Psychological harm / Emotional Distress: Participant information sheet, consent form, right to withdraw, debriefing, signpost to service support. Support from DoS available for researcher. Researcher is following UEL Code of Practice for Research Ethics, British Psychology Society's Code of Ethics and Conduct. Privacy & Confidentiality: All interviews will be conducted from a private space (researcher). Participant will be asked to be in a private space they are comfortable sharing information and confirm this at start of interview. Researcher will blur background so as not to reveal anything about their location. Researcher and participant will agree on having video on or off during interview. Research to be conducted in accordance with GDPR, Data Protection Act (2018) and the BPS Guidelines for Internet-Mediated Research. Data Management Plan in place and signed off. Data stores on UEL OneDrive for Business Raw data files deleted once transcribed. Identifiable information removed. All files password protected and only accessible by researcher Policy compliance: UEL's Research Data Management Policy, UEL's Data Protection Policy, UEL's Data Backup Policy, UEL Code of Practice for Research Ethics, British Psychology Society's Code of Ethics and Conduct Possibility of identification of participants: Direct quotations from participants will likely be included in the final thesis. Anonymity and confidentiality accounted for and carefully monitored through the process. Any potentially identifiable information will be removed or altered prior to inclusion.	
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	Risk of stress & burnout: Support from DoS. Support in personal life. Adhering to timescales. Regular breaks Musculoskeletal pain – increased risk due to existing nerve condition in hands/ arms: Covered by UEL Health & Safety Policy and Handbook https://uelac.sharepoint.com/sites/healthandsafetyunit/SitePages/Health-and-Safety-Handbook.aspx Management strategies in place as advised by medical professionals (typing, rests, hand and wrist support, painkillers) Disability team aware. Risk of verbal/online abuse from anyone who sees recruitment poster: Contact details are university email (monitoring available)Researcher support from DoS	
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to**	**YES** ☒	

	complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:			
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐	
	If yes, where?	Via MS Teams from home of researcher and participant location chosen by them		
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒	
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment	**YES** ☐		

	form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	
5.7	**Additional guidance:** ▪ 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 Director of Impact and Innovation, Professor Ian Tucker (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 also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (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.

Section 6 – Disclosure and Barring Service (DBS) Clearance

6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	**YES** ☐	**NO** ☒
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or 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 with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		
6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** ☒	**NO** ☐
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** ☒	**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	**001744225310**	

	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). ▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.		
	Section 7 – Other Permissions		
7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☐	**NO** ☒
	If yes, please provide their details.		
	If yes, written permission is needed from such organisations (i.e., 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). Please confirm that you have attached written permission as an appendix.	**YES** ☐	
7.2	**Additional guidance:** ▪ 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 or approval letter. 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. ▪ If the organisation has their own ethics committee and review process, a 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.

Section 8 – Declarations		
8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	**Ellis Hayes**
8.3	**Student's number:**	**2195516**
8.4	**Date:**	**07/07/2023**
Supervisor's declaration of support is given upon their electronic submission of the application		

APPENDIX F: UEL ETHICS REVIEW DECISION LETTER (SUBJECT TO MINOR AMENDMENTS)

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in blue | **Student:** Please complete/read sections in orange

Details	
Reviewer:	**Rachel Tribe**
Supervisor:	**Navya Anand**
Student:	**Ellis Hayes**
Course:	**Prof Doc in Clinical Psychology**
Title of proposed study:	**Understanding the experiences of the Trans community when accessing NHS Mental Health Services: A Thematic Analysis**

Checklist (Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐

Data collection appropriate for target sample	☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **<u>before</u>** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records.

	Minor amendments guidance: typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES

Minor amendments

Please clearly detail the amendments the student is required to make

There are several minor amendments required to ensure that this application is at the appropriate professional and ethical level.

In section 3.7 the trainee needs to add UEL before Microsoft teams and in the other places Microsoft teams is mentioned
Amendment made

5.1 The trainees seems to concentrate on potential risks to herself rather than the participants, this section requires further work, as this section is about participants not the researcher. Also providing a list of set of bullet points and not clear professional prose is not ideal.
Following discussion with my DoS, we were advised to use bullet points within the ethics form to be succinct. Section 5.1 clearly outlines possible risks to participants and how these will be minimised. The full risk assessment is attached to the ethics form where more detail is elaborated on with regards to both risk to myself as the researcher and risk to participants.

In 6.1 It is unclear why the trainee has defined the participants as vulnerable, this needs clarifying or has the wrong box just been ticked?
Amendment made
Although the participants can be considered vulnerable by virtue of being part of the LGBTQ+ community, within the definition of section 6.1 relating to consent we agreed to change this.

I would suggest that the photo of the trainee is not included on the recruitment poster, this is not normal professional practice.

Following discussion with my DoS, I will keep my photo on my recruitment poster. This is considered standard practice and I would also like potential participants to see who I am as the researcher (i.e., I am a white, female presenting cis woman)

Exclusion criteria needs to include not currently receiving psychological or psychiatric help. Following discussion with my DoS, I will not be adding this as an exclusion criterion for the following reasons

- **May significantly reduce the pool of participants**
- **No rationale for excluding those currently in treatment (e.g., someone may be currently seeing a private psychologist long term, this does not mean they are unable to consent to or engage in the project)**
- **The project is not affiliated to any NHS service, so no conflict of interest**

On the risk assessment form, the trainee states that their thesis will address a gap, this needs changing, however much the trainee may wish this to be the case, one doctoral thesis sadly, will not address a gap, although it may contribute to it.
Amendment made

Most importantly, it is unclear if the trainee will require NHS ethics and this needs to be explored. **NHS Ethics are not required for my project, I will not be recruiting through NHS services, rather advertising my study within the public domain using social media and personal/professional connections I have made over time.**

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐

MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature

Reviewer:	**Rachel Tribe**
Date:	**26/06/2023**

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data

Student name: (Typed name to act as signature)	**Ellis Hayes**
Student number:	**2195516**
Date:	**11/07/2023**

Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required

APPENDIX G: TITLE CHANGE APPROVAL

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents	
A copy of the approval of your initial ethics application.	**YES** ☐

Details	
Name of applicant:	**Ellis Hayes**
Programme of study:	**Prof Doc in Clinical Psychology**
Title of research:	Understanding the experiences of the Trans community when accessing NHS Mental Health Services: A Thematic Analysis
Name of supervisor:	Dr Navya Anand / Dr Lorna Farquharson

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	Understanding the experiences of the Trans community when accessing NHS Mental Health Services: A Thematic Analysis
New title:	"Why would they listen to you? You're just a crazy trans person" Understanding the experiences of the Trans community when accessing NHS Mental Health Services: A Thematic Analysis
Rationale:	Adding a quote retrieved from interviews

Confirmation

Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student's signature

Student: (Typed name to act as signature)	**Ellis Hayes**
Date:	**29/03/2024**

Reviewer's decision

Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The new title reflects better the research study and will not impact the process of how the data are collected or how the research is conducted.**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**03/04/2024**	

APPENDIX H: PARTICIPANT INFORMATION SHEET

University of East London

PARTICIPANT INFORMATION SHEET

Title of research:
Understanding the experiences of the Trans community when accessing NHS Mental Health Services: A Thematic Analysis

Contact person: Ellis Hayes
Email: u2195516@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Ellis Hayes. I am studying for a Professional Doctorate in Clinical Psychology at the University of East London (UEL). As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into the experience of Trans* people when accessing NHS Mental Health Services.

Why have I been invited to take part?

I am inviting members of the Trans community to take part in my research.

To be eligible to participate in this study, we ask that you read the following inclusion and exclusion criteria carefully. If you have any questions about your suitability to participate in this research, please contact me using the email address listed at the bottom of this form.

Inclusion Criteria:

- Adult aged over 18
- Trans*
- Had an appointment with an NHS therapist lasting at least 30 minutes
- Appointment not as part of a gender identity service
- UK based
- English speaking

Exclusion Criteria:

- Communication needs not supported by Augmentative and Alternative Communication (AAC)
- Personal or professional connection to researcher (for interviews)
-

** I will use 'trans' as an umbrella term to include any person whose gender identity is not the same as the sex they were assigned at birth. This will be inclusive of but not limited to"...transgender, gender-queer, gender-fluid, non-binary, gender-variant, genderless, agender, nongender, third gender, bi-gender, trans man, trans woman, trans masculine, trans feminine and neutrois" (Stonewall, 2020).*

Do I have to take part?
No, it is entirely up to you whether you take part or not, participation is voluntary.

What will happen to me if I agree to take part?
If you agree to take part, you will be asked to meet with me using Microsoft Teams to take part in a structured but informal interview. This will include several questions relating to your experience with NHS Mental Health Services.

It is expected that the interview will take no more than 45 minutes but will be booked for 1 hour to give space to discuss in more detail or talk about any concerns you may have.

This interview will be audio recorded using Microsoft Teams which will produce both an audio file and a written transcription of what we talk about.

Can I change my mind?
Yes, you can change your mind at any time and withdraw without explanation, disadvantage, or consequence. If you would like to withdraw from the interview you can do so by letting me know at any time. If you withdraw, the recording will be stopped, and your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?
We do not anticipate any disadvantages or risks for participating in this study. We appreciate that you are taking time out of your busy schedule to participate in this research.

Due to the nature of these personal conversations, it is possible that you may experience some strong emotions during the interview. However, we do not expect that this process will be too distressing and will ensure that you are not feeling upset prior to leaving the interview. During the interview we can take breaks, skip questions and you can choose to end the interview at any time. If you end the interview, your data will not be recorded.

Whether you complete the interview or not you will be provided with a debrief sheet which contains information about external support services you may want to reach out to. You can also contact the researcher or the wider research team to discuss any concerns you have.

What are the possible benefits of taking part?
Taking part in this research may allow you to explore how you make sense of your experiences of mental health services as a trans person.
You can use this space to reflect on your experiences, whether they have been positive, negative, or neutral in a space separate from the clinicians and services involved.

How will the information I provide be kept secure and confidential?
In this research study we will have access to the following information about you: your name, age and email address.

We will also have the information you discuss in your individual interview including information about your gender identity, and mental health support you have received. This will be saved as an audio recording and in the form of an anonymised transcript. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes.

The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public) through journal articles, conference presentations, talks, magazine articles, blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided, this is entirely optional.

Anonymised research data will be securely stored by Dr Navya Anand for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?

My research has been approved by the School of Psychology 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.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me: **Ellis Hayes – u2195516@uel.ac.uk**

If you have any questions or concerns about how the research has been conducted, please contact either:

Research Supervisor: Dr Navya Anand
School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: N.Anand@uel.ac.uk
or
Chair of School Ethics Committee: Dr Trishna Patel
School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: t.patel@uel.ac.uk

Thank you for taking the time to read this information sheet

APPENDIX I: RECRUITMENT POSTER

University of East London

SEEKING RESEARCH PARTICIPANTS

Are you over 18, Trans* and living in the UK?

Have you had an appointment with an NHS Mental Health Service over 30 minutes in length?

Would you like to share this experience via remote interview?

*Any person whose gender identity is not the same as the sex they were assigned at birth

About Me

My name is Ellis Hayes and I am a trainee clinical psychologist at University of East London
I am a cis woman with a passion for trans rights and LGBTQ+ allyship

Find Out More

u2195516@uel.ac.uk

This study has received ethical approval from the University of East London Ethical Committee

APPENDIX J: INFORMED CONSENT FORM

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Understanding the experiences of the Trans community when accessing NHS Mental Health Services: A Thematic Analysis
Contact person: Ellis Hayes
Email: u2195516@uel.ac.uk

Please initial box

1. I confirm that I have read the participant information sheet (Version 1.1) for the above study and that I have been given a copy to keep. ☐
2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
3. I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage. ☐
4. I understand that if I withdraw during the study, my data will not be used. ☐
5. I understand that I have 3 weeks from the date of the interview to withdraw my data from the study. ☐
6. I understand that my interview will be recorded using Microsoft Teams ☐
7. I understand that my personal information and data, including audio/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.

8. It has been explained to me what will happen to the data once the research has been completed. ☐

9. I understand that short, anonymised quotes from my interview 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. ☐

10. 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 (optional). ☐

11. I agree to take part in the above study ☐

______________	________________	________________
Name of Participant	Date	Signature
______________	________________	________________
Name of Person taking consent	Date	Signature

APPENDIX K: PARTICIPANT DEBRIEF SHEET

University of
East London

PARTICIPANT DEBRIEF SHEET

Understanding the experiences of the Trans community when accessing NHS Mental Health Services: A Thematic Analysis

Thank you for participating in my research study on the experience of the Trans community when accessing NHS Mental Health Services. This document offers information that may be relevant considering you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for any personal information processed as part of this research project. The University will ensure that your personal data is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public) through journal articles, conference presentations, talks, magazine articles, blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Navya Anand for a maximum of 3 years, following which all data will be deleted.

What if I 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 distress or harm of any kind.Nevertheless, it is 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:

Mindline Trans	A confidential emotional, mental health support helpline Monday & Friday 8pm - midnight	0300 330 5468 https://mindlinetrans.org.uk/
LGBT Foundation	National charity delivering advice, support and information services	0345 3 30 30 30 (Mon-Fri 10am-6pm) helpline@lgbt.foundation https://lgbt.foundation/
Switchboard	Helpline to talk things through confidentially. Nothing is off limits.	0300 330 0630 (Everyday 10am-10pm) chris@switchboard.lgbt https://switchboard.lgbt/ Web Chat Service
Samaritans	Emotional support 24 hours a day - in full confidence.	Call 116 123 - it's FREE. Or email **jo@samaritans.org.uk**.
SHOUT	If you're experiencing a personal crisis, are unable to cope and need support.	Text Shout to 85258
CALM	The Campaign Against Living Miserably (CALM) is leading a movement against suicide.	Call the CALM helpline on 0800 58 58 58 or use their webchat **here**. The helpline and webchat are both open 5pm to midnight, 365 days a year.

Who can I contact if I have any questions/concerns?

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

Ellis Hayes – u2195516@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Navya Anand School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: N.Anand@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology,
University of East London, Water Lane, London E15 4LZ.
Email: t.patel@uel.ac.uk

Thank you for taking part in my study

APPENDIX L: LIVED EXPERIENCE CONSULTANTS

Consultant 1 – Heather

Heather reached out from TransLondon, a peer support group on Facebook. She provided written feedback via email which included:

- Use of snowball sampling by advertising on social media and community-based support groups
- Semi-structured interviews to probe answers from own knowledge and experience
- Identifying intersectionality within participants alongside gender identity

Consultant 2 – Ollie

Ollie reached out from an NHS Trust LGBTQ+ Network and met with the researcher via video call. His feedback included:

- Including questions about gender identity being pathologised
- Ensure questions give the opportunity to discuss positive experiences as well as negative and neutral
- Offering written surveys first then the option to receive a call back for an interview

It is of note that Ollie also reached out to participate in the study. Following discussion with the DoS and given that he was not paid for his consultancy time, it was decided this was appropriate and Ollie was interviewed as a participant.

Consultant 3 – Rae

Rae reached out from Gender Identity Research and Education Society (GIRES) and again met with the researcher via video call. Their feedback included:

- Offering written surveys either before or after face-to-face interviews
- Changing the wording of one exclusion criterion to ensure people with learning disabilities or communication needs are not unfairly excluded
- Focus on the consideration of power within the interviews as the researcher will be representing NHS clinicians

People's Committee

When proposing this research, a consultation with the UEL People's Committee was arranged as part of the lecture timetable. The People's Committee is lived experience group who are employed by UEL. They have varied experiences of accessing mental health services, or as family, friends or cares of people who have accessed mental health services. The representatives from the People's Committee provided the following feedback:

- People may be unlikely to complete written surveys if they do not understand the wording of a question or what it is asking

APPENDIX M: INTERVIEW SCHEDULE

1. Intros – personal, research, time limits
2. Demographics
3. Can you tell me briefly about the context of this appointment?
4. What was your experience of this appointment?
5. Why do you think the appointment happened the way it did? What sense have you made of this?
6. How did you feel before/during/after the appointment?
7. Why do you think you felt this way about the appointment?
8. Finally is there anything else you would like to add?

APPENDIX N: INTERVIEW PROMPTS

1. Intros – personal, research, time limits

- Names and pronouns

- Thank you for making the time to speak to me today about some of your experiences. As you know from the information you have received about the interview today, it is part of my doctoral research project that seeks to better understand the experiences of the trans community when accessing NHS mental health services.

- Reminder about being able to end the interview, pause to take a break, or to skip questions if needed.

- We have about an hour, and it's most important I hear from you about your experiences. I have several questions to ask and some prompts I will use if needed to further understand. I may also stop you if our conversation is moving away from the question or topic, this is just to ensure we cover everything.

- My position and identity as a cis woman.

2. Demographics

- I am going to ask some brief demographic information; this will not be used to identify you in anyway. It's more for me to gather some context as to who I am interviewing and see if there are any themes (i.e., I interviewed all trans women, over the age of 40 but no non-binary people) I can then think about the impact of this.

- Age.

- Ethnicity.

- Location.

- Gender identity - Experience as a trans person if they want to share this context.
  Explain my reasons for wanting to know this – i.e., people will have lots of different experiences and the context can be useful.

3. Can you tell me briefly about the context of this appointment?

- Can you tell me when this appointment took place?
- Where in the country did the appointment take place?
- Was the appointment face to face, via telephone or virtual using video calling?

  - What type of professional was the appointment with?
  - Was it a one off?
  - Was it ongoing appointments?

4. What was your experience of this appointment?

a) Did you feel the professional understood gender / trans identities / the trans experience?

- If yes, how did they make you feel this way?
- If no, how did they make you feel this way?

b) Can you tell me how you thought the professional considered and understood your gender identity within this appointment?

c) What was your experience of your pronouns being understood within the appointment?

- Were you asked about your pronouns?
- Were they used correctly?

d) Do you feel like your trans identity was conflated with the mental health issue you were trying to discuss?

- Were the 2 being linked?
- Was it suggested one was contributing to the other?

5. Why do you think the appointment happened the way it did? What sense have you made of this?

6. How did you feel before/during/after the appointment?

e) Did you feel supported by the professional during and after this appointment?

- If yes, what did they do (or not do) to make you feel this way?
- If no, what did they do (or not do) to make you feel this way?

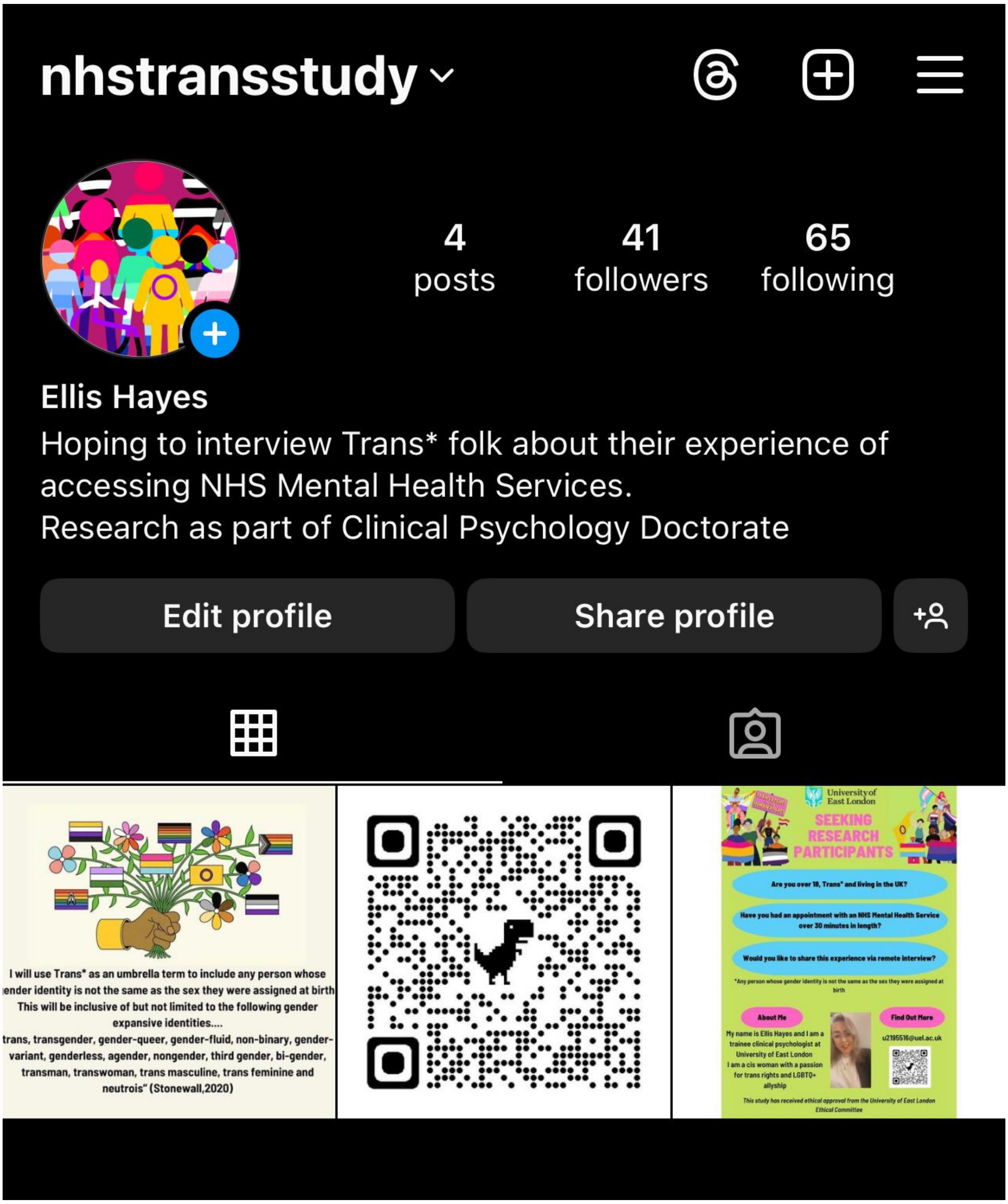
f) Did you feel the professional was willing to change their approach?

  - If yes, what did they do (or not do) to make you feel this way
  - If no, what did they do (or not do) to make you feel this way?

7. Why do you think you felt this way about the appointment?

8. Finally is there anything else you would like to add?

APPENDIX O: INSTAGRAM ACCOUNT



nhstransstudy

4 posts
41 followers
65 following

Ellis Hayes

Hoping to interview Trans* folk about their experience of accessing NHS Mental Health Services.
Research as part of Clinical Psychology Doctorate

I will use Trans* as an umbrella term to include any person whose ender identity is not the same as the sex they were assigned at birth This will be inclusive of but not limited to the following gender expansive identities.... trans, transgender, gender-queer, gender-fluid, non-binary, gender-variant, genderless, agender, nongender, third gender, bi-gender, transman, transwoman, trans masculine, trans feminine and neutrois" (Stonewall,2020)

University of East London

SEEKING RESEARCH PARTICIPANTS

Are you over 18, Trans* and living in the UK?

Have you had an appointment with an NHS Mental Health Service over 30 minutes in length?

Would you like to share this experience via remote interview?

*Any person whose gender identity is not the same as the sex they were assigned at birth

About Me

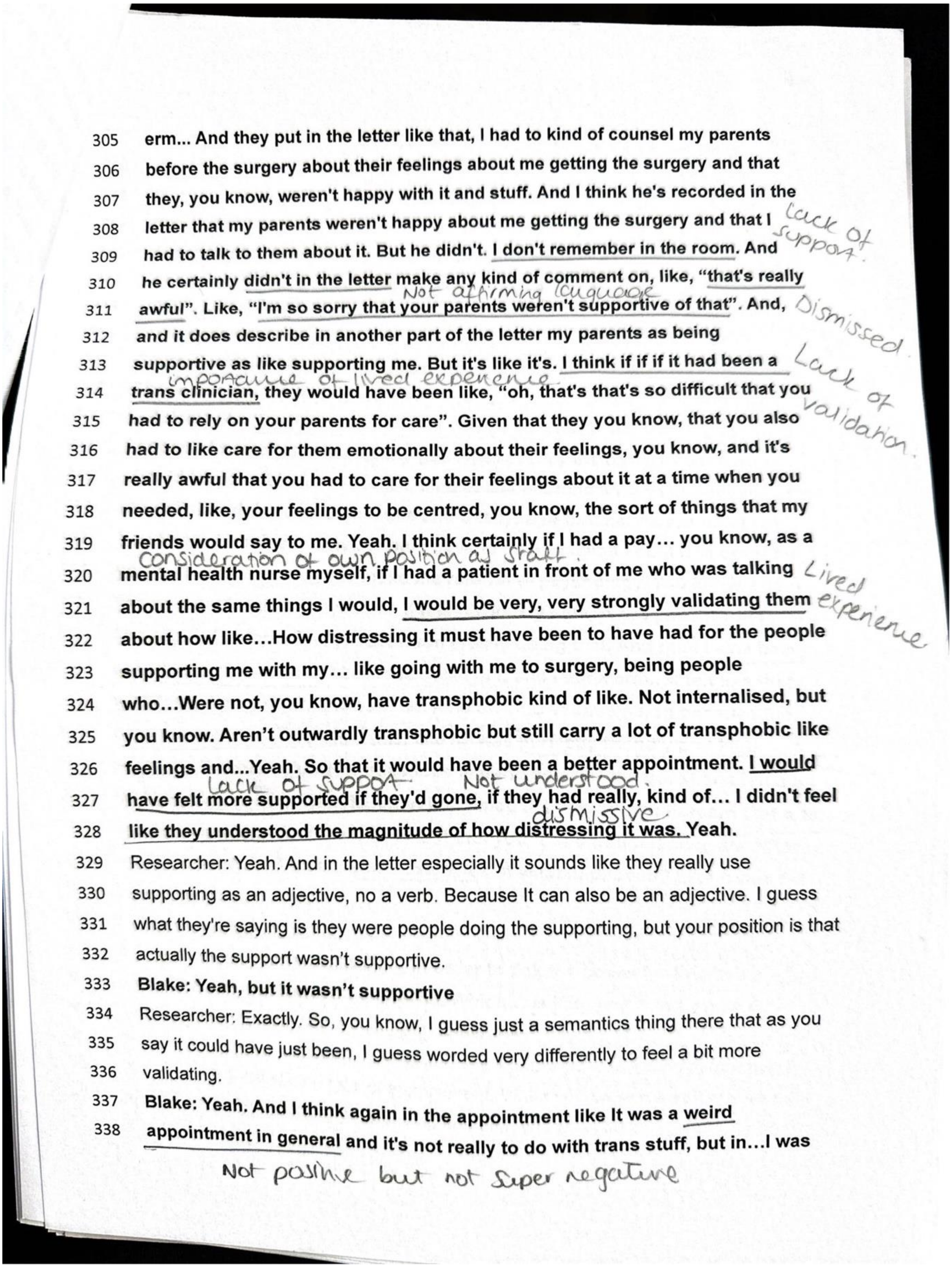
My name is Ellis Hayes and I am a trainee clinical psychologist at University of East London
I am a cis woman with a passion for trans rights and LGBTQ+ allyship

Find Out More

u2195516@uel.ac.uk

This study has received ethical approval from the University of East London Ethical Committee

APPENDIX P: TRANSCRIPT EXCERPT INCLUDING CODING



erm... And they put in the letter like that, I had to kind of counsel my parents before the surgery about their feelings about me getting the surgery and that they, you know, weren't happy with it and stuff. And I think he's recorded in the letter that my parents weren't happy about me getting the surgery and that I had to talk to them about it. But he didn't. I don't remember in the room. And he certainly didn't in the letter make any kind of comment on, like, "that's really awful". Like, "I'm so sorry that your parents weren't supportive of that". And, and it does describe in another part of the letter my parents as being supportive as like supporting me. But it's like it's. I think if if if it had been a trans clinician, they would have been like, "oh, that's that's so difficult that you had to rely on your parents for care". Given that they you know, that you also had to like care for them emotionally about their feelings, you know, and it's really awful that you had to care for their feelings about it at a time when you needed, like, your feelings to be centred, you know, the sort of things that my friends would say to me. Yeah. I think certainly if I had a pay… you know, as a mental health nurse myself, if I had a patient in front of me who was talking about the same things I would, I would be very, very strongly validating them about how like…How distressing it must have been to have had for the people supporting me with my… like going with me to surgery, being people who…Were not, you know, have transphobic kind of like. Not internalised, but you know. Aren't outwardly transphobic but still carry a lot of transphobic like feelings and...Yeah. So that it would have been a better appointment. I would have felt more supported if they'd gone, if they had really, kind of… I didn't feel like they understood the magnitude of how distressing it was. Yeah.

Lack of support.
Not affirming language
Dismissed
Lack of validation.
importance of lived experience
consideration of own position as staff.
Lived experience
Lack of support
Not understood.
dismissive

Researcher: Yeah. And in the letter especially it sounds like they really use supporting as an adjective, no a verb. Because It can also be an adjective. I guess what they're saying is they were people doing the supporting, but your position is that actually the support wasn't supportive.

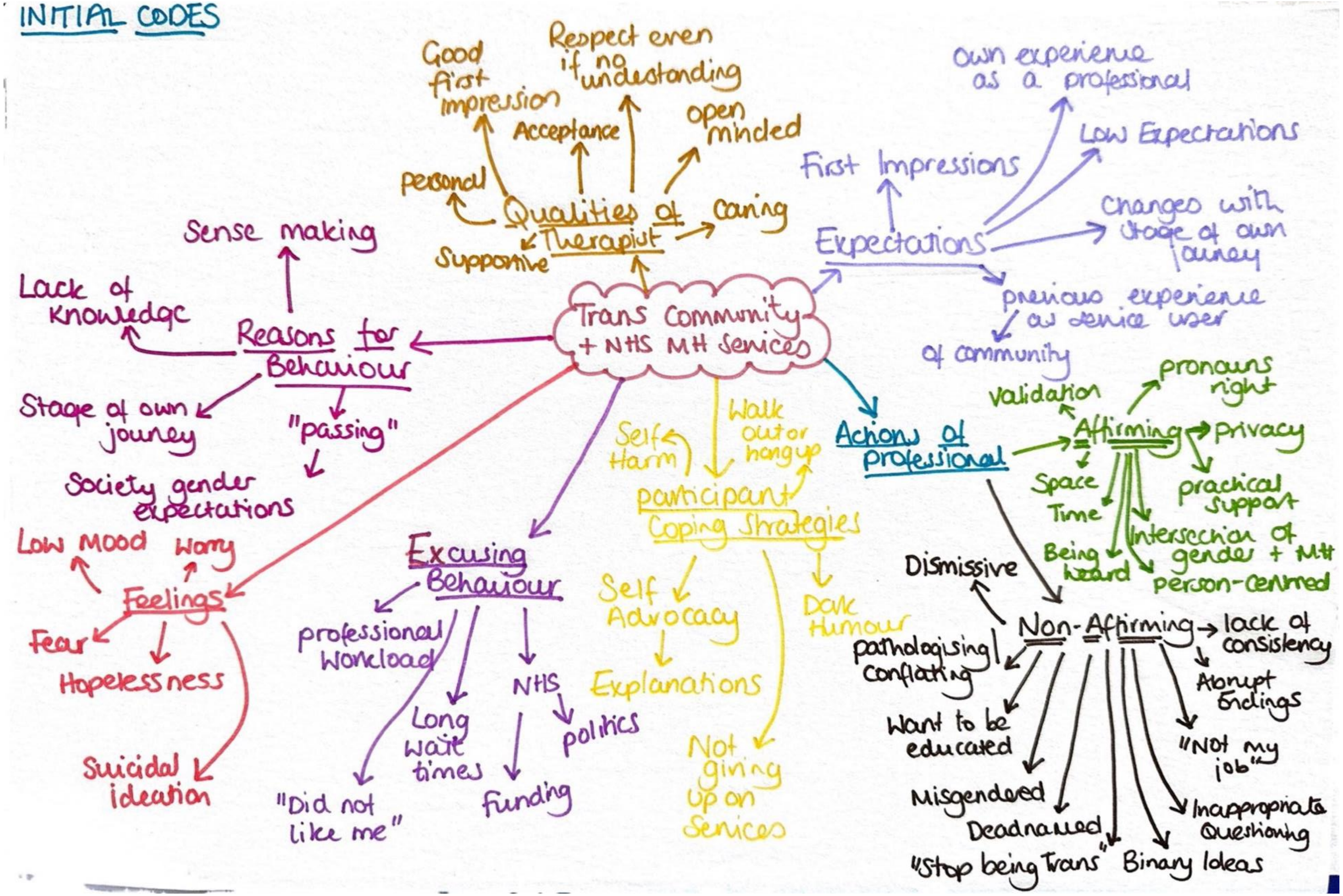
Blake: Yeah, but it wasn't supportive

Researcher: Exactly. So, you know, I guess just a semantics thing there that as you say it could have just been, I guess worded very differently to feel a bit more validating.

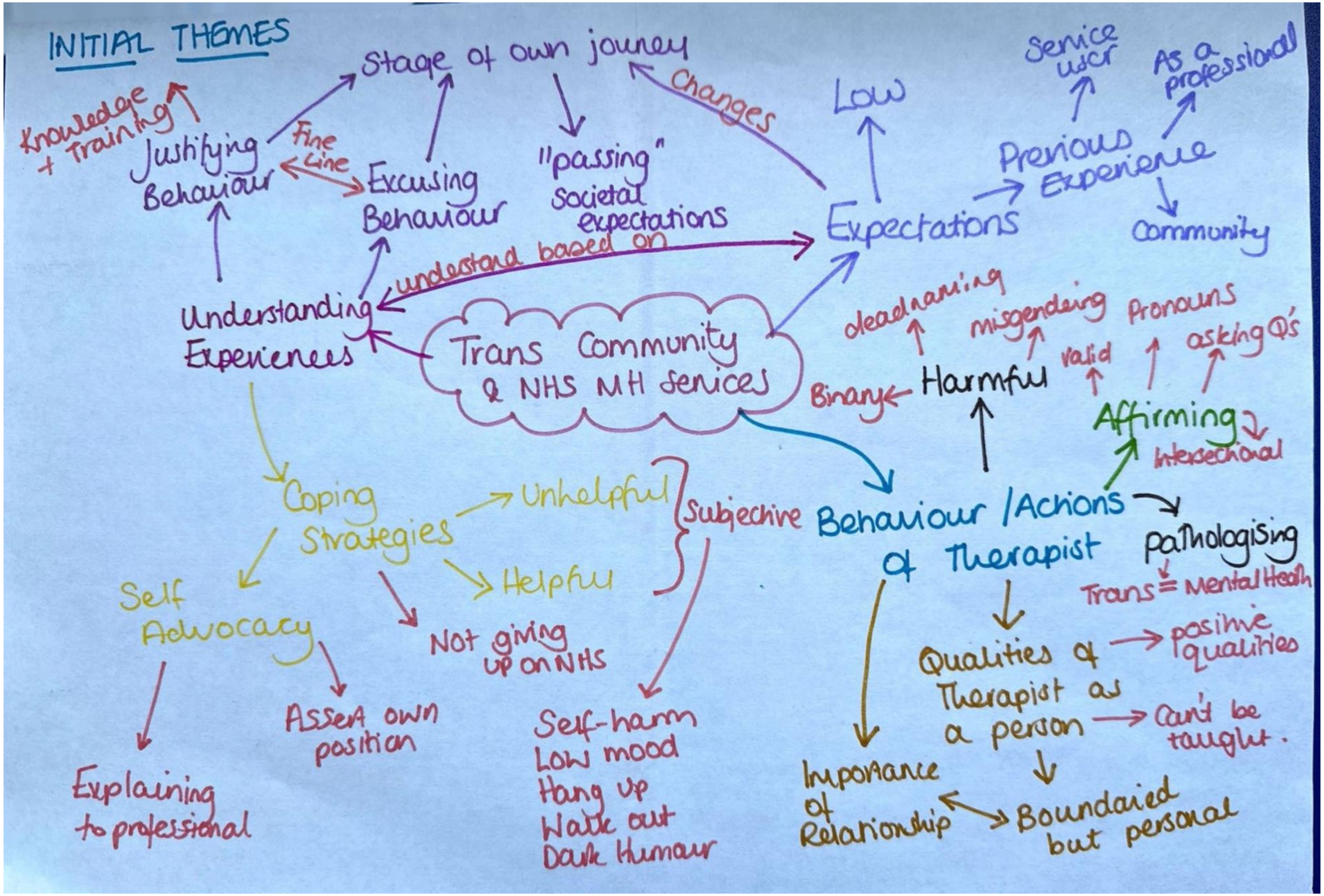
Blake: Yeah. And I think again in the appointment like It was a weird appointment in general and it's not really to do with trans stuff, but in…I was

Not positive but not super negative

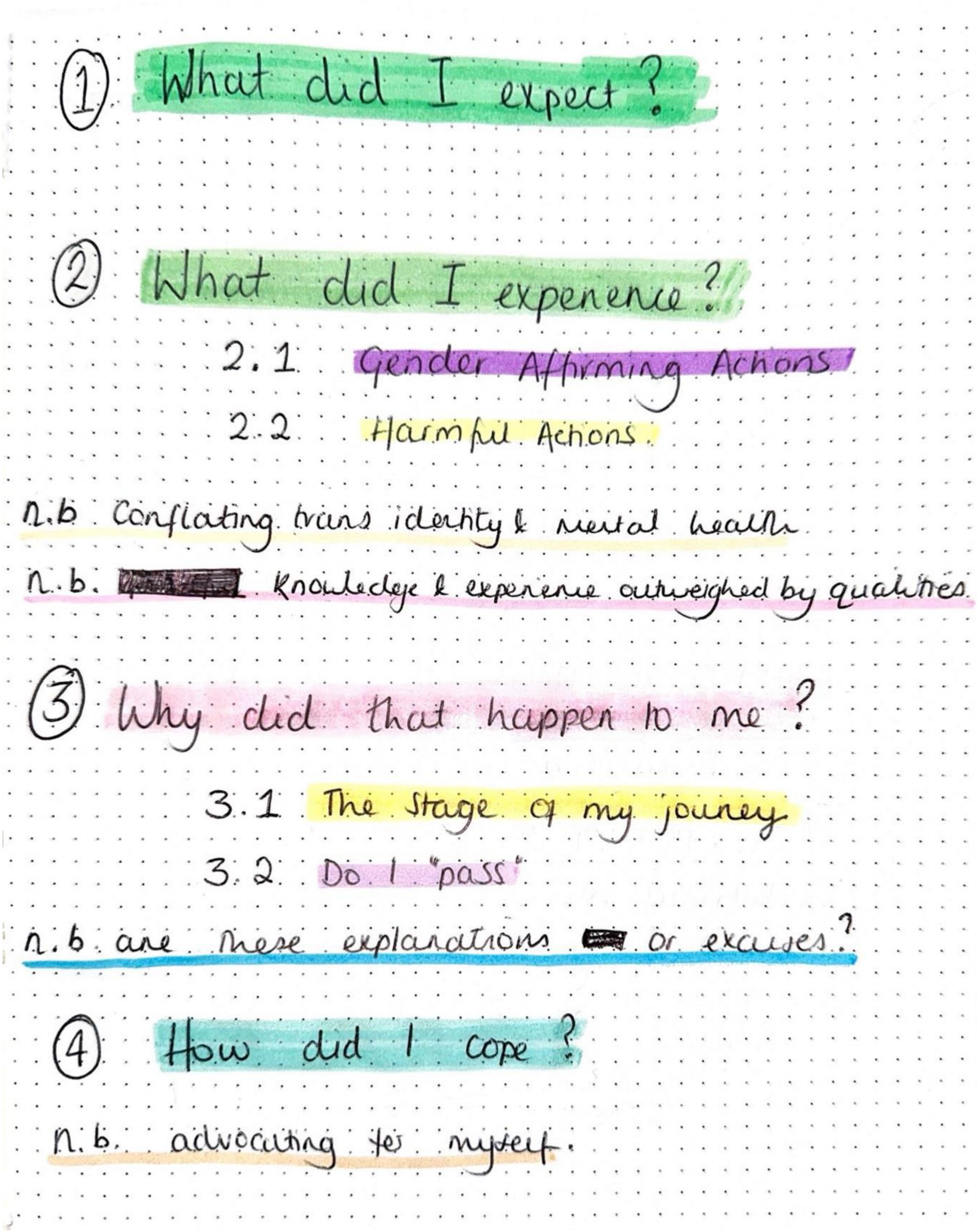
APPENDIX Q: INITIAL THEMES



APPENDIX R: REVISED THEMES



APPENDIX S: FINAL THEMATIC MAP



① What did I expect?

② What did I experience?

2.1 Gender Affirming Actions

2.2 Harmful Actions.

n.b Conflating trans identity & mental health

n.b. [redacted] Knowledge & experience outweighed by qualities

③ Why did that happen to me?

3.1 The stage of my journey

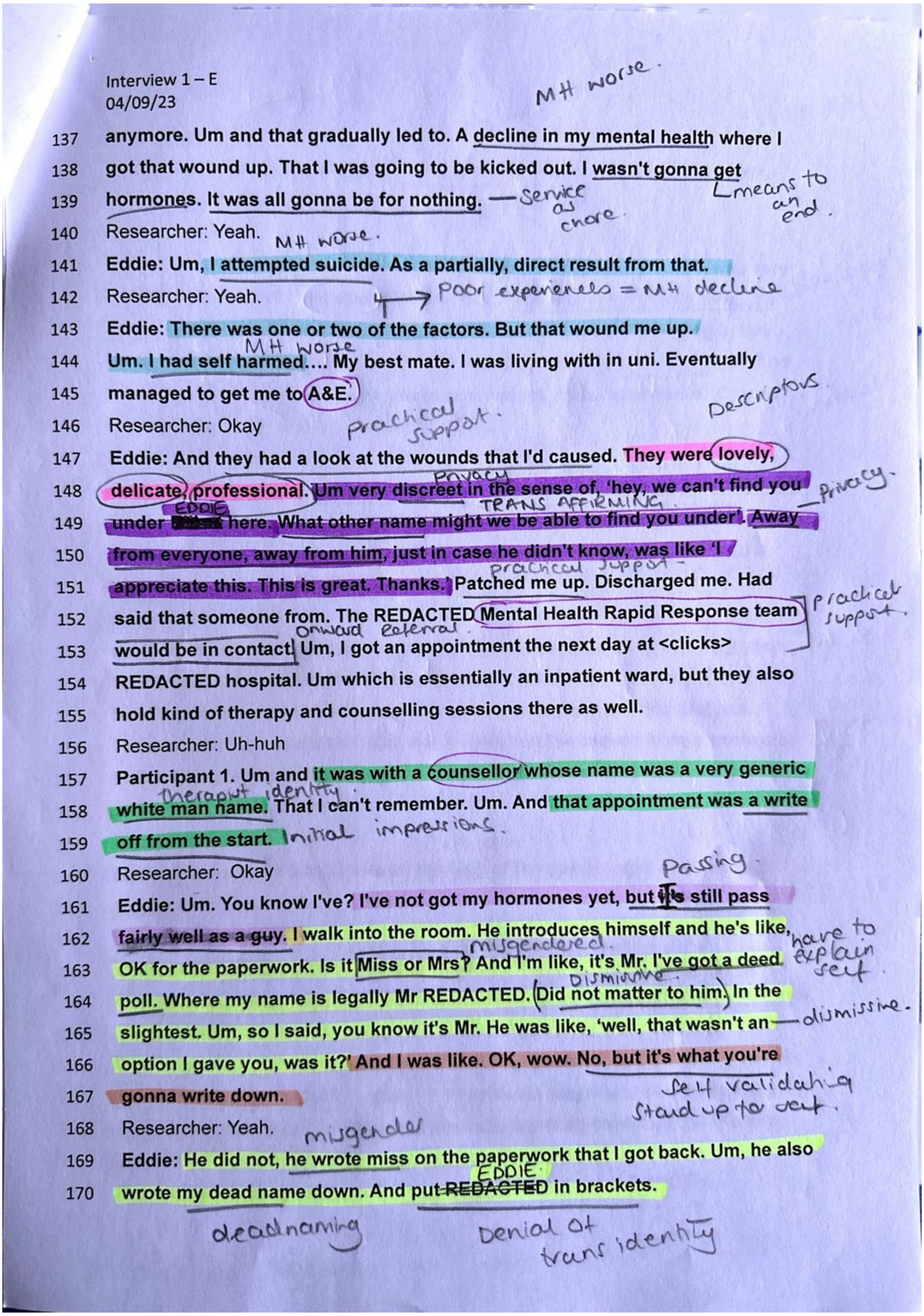
3.2 Do I "pass"

n.b. are these explanations [redacted] or excuses?

④ How did I cope?

n.b. advocating for myself.

APPENDIX T: TRANSCRIPT EXCERPT SHOWING FULL ANALYTIC PROCESS



Interview 1 – E
04/09/23

MH worse.

anymore. Um and that gradually led to. A decline in my mental health where I got that wound up. That I was going to be kicked out. I wasn't gonna get hormones. It was all gonna be for nothing. — Service as chore. — Lmeans to an end.

Researcher: Yeah.

MH worse.

Eddie: Um, I attempted suicide. As a partially, direct result from that.

Researcher: Yeah.

→ Poor experiences = MH decline

Eddie: There was one or two of the factors. But that wound me up.
MH worse
Um. I had self harmed…. My best mate. I was living with in uni. Eventually managed to get me to A&E.

Researcher: Okay

practical support.

Descriptors.

Eddie: And they had a look at the wounds that I'd caused. They were lovely, delicate, professional. Um very discreet in the sense of, 'hey, we can't find you under [redacted] EDDIE here. What other name might we be able to find you under'. Away from everyone, away from him, just in case he didn't know, was like 'I appreciate this. This is great. Thanks.' Patched me up. Discharged me. Had said that someone from. The REDACTED Mental Health Rapid Response team would be in contact. Um, I got an appointment the next day at <clicks> REDACTED hospital. Um which is essentially an inpatient ward, but they also hold kind of therapy and counselling sessions there as well.

Privacy — TRANS AFFIRMING. — Privacy. — practical support — practical support. — onward referral.

Researcher: Uh-huh

Participant 1. Um and it was with a counsellor whose name was a very generic white man name. That I can't remember. Um. And that appointment was a write off from the start.

therapist identity. — Initial impressions.

Researcher: Okay

Passing.

Eddie: Um. You know I've? I've not got my hormones yet, but it's still pass fairly well as a guy. I walk into the room. He introduces himself and he's like, OK for the paperwork. Is it Miss or Mrs? And I'm like, it's Mr. I've got a deed poll. Where my name is legally Mr REDACTED. Did not matter to him. In the slightest. Um, so I said, you know it's Mr. He was like, 'well, that wasn't an option I gave you, was it?' And I was like. OK, wow. No, but it's what you're gonna write down.

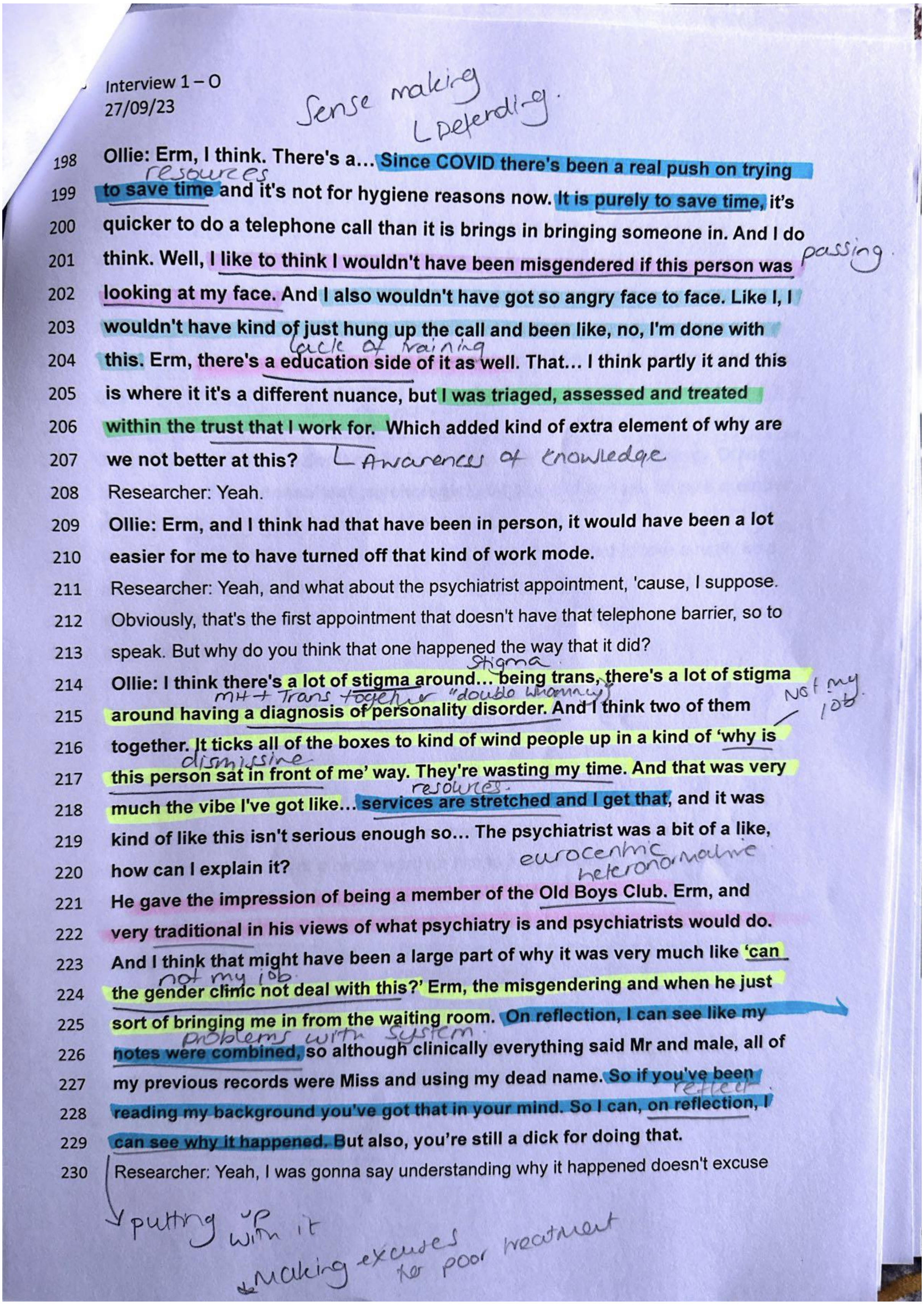
have to explain self. — misgendered. — Dismissive. — dismissive. — Self validating Stand up for self.

Researcher: Yeah.

misgender

Eddie: He did not, he wrote miss on the paperwork that I got back. Um, he also wrote my dead name down. And put ~~REDACTED~~ EDDIE in brackets.

deadnaming — Denial of trans identity



Interview 1 – O
27/09/23

Sense making
L defending.

Ollie: Erm, I think. There's a… Since COVID there's been a real push on trying to save time and it's not for hygiene reasons now. It is purely to save time, it's quicker to do a telephone call than it is brings in bringing someone in. And I do think. Well, I like to think I wouldn't have been misgendered if this person was looking at my face. And I also wouldn't have got so angry face to face. Like I, I wouldn't have kind of just hung up the call and been like, no, I'm done with this. Erm, there's a education side of it as well. That… I think partly it and this is where it it's a different nuance, but I was triaged, assessed and treated within the trust that I work for. Which added kind of extra element of why are we not better at this?

resources
passing.
lack of training
L Awareness of knowledge

Researcher: Yeah.

Ollie: Erm, and I think had that have been in person, it would have been a lot easier for me to have turned off that kind of work mode.

Researcher: Yeah, and what about the psychiatrist appointment, 'cause, I suppose. Obviously, that's the first appointment that doesn't have that telephone barrier, so to speak. But why do you think that one happened the way that it did?

Ollie: I think there's a lot of stigma around… being trans, there's a lot of stigma around having a diagnosis of personality disorder. And I think two of them together. It ticks all of the boxes to kind of wind people up in a kind of 'why is this person sat in front of me' way. They're wasting my time. And that was very much the vibe I've got like… services are stretched and I get that, and it was kind of like this isn't serious enough so… The psychiatrist was a bit of a like, how can I explain it?

He gave the impression of being a member of the Old Boys Club. Erm, and very traditional in his views of what psychiatry is and psychiatrists would do. And I think that might have been a large part of why it was very much like 'can the gender clinic not deal with this?' Erm, the misgendering and when he just sort of bringing me in from the waiting room. On reflection, I can see like my notes were combined, so although clinically everything said Mr and male, all of my previous records were Miss and using my dead name. So if you've been reading my background you've got that in your mind. So I can, on reflection, I can see why it happened. But also, you're still a dick for doing that.

stigma.
MH + Trans together "double whammy"
Not my job.
dismissive
resources.
eurocentric
heteronormative
not my job.
problems with system.
reflect

Researcher: Yeah, I was gonna say understanding why it happened doesn't excuse

putting up with it
making excuses for poor treatment