# Exploring Transgender and Gender Diverse People's Experiences of UK Mental Health Services

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# ABSTRACT

**Background:** Transgender and gender diverse people experience worse mental health outcomes than their cisgender counterparts. However, there is a lack of understanding by mental health professionals (MHPs) of the issues this community faces (Bauer et al., 2009). There is a lack of research on the experiences of transgender and gender diverse (TGD) people accessing and using mental health services in the UK.

**Aims:** This study aims to explore TGD people's experiences of accessing and using mental health services and identify the impact of barriers to engaging with services.

**Methods:** Individual semi-structured interviews were conducted with sixteen transgender and gender diverse people in the UK, aged between 18-34 years old. A critical realist perspective was used. Results were analysed using Thematic Analysis.

**Results:** Thematic analysis from a critical realist perspective identified three main themes, each including their own subthemes: "I don't want to have to be Google" ('Educating the Professional', 'If Not Us, Then Who?'), Discriminatory Service Provision ('Services Cannot Help Me', 'Harmful Professional Practice', 'The Search for Affirmation') and Bringing my Whole Self ('Trust and Safety', Denied Space to be Authentic Self', 'Choose One: Mental Health or Gender').

**Conclusions:** The results are discussed in relation to the Gender Minority Stress and Resilience Model and previous research. The findings provided insight into how transgender, and gender diverse people access, use and navigate mental health services. Difficulties were found in relation to lack of education and discriminatory practices when using these services. The study highlights the importance of well-informed, unbiased, and thoughtful mental health professionals in providing care for transgender and gender diverse patients. These findings were also discussed in relation to relevant social, political and media discourses.

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## LIST OF ABBREVIATIONS

APA – American Psychiatric Association

DSM – Diagnostic and Statistical Manual of Mental Disorders

GIC – Gender Identity Clinic

GMSR – Gender Minority Stress and Resilience

MHP – Mental Health Professional

NHS – National Health Service

NICE – National Institute of Clinical and Heath Excellence

ONS – Office for National Statistics

TGD – Transgender and Gender Diverse

WHO – World Health Organization

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# 1 INTRODUCTION

## 1.1 Chapter Overview

This chapter will begin by considering the terminology outlining differences between sex and gender. The historical and current contexts relevant to transgender and gender diverse individuals will be explored, outlining key elements of how historical narratives and events have shaped current contexts. Important aspects of gender-related stress will be discussed within the context of the Gender Minority Stress and Resilience model. Physical and mental health outcomes for transgender and gender diverse people will be explored within the framework of this model, contextualising the difficulties experienced. Access to and experiences of mental health services will be considered, aiming to identify strengths and challenges in service provision for transgender and gender diverse people. A review of the literature will be presented, highlighting gaps in the literature, alongside a rationale for the proposed study aims and framing of the research questions.

## 1.2 Terminology and Language: An Evolving Arena

### 1.2.1 Sex and Gender

The concepts of sex and gender were once understood as unequivocal markers of identity with the terms often being conflated or used interchangeably (Johnson et al., 2009). More recently, these terms have undergone a significant re-examination of their meanings, moving away from the simplistic understanding of sex and gender as binary terms, male or female, into a more nuanced and complex understanding of biology, identity, and culture (Butler, 2004).

Traditional definitions of sex relate to biological aspects seen as binary, classifying individuals by their biological attributes as either male or female (Johnson et al., 2009). Sex is typically assigned at birth by health professionals, based on external markers such as genitalia and secondary sex characteristics, despite the biological concepts of sex encompassing factors such as chromosomes and hormones (Bates et al., 2022). As society's understanding of biology and genetics advances, there is a growing recognition of complexity and variability within biological determinations of sex, with studies showing this variation cannot be captured within a male and female binary distinction (Montañez, 2017).

Money and colleagues (Money et al., 1955) were some of the first to raise a distinction between gender and sex. They conceptualised gender as a societal and cultural construct, referring less to physical characteristics and focusing more on psychological characteristics and behaviour. It was not until Unger (1979) that this was followed up, proposing a shift away from using the term 'sex' in psychological texts. Unger argued the use of the word 'sex' allowed research to only consider biological causes of difference between men and women. This meant that potential other causes of differences could be overlooked, including social and behavioural factors. Unger preferred the term 'gender' as it also made reference to societally expected traits and behaviour. The concept of gender has historically been based upon the binary categories of sex, with masculine and feminine being used to describe and understand the qualities attributed to individuals (Butler, 1999). However, more recent conceptualisations of gender seek to transcend these binaries. The term gender includes an exploration of the interplay of femininity and masculinity, as this relates to individuals' internal senses of self (Girshick, 2008).

### 1.2.2 Concepts and Definitions of Gender Identity

The term gender is associated with the language of identity and how people are perceived, with a biological sex of male using terms such as man or boy and a biological sex of female, woman or girl. These terms have typical associations linked to cultural and social differences between them, with both carrying certain expectations for behaviour and social roles (Diamond, 2002). These expectations feed into the creation of identity, with the norms for this identity being linked to biological sex (Wiseman & Davidson, 2011). In this research, gender identity will refer to an individual's sense of their own gender, which may not align with their sex assigned at birth (Warrier et al., 2020). People who are cisgender identify with the sex assigned to them at birth, while people who are transgender do not identify with their sex assigned at birth (House et al., 2019). Gender identities are formed despite strong societal expectations about what is considered normal for biological sex;

however, it is argued that identities are flexible, always evolving and changing over time (Johnson et al., 2009).

Gender expression refers to an outward presentation of gender by individuals including their names, dress codes, mannerisms, or voices. These may correspond to masculine and feminine presentations but may also fall outside the norms of typical gendered characteristics (Bloom et al., 2021). Cisgender and transgender people all experience their gender identities differently, with each person experiencing varying levels of masculinity, femininity, and androgyny (Puckett et al., 2016).

Gender diversity encompasses the range of gender identities which fall outside the binary categories of male or female. This includes non-binary identities which may refer to identifying with no gender, a combination of genders, a gender outside of male or female or moving between gender. It also includes transgender identities which often fall into binary constructs of transgender man or transgender woman (Mermaids, 2021). The term transgender and gender diverse (TGD) will be used as an umbrella term to encompass the diversity of gender identities and represent a wider variety of gendered or non-gendered labels, except when using specific terminology found in studies or historic contexts.

### 1.2.3 Gender and Sexuality

The literature on gender often includes reference to sexuality or sexual orientation. Whilst related, these terms refer to separate aspects of identity. Sexual orientation is a part of sexuality which relates to genders or lack of genders that a person is or is not emotionally, sexually, or romantically attracted to. This is thought to develop independently of gender identity (American Psychological Association, 2015). A person who identifies as transgender or gender diverse may identify their sexual orientation in a variety of ways, independent of what their gender identity is.

The Lesbian, Gay, Bisexual, Transgender, Queer plus (LGBTQ+) community represents a diverse range of individuals who have varied experiences of gender and sexuality which are regarded to fall outside of social and cultural norms. The plus represents multiple other identities which fall outside of heteronormative expectations (Stonewall, 2020). The grouping of these identities, which may seem distinct in many ways, is rooted in shared historical experiences of marginalisation and oppression based on their divergence from societal expectations in their sexual orientations and gender identities (Institute of Medicine, 2011). This shared history is solidified in joint advocacy and activism for their legal right to exist, to marry, to live in peace and fight against discrimination and inequality in healthcare (Bronski, 2011).

There is a tendency within LGBTQ+ literature to conflate sexual orientation and gender identity. Galupo et al. (2016) spoke about the focus on issues of sexual orientation and LGBQ identities, missing out vital differences in stigma and discrimination experienced by transgender individuals. Hudson-Sharp and Metcalf (2016) published a review of LGBT healthcare which saw a lack of evidence pertaining to transgender issues of health. The Stonewall LGBT in Britain report (2018) showed various instances in which outcomes were worse overall for TGD people than their LGB counterparts, including access to healthcare, rates of unequal treatment and discrimination by healthcare staff, rates of suicidal thoughts and mental health diagnoses. The inclusion of transgender people in research with LGB people can conflate results and show better outcomes for TGD people than are true.

## 1.3 History Informing Current Context

The word transgender has only been used widely over the last few decades, with definitions remaining variable but broadly settling on people who do not live their lives as the sex they are assigned at birth (Stryker, 2008a). Terms like transsexual and cross-dresser were more predominant pre-1970. Transsexual referred to a desire to physically transition to match with their gender identity, while cross-dressing related to a person’s presentation of themselves, now known as gender expression (Vidal-Ortiz, 2008). These terms were accompanied by stigma and discrimination, followed by the studies of the 20th century focusing on the idea of gender variance as a pathological condition (Vidal-Ortiz, 2008). The term transgender emerged in the 1970s, used more regularly as a term inclusive of cross-dressing, transsexual people and people who were ‘gender variant’ (Williams, 2014). By the 1990s the term transgender was being used in much the same way as it is today, serving as an umbrella term for various types of gender diversity (Vicente, 2021).

### 1.3.1 Medicalisation and Pathologisation of TGD Identities

The first two editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) did not mention gender identity (American Psychiatric Association (APA), 1952, 1968) instead having more of a focus on psychoanalytic theories of functioning. The growing movement toward symptom-based frameworks of understanding mental illness (Zucker & Spitzer, 2005) meant gender identity diagnoses were included for the first time in the third edition, the DSM-III (APA, 1980). This included both child and adult diagnoses, “gender identity disorder of childhood (GIDC)” and “transsexualism” and offered guidance for methods of treatment.

The International Classification of Diseases 10th edition (ICD-10) by the World Health Organisation (WHO, 1992) also included a diagnosis of transsexualism and Gender Identity Disorder in Children (GIDC). GIDC was thought of as a treatable condition in children with the aim of to preventing a later diagnosis of transsexualism in adulthood, avoiding surgery or social transition. With the arrival of the DSM-IV (APA, 1994), these diagnoses were collapsed into one definition of Gender Identity Disorder (GID). This encompassed “a strong and persistent cross-gender identification” but also considered the individual experiencing discomfort or distress related to their gender.

There continued to be controversy over the inclusion of these diagnoses, with arguments that diagnoses pathologise the existence of gender variance, with TGD movements and research calling for a better recognition of gender diversity (Bockting & Ehrbar, 2006; Knudson et al., 2010). Bockting and Ehrbar advocated for a diagnosis differentiating between gender role nonconformity and gender dysphoria, stating the conflation of these means an individual may be diagnosed for not conforming to gender stereotypes, rather than a feeling of distress associated with gender identity. Hill et al. (2006) surmised that a reform of the diagnosis was needed rather than a removal, as despite perpetuating social stigma and reinforcing negative ideas that transgender individuals are ‘mentally ill’, it provides access to care and a basis for intervention.

### 1.3.2 Current Context

DSM-5 (APA, 2013) introduced the diagnosis of “gender dysphoria”, aiming to focus on the feelings of distress some TGD people experience. This marked a move away from the stigmatisation of TGD identities and the idea that being TGD needed diagnosis. Instead, it considered the incongruence felt between sex assigned at birth and the gender experienced by the individual (APA, 2013). The ICD-10 was revised to consider the stigmatisation of the designation of TGD identities as mental disorders. The ICD-11 (WHO, 2019) recognised the need to continue to include a diagnosis for continued medical and psychological support for those suffering from distress (Reed et al., 2016). This diagnosis was changed to Gender Incongruence and was categorised similarly to the DSM-5, referring to an incongruence between sex at birth and gender experience. Unlike the DSM-5, the ICD-11 moved this from a diagnosis of mental health to one of sexual health, in an effort to destigmatise identifying as TGD or receiving this diagnosis (WHO, 2019).

Despite a move towards depathologisation and attempts to decrease stigma, the transgender community are still one of society’s most vulnerable populations. They experience a myriad of human rights violations, including a lack of access to gender-affirming care, discrimination and abuse (Uppalapati et al., 2017).

#### 1.3.2.1 *Transgender and Gender Diverse Population*

Estimates of the size of the TGD population vary depending on definitions used to define being TGD and methods of measurement. In 2023 a UK study of primary care services used previously recorded electronic data, finding 2,462 out of 7,064,829 individuals had a recorded TGD identity, equating to 0.03% (McKechnie et al., 2023). The UK Office for National Statistics (ONS; 2023) collected data on gender identity in the 2021 England and Wales census, with 45.7 million, or 94% of the population (aged 16 years and over), answering this question. Of those who answered, 262,000 said the gender they identify with does not match with their sex registered at birth. This equates to 0.5% of the England and Wales population identifying as transgender or gender diverse. This is consistent with US figures by Herman et al. (2022) collating national US surveys from 2017-2020, finding over 1.6 million adults and youth (aged 13 years and over) identify as TGD in the US, equating to 0.6% of the population. Torjesen (2018) reported a 240% increase in referrals to gender dysphoria clinics in the UK in the five years prior, which suggests a growing visible population.

However, estimates suggest TGD populations are likely to be larger than recorded. Kronk et al. (2022) consider personal self-identification as the gold standard of estimating TGD populations. Others utilise procedural or medical and diagnostic related codes, prioritising privileged TGD individuals who can access healthcare and provide their healthcare providers with accurate information. McKechnie et al. (2023) reported increasing figures within healthcare systems over the years, which may be consistent with more awareness and acceptance of TGD people in society, resulting in transgender individuals feeling safer to disclose their identities. Despite this, it is still likely estimated rates are understated due to a continued prevalence of stigma and discrimination against TGD individuals, including within healthcare services.
A further difficulty in TGD population estimates relates to difficulties with recording the nuance of TGD identities. This can be seen through a misunderstanding of non-binary and gender non-conforming identities and people who do not identify with gender terminology, despite living as a different identity to their sex assigned at birth. This limits data collection on forms and paperwork due to a lack of correct identity options (Lett & Everhart, 2022).

#### 1.3.2.2 *Influences on Transphobia*

Broader structures and ideologies have an influence on levels of transphobia in the UK and wider world. The patriarchy is a continued dominant social structure where cisgender men hold primary power and are at the top of most hierarchies, institutionalising male dominance over women and gender minorities (Johnson, 2005). This upholds strict gender norms, with patriarchal systems holding narrow definitions of femininity and masculinity. Any deviation from these norms is seen as unacceptable, often being met with invalidation or even hostility (Kitzinger & Wilkinson, 1993). Patriarchal norms seek to exert control over bodies and identities, specifically when these bodies or identities are seen to challenge gender norms, and by extension gender roles (Butler, 1990). This enforcing of gender binaries seeks to exclude and reject those who challenge these norms, stigmatising TGD lives and perpetuating discrimination and transphobia against those who do not conform to patriarchal standards.

Whiteness is an ideological construct which values the lives, experiences and norms of white people over those who belong to marginalised racialised groups (Frankenberg, 1993). Frankenberg examined how whiteness operates as a social construct, shaping identities, cultural norms and power structures. This is inclusive of gender norms, through the centring of white, cisgender, heterosexual narratives, marginalising or attempting to erase expressions of difference. Whiteness prioritises and privileges those who conform to norms, enabling them better access to social, economic and cultural resources. Harris (1993) discussed how whiteness operates as social capital and a structural advantage, with the power to enforce gender norms which seek to marginalise non-white and non-cisgender identities. Whiteness reinforces frameworks where people falling outside of social and cultural norms are seen as abnormal or deviant, upholding transphobic narratives.

#### 1.3.2.3 *Public Opinion: Political Climate and Media Coverage*

The UK has made slow progress on issues of TGD rights. The Gender Recognition Act (UK Government, 2004) gave TGD individuals the legal right to change their gender and marry in their “chosen” gender, without insistence the individual had undergone any gender-related medical procedures. This did not include any individuals who did not identify within the gender binary (Hines & Santos, 2018). Due to the calls for revision of the Gender Recognition Act to become more inclusive, a public consultation was organised by the government. From 2004 to 2018, public opinion was in favour of TGD rights with most people agreeing a diagnosis of gender dysphoria should not be required to transition (64%) and agreeing the requirement of a medical report for transition should be removed (80%) (UK Government, 2020). In the following years, a focus developed on issues of single-sex spaces, namely the use of bathrooms matching people’s gender identity (McLean, 2021). Gender Critical (GC) Feminists or Trans-Exclusionary Radical Feminists (TERFs) became vocal about their disagreement that transgender women should be allowed to use women’s bathrooms, sparking a debate on “women-only spaces” to the exclusion of any non-cisgender women (Hines, 2019). The debate centred around the idea that the rights of transgender women would undermine and impose upon cisgender women’s rights.

Non-binary ideas of sex and gender are not new. These concepts have existed across various cultures and historical periods, long before they became a subject of modern debate in the UK. However, within the current social climate, these ideas have been politicised and TGD identities are often exploited in broader cultural and political conflicts. However, recently TERFs are suggesting only cisgender women should be allowed in single-sex female spaces, such as changing rooms and prisons. TERFs alleged that trans-women pose a threat to their safety (Murib, 2021). Accusations have been made against transgender women of violence and sexual assault despite no evidence of these claims (McLean, 2021). Hasenbush et al. (2019) found no link between US criminal incident reports and laws allowing transgender individuals access to single-sex spaces of their identified gender. These claims are reminiscent of allegations made against LGB people as predatory or deviant in the 1980s (D’Emilio, 1993).

Groups believing TGD people should not be thought of alongside LGB individuals are gaining popularity. They believe TGD people’s differences are that of gender and not sexuality and the groups should be separate (Mucciarroni, 2008). These exclusionary LGB groups, alongside TERFs, are utilising their voices to platform transphobic views and hate speech and are likely to be influencing the public’s opinion on TGD people’s rights (Turnbull-Dugarte & McMillan, 2022). Public opinion in the UK was measured by the British Social Attitudes (BSA; Curtice et al., 2019) survey, which found 82% of the British population stating they are “not prejudiced at all” towards TGD people, but when conducted again in 2023 this had declined to 64% (Clery, 2023).

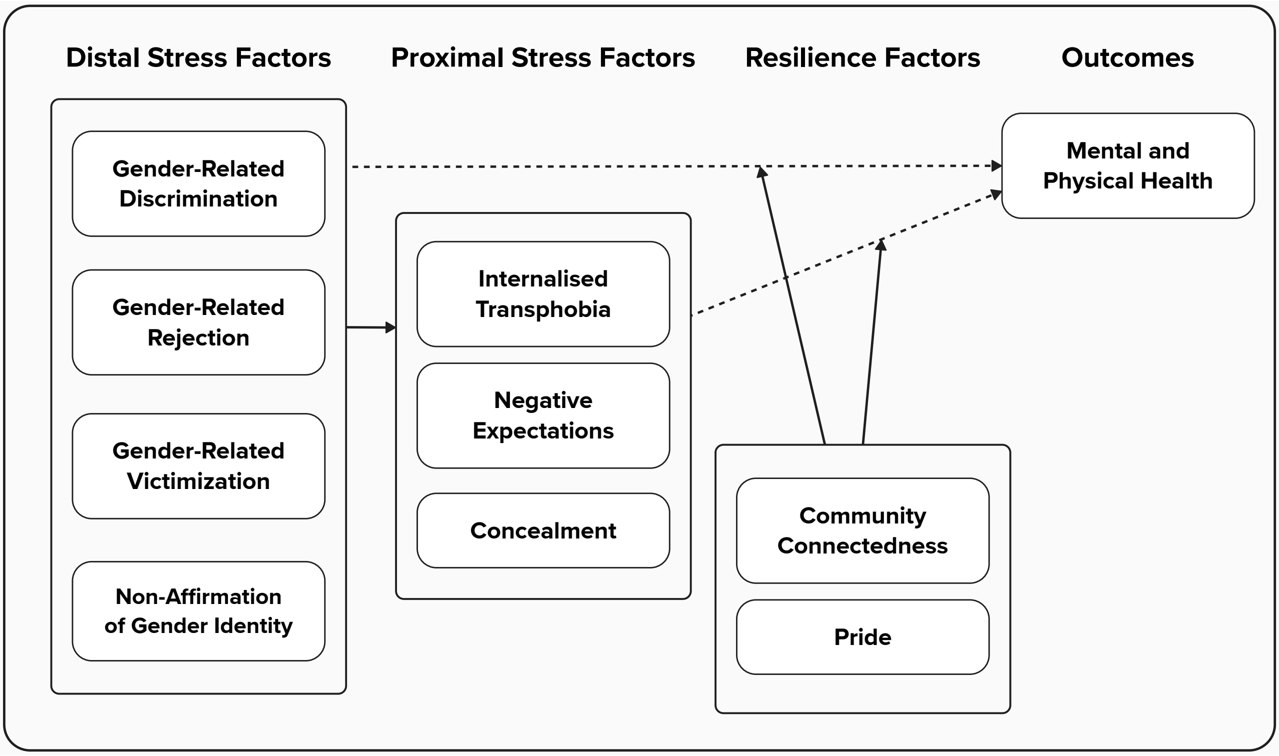
The BSA 2023 spoke to substantial changes in attitudes about TGD lives, suggesting that extreme political views and inflammatory media coverage have influenced opinion. Clery also suggested this follows a similar pattern of the shift in opinion of LGB people and relationships, following the HIV and AIDS crisis and the introduction of Section 28 in the 1980s. Data from the Home Office (2023) has shown increases in hate crimes against TGD people over the last three years of up to 56%, with an 11% increase between 2022 and 2023. The Home Office suggests this could be due to the political climate and media coverage or better reporting of crime: “Transgender issues have been heavily discussed by politicians, the media and on social media over the last year, which may have led to an increase in these offences, or more awareness in the police in the identification and recording of these crimes." (Home Office, 2023).

## 1.4 Gender-Related Stress Factors

Gender-related stress can be understood using a variation of the Minority Stress Model (Meyer, 2003), which initially sought to understand and explain mental health disparities experienced by individuals belonging to marginalised groups. TGD individuals experience stressors which are under-researched in the literature (Rood et al., 2017a). Testa et al. (2015) developed the Gender Minority Stress and Resilience Model (GMSR) to provide a conceptual framework to understand the experiences of gender minority individuals. They aimed to examine and understand the external and internal stressors faced by gender minority individuals, the factors contributing to their resilience and how these impact on wellbeing.

**Figure 1**

*Gender Minority Stress and Resilience Model*



In the GMSR, distal stressors refer to external factors, experienced outside of the individual which may exert significant influence on wellbeing. The GMSR model posits that distal (or external) stressors are likely to have a negative impact on the psycho-social wellbeing of TGD people which can have further negative impacts on their lives. Testa et al. (2015) outlined four hypothesised distal stressors: gender-related victimisation, gender-related rejection, gender-related discrimination, and identity non-affirmation.

Transgender individuals face gender-related victimisation in many forms including harassment, abuse, and violence. Research in the US found over half of transgender youth studied had been discriminated against in relation to using bathrooms (Price-Feeney et al., 2021). Transgender college students in the US were found to face higher rates of violence when compared to cisgender individuals (Griner et al., 2017). According to Testa et al. (2012) violence is associated with a four times higher suicide risk in transgender individuals.

Structural transphobia refers to systemic and institutionalised forms of gender-related discrimination against TGD individuals within societal structures, having negative impacts on wellbeing, quality of life and mental health (Price et al., 2021). This can include policies and practices within institutions, such as a lack of gender inclusive policies and discriminatory hiring processes, perpetuating inequality and marginalisation of TGD people (Price et al., 2021). Mizock et al. (2018) conducted a qualitative study in the US where participants spoke to a lack of social support, advancement barriers and inclusive policy in their workplaces. Structural transphobia has also been seen in terms of disparities and barriers in accessing housing, education and employment for transgender people (Flores et al., 2015).

Gender-related rejection and non-affirmation of gender identity are two further distal stressors identified by the GSMR model. In one of the largest surveys of transgender people in the US, it was found that 26% of participants were rejected by an immediate family member, with that family member cutting off contact, and a further 10% had experienced violence from family members due to their gender identity (James et al. 2016). In the same study, it was found that 19% of transgender people left their faith communities as they had been rejected by them. In a study with a range of gender identities, Riggs et al. (2018) found that transgender and non-binary respondents were more likely to have experienced familial rejection and violence. Both studies found that familial rejection and violence caused negative impacts on multiple aspects of their lives, including physical wellbeing, safety, and mental health. Non-affirmation of gender identity is a lack of acknowledgement and validation of a person's self-identified gender and can include misgendering, using the wrong name or pronouns and non-acceptance in ignoring or failing to support the person's gender identity (Testa et al., 2015). When a person does not receive this, it can negatively impact their quality of life (Nobili et al., 2018).

### 1.4.2 Proximal Stress Factors

Proximal stressors in the GMSR model encompass internal stressors faced by TGD individuals in their daily life due the impact of distal stressors. Proximal stressors can also impact the wellbeing and quality of life experienced by TGD people. Testa et al. (2015) hypothesised three proximal stressors in the GMSR: internalised transphobia, negative expectations of future events and non-disclosure of identity.

Internalised transphobia is the acceptance and internalisation of negative societal attitudes, stereotypes or prejudices leading to distress in transgender individuals about their own gender identity (Inderbinen et al., 2021). White-Hughto et al. (2015) discussed how internalised stigma can lead to difficulties such as expectations of rejection, concealment of what is being stigmatised and reduced coping mechanisms for stressors, drawing links to the adverse health outcomes experienced by transgender people.

Negative expectations refer to the anticipation gender minority individuals may have about encountering prejudice, discrimination, or any negative reactions towards them due to their gender identity (White-Hughto et al., 2015). Rood et al. (2016) examined the impact of expectations of rejection on transgender and gender non-conforming individuals in the US and found that the experience of expecting rejection was frequent in their lives in many contexts which negatively impacted their wellbeing. Cruz (2014) spoke to anticipated poor care and discrimination from healthcare providers contributing to postponement of help-seeking. Cruz noted that 50% of transgender and gender non-conforming people in the US delay seeking needed care, 30% higher than the general population (Cunningham & Felland, 2008).

For TGD people, non-disclosure of identity is the choice to not share their gender identity due to fear of discrimination or negative impacts on their wellbeing. Rood et al. (2017a) interviewed transgender individuals who spoke about identity concealment and non-disclosure as a source of stress which is associated with fear of negative reactions. However, this led to other difficulties including feelings of inauthenticity and self-hatred, leaving transgender people feeling exhausted.

### 1.4.3 Resilience Factors

Meyer (2015) described resilience as the ability of the individual to effectively cope with and recover from experiences of adversity, maintaining or regaining functioning despite significant stressors. Testa et al. (2015) categorised the resilience of gender minority individuals in two categories: pride and community connectedness. Hendricks and Testa (2012) thought that these resilience factors may mitigate and protect from the impact of minority stressors for TGD people.

Pride refers to the ability of TGD people to feel like their lives are a gift, proud to be out as a transgender person and feeling accepted (Bockting et al., 2020). There is little research on how pride impacts on distal and proximal minority stressors. Matsuno and Israel (2018) suggested that a person who experiences stigma or rejection yet has a high level of pride in relation to their gender identity, will experience less distress and negative outcomes than those with lower levels of identity pride.

Frost and Meyer (2012) described community connectedness as the extent to which individuals feel a sense of belonging in a group or wider community. Pflum (2015) explored the effects of community connectedness for 865 transgender participants in the US. They found that general social support was significantly negatively associated with symptoms of mental health difficulties. Sherman et al. (2020) conducted a review of literature on the effects of community connectedness, finding that higher levels of perceived community connectedness were associated with improved mental health, increased access to seeking out healthcare and feeling higher levels of comfort in their gender identity and transition.

### 1.4.4 Critiques of GMSR

The GMSR provides a comprehensive framework to understand the stressors faced by TGD people and factors contributing to their resilience. However, it is important to note that the GMSR fails to account for the role of gender dysphoria as a proximal stressor. Gender dysphoria is a term which is well known as a diagnosis, but also refers to distress or discomfort which may arise when a person's gender identity and sex assigned at birth do not match (Coleman et al., 2012). When referring to the diagnosis of gender dysphoria, it is conceptualised as a problem located within the individual, whilst gender dysphoria as a concept is affected by social expectation (Cooper et al., 2020). Lindley and Galupo (2020) stress the importance of the inclusion of gender dysphoria amongst proximal stressors for TGD people. They reported that gender dysphoria can be impacted by distal stressors and correlates with the proximal stressors proposed in the GMSR. Gender dysphoria was also associated with negative mental health outcomes.

The GMSR utilises Western ideas of what it is to be TGD, focusing on mostly white, middle class or urban populations and ignoring the impacts of culture, race, and other minority identities. Much of the research based around TGD experiences is focused on these groups, limiting the generalisability of all findings and models to populations that are underserved by research. The consideration of multiple identities and intersectionality is needed to truly understand the experiences of populations who fall outside of research norms. Utilising intersectionality theory, which speaks to experiences of individuals with multiple minoritised identities, can show how intersecting identities with overlapping stigma and discrimination shape people's experiences (Parent et al., 2019). Further research models should include an intersectional lens to gain a better understanding of all TGD experiences.

## 1.5 Health Outcomes

### 1.5.1 Access to Healthcare for TGD People

Access to healthcare for TGD people has been a complicated process, especially when seeking gender-affirming healthcare. Winter at al. (2016) suggest that this process is made more complex by leftover ideas about TGD people being “mentally disordered” with care providers discriminating and intentionally withholding access to services or not having the right information to provide support. Structural barriers are in place for TGD people who wish to access services in many countries, including long waiting lists, limited services providing TGD specific care and a lack of training for healthcare providers on how to work with TGD people (White-Hughto et al., 2015).

In the UK, waiting lists can stretch up to 5 years for gender-affirming care through the National Health Service (NHS). Boyd et al. (2022) found mean waiting times of 26 months. Boyd and colleagues also noted inconsistencies in care, with irregularities and contradictions found in national and international guidelines for quality TGD healthcare. No guidelines were found for primary care settings, with general practitioners (GPs) unable to adhere to safe and quality care when utilising competing inconsistent wider guidelines. This is particularly difficult for TGD people in the UK as the GP is the primary point of access for referral to NHS TGD services (Vincent, 2018).

A further barrier for TGD people accessing healthcare is health professionals having little knowledge of TGD issues and at times relying on their patients to educate them, taking an emotional toll and meaning TGD people are less likely to be referred to the services they need (Persson-Tholin & Broström, 2018). Difficulties also arise in navigating complex healthcare systems when providers lack knowledge; TGD people face the burden of seeking out non-discriminatory care on their own (Ross et al., 2016). Ross and colleagues also found that TGD individuals in the US needed to rely on each other to navigate healthcare systems in place of professional help. This leads to a general distrust of healthcare services, limited access to services for TGD people and an avoidance of these services due to expectations of negative outcomes (Redcay et al. 2021).

UK primary care providers were interviewed about their understanding of barriers for TGD individuals. Healthcare professionals discussed similar topics including structural barriers such as long waiting times, lack of TGD specialist services, educational barriers on the part of the healthcare professionals and a lack of training on TGD issues. Cultural and social barriers including discriminatory attitudes also affected TGD people (Mikulak et al., 2021).

### 1.5.2 Physical Health Outcomes

There has been a lack of research in health outcomes for TGD people, specifically in the UK, including research on their health outcomes in relation to gender-affirming care such as hormone therapy or gender-affirming surgery (Lo & Horton, 2016). This is despite TGD people needing to use healthcare services as frequently as, if not more often than, their cisgender counterparts (Ellis at al. 2015). There are likely various reasons for this, with Lo and Horton (2016) suggesting that the prevalence of the idea of gender diversity being equated with a mental health diagnosis may mean general health concerns are dismissed as part of mental health issues.

TGD people are reported to have worse health outcomes than corresponding cisgender cohorts. TGD people, specifically transgender women, receiving hormone therapies are at a higher risk of cardiovascular disease and heart attacks (Myocardial Infarction) than cisgender people (Connelly et al., 2019; Streed et al., 2017). This is less well documented in transgender male patients, but some studies have found that transgender men are twice as likely to have cardiovascular disease than their cisgender male counterparts (Glintborg et al., 2022). It remains to be understood whether this is a consequence of hormone therapy, risk factors related to sex at birth or risk factors relating to psychosocial stressors across their lifespan (Streed et al., 2021). However, there is difficulty understanding these results due to a lack of clear data about control groups. There are calls for further research on the topic, due to uncertainty around whether TGD people should be compared against their sex at birth or their gender (Connelly et al., 2019).

Studies have found that transgender people have high rates of binge and heavy drinking, alongside alcohol use disorder (Gilbert et al., 2018). Gilbert et al. also spoke to the limitations of these studies, including difficulty with operationalising definitions of hazardous drinking and a lack of coherent differentiation between sex and gender. Connolly et al. (2022) found high rates of general substance use amongst TGD people, including alcohol and cannabis. They emphasised the importance of reporting on TGD identities in a more nuanced way to understand the complexities of each identity's relationship to substance use. More recently, using data from a 2016-2018 survey from TransPop of transgender adults with cisgender comparisons, Kidd et al. (2023) found no significant differences in reported drug and alcohol usage between transgender and cisgender adults. Non-binary people were found to have the highest odds of substance use, further showing a need for a breakdown of gender identity categories in studies and sampling.

There is a small, but growing body of literature for physical health outcomes in TGD people but many of these studies are, as reported, of varying quality. It is important for researchers to continue to study TGD health outcomes, with an understanding of the nuance of gender identity and a greater understanding of sex vs gendered control participants. This research should account for social and psychological factors when speaking to TGD outcomes.

### 1.5.3 Mental Health Outcomes

Many studies have documented the high prevalence of psychological distress and high rates of mental health diagnoses for TGD individuals (Pinna et al., 2022). Dawson et al. (2017) used questionnaire results of a large online sample of adults in the US to attempt to better understand rates of diagnosis of mental health disorders in the transgender community in relation to their prevalence in the overall population. Dawson and colleagues found transgender individuals have higher rates of diagnoses of depression and anxiety relative to those identifying as male or female in the study. They did not explore the rates in relation to other transgender identities, with transgender/gender variant being the only category to identify by for TGD people. Wanta et al. (2019) found transgender patients experiencing higher rates of psychiatric diagnosis (58%) than the cisgender patients (13.6%). Interestingly, many TGD people require a psychiatric diagnosis to receive a referral for any gender-affirming care, submitting them to mental health diagnostic processes, which can both medicalise and stigmatise their identities (Dewey & Gesbeck, 2016).

Rates of anxiety and depression are amongst the most well-documented mental health outcomes for TGD people with multiple studies finding higher rates of depression and anxiety for TGD people (Wanta et al. 2019). They found rates of diagnosed depression and anxiety for transgender adults were 31% and 31% in comparison to 4.8% and 8% respectively in cisgender adults. This has been corroborated in further studies with rates of depression and anxiety symptoms in a smaller population of transgender people at 33.3% and 29.6% (Hajek et al., 2023), threefold increased risk of an anxiety disorder compared to controls, notably with transgender males experiencing more anxiety than transgender females (Bouman et al., 2017). Professionals need to better understand the complexities of TGD identities and the impact of stigma, discrimination and other stressors on their mental health. These studies all utilise various sample sizes and methods of sampling but come to similar conclusions. Limitations of these studies included utilising records which only allow respondents to label themselves as transgender, likely losing people who do not identify with the term or identify with other labels. This prevents an understanding of the nuances of the prevalence of depression and anxiety in people who identify as other genders or no gender at all. Many studies also looked at clinical samples, which means some results are less generalisable to non-clinical populations of TGD people (Bouman et al., 2017; Wanta et al. 2019).

Evidence suggests TGD people experience higher rates of post-traumatic stress disorder (6.7% for transgender individuals vs 0.52% in cisgender individuals), psychotic disorders (4.7% vs 0.53%), personality disorders (5.9% vs 0.37%) and eating disorders (2% vs 0.25%) (Wanta et al. 2019). A diagnosis of borderline personality disorder (BPD) is more likely for TGD people. There is a documented lack of understanding of TGD issues within healthcare services, and it is possible that clinicians over-diagnose BPD in TDG individuals (Rodriguez-Seijas et al. 2023). Eating disorders and body dysmorphia also have a complex relationship with gender dysphoria. Hartman-Munick et al., (2021) found some TGD individuals developed disordered eating patterns to stop development of gender markers, such as menstruation and breast development. TGD individuals explained that with hormone therapies this would have been less of an issue. However, in the same study, some TGD individuals spoke to their eating disorder and body image issues as separate from their TGD identity. This calls for a better awareness of treatment for TGD people which must be sensitive to the individual's understanding of what is happening for them (Hartman-Munick et al., 2021).

TGD people also have higher rates of suicidality and suicide attempts, with rates of suicidality throughout the lifetime (suicidal ideation and thoughts of suicide) indicated to be approximately 55% of TGD adults compared to the general population’s 9.2% rate. Higher rates of attempted suicide are also prevalent with estimates around 29% versus 2.7% in the general population. (Adams et al. 2017; Nock et al., 2008). Adams et al. (2017) spoke to stigma as well as structural barriers experienced by TGD people such as difficulties accessing TGD-affirming healthcare and that evidence shows in some cases suicidality and suicide attempts decrease when transition goals are met. These results were found to be similar for transgender men and women, but slightly lowered in non-binary people, perhaps due to lowered importance of transition for people with non-binary identities.

Studies containing results for gender identities other than simply ‘transgender’ are rare, creating difficulty understanding difference between people who identify outside of binary gender or do not identify with a label of transgender (Matsuno et al. 2022). Studies of transgender health need to be more expansive in their identification of gender identities to fully understand the disparities between transgender and cisgender populations, and between identities within gender minority populations. Many of these studies posit minority stressors such as violence, discrimination and transphobia as associated and correlated to mental health outcomes (Cerel et al. 2021). This is supported by the GMSR theory outlined in Section 1.4. As well as these factors, it can be understood from the research that whilst transgender people are at more risk of poor health outcomes, services are perpetuating many of the minority stressors that are associated with these poor outcomes (Poteat et al., 2013).

## 1.6 TGD People’s Experiences of Services

### 1.6.1 Accessing and Using Physical Health Services

Transgender people report experiencing difficulties with health services and healthcare professionals, but little research can be found in UK settings. In England and Wales, TGD people speak to difficult experiences with their primary care providers (GPs) (Wright et al., 2021). Wright et al. (2021) discussed problems being seen as a person outside of their transgender identity, which they felt was sometimes a barrier to getting the care they needed, including care for health conditions unrelated to being TGD. They outlined concerns around GPs lack of knowledge about transgender health and their uncertainties about what to do and how to treat them. Wright et al.'s participants thought this fed into difficulties getting referrals to GIC services, with GPs either refusing to do so, or lacking the knowledge of how to do it. TGD people also discussed "good care", speaking about feeling listened to and GPs being willing to learn. For some, it was about GPs having already done their own research and not using their appointment to learn from them.

In a UK study by Shepherd and Hankel (2021), TGD people discussed the failure of healthcare records and systems, with changing gender identity on NHS systems requiring a new NHS record number, leading to the loss of all previous medical data. TGD people also spoke to having to "choose" a gender, with no option to select a transgender identity, meaning they were registered as a male or female on the system. This leads to health difficulties such as automated reminders for "women's" health, including cervical screenings, not being received by transgender men despite these health issues still being relevant for them.

Similar accounts have been found outside of UK contexts. De Santis et al. (2020) interviewed 25 transgender women in the US about their experiences of health services. They spoke to difficulties such as direct discrimination and misgendering from healthcare providers. This was perpetuated by a lack of choice of healthcare services, little ability to change providers and an absence of LGBTQ+ identified providers.

Poteat et al. (2013) conducted interviews with 55 transgender men and women in the US, finding they were prepared for services to lack knowledge about their identities and about their physical healthcare. They described frustration with healthcare staff who used the wrong names and pronouns. They also spoke to the well documented lack of knowledge in services, with providers expecting to be educated by their patients or a lack of follow up care with medications that had been prescribed by other providers. They spoke to specific instances of having to provide their own treatment plan to their medical provider.

### 1.6.2 Accessing and Using Mental Health Services

There are fewer studies that focus on the experiences of TGD people in mental health services globally. Studies mainly focus on LGBTQ+ experiences or provider perspectives, rarely speaking to the specific experience of TGD people (Holt et al., 2021). There is a long and complex history of the pathologisation of TGD people by mental health professionals (MHP) which may influence the experiences of TGD people in mental health services. This may be due to their own personal feelings about accessing this care or the legacy of medicalising TGD identities having an influence on the care offered to TGD people (Panchal et al., 2022).

As in physical healthcare settings, TGD people also experience discrimination and stigmatisation in mental health services (McCullough et al., 2017). Studies conducted globally have shown that TGD people deal with negative experiences with MHPs, including experiences of unsafe, discriminatory, and invalidating care (Benson, 2013; Bess & Stabb, 2009). TGD people also report difficulties finding MHPs who can provide knowledgeable and experienced care for TGD specific issues (Austin & Goodman, 2018). TGD people reported feeling better understood by LGBTQ+ providers, feeling more comfortable working with people who had a better knowledge of their difficulties and could empathise with them (Bess & Stabb, 2009).

Negative experiences have also included gatekeeping by MHPs, whose roles can include onward referrals to gender-affirming care (Mizock & Lundquist, 2016). Gender-affirming services often require a diagnosis of gender dysphoria, which may require contact with a variety of MHPs to attain. This leads to a difficulty for TGD people feeling stigmatised by MHPs who must provide them with a diagnosis to receive care (Drescher, 2010). For some, the fear of gender-affirming services being gatekept led them to conform to stereotyped behaviour in their appointments to ensure a referral (Carroll-Beight & Larsson, 2018).

Simeonov et al. (2015) found in a survey that 50% of TGD respondents had stopped using mental health services because of difficulties within the services due to their gender identity, including feeling unsafe and experiencing transphobia. Despite the well-documented higher rates of psychological distress of TGD people in relation to cisgender people (Baker, 2019), there have been few studies on TGD people's experiences of accessing mental health services and the impacts of using these services and interacting with MHPs.

In the UK, there is very little research focusing on TGD people's experiences of mental health services. This lack of research leaves many questions when attempting to understand the reasons for poor mental health outcomes for TGD people in the UK. More research into how TGD people experience this care would begin to illuminate potential strengths and weaknesses of these services for this community. The importance of hearing TGD voices in the research literature is paramount, allowing people to speak to their experiences to understand the importance of shining a light on a community that has been overlooked (de Vries et al., 2023).

## 1.7 Scoping Review

The majority of literature written about TGD healthcare experiences in the UK relates to their experiences of physical healthcare or gender-related care (Hobster & McLuskey, 2020; Wright et al., 2021). The mental health service literature in the UK tends to be focused on LGB populations (Rees et al., 2020) or service provider perspectives of working with TGD people (Mollitt, 2022). Research focused on LGB populations misses the nuance of specific context and history for TGD people (Holt et al., 2021). Service provider perspectives, whilst useful in understanding the professional perspective, cannot account for the experiences of TGD people in services. As such, studies not specifically focusing on TGD people and studies utilising only service provider perspectives on TGD care were excluded.

Due to the scarcity of literature for TGD people's experiences of mental health services in the UK, a scoping review was deemed most appropriate to identify research gaps. It aimed to identify and understand the current literature on TGD experiences of mental health services in the UK. The scope of the review used the framework by Booth et al. (2016):

1. Who: Transgender and gender diverse people
2. What: Experiences of using mental health services in the UK

3. How (How will the study impact on the who): Identify and evaluate current research on TGD people's experiences of mental health services in the UK

Multiple databases were used to identify relevant literature: PSYCHINFO, Science Direct, CINAHL Plus, PsychArticles and grey literature through Google Scholar, University of East London library search and references found from relevant studies. Appendix A contains a flowchart for the search strategy, including terms used, inclusion and exclusion criteria. Three papers were identified to be included in the review.

### 1.7.1 Ellis et al. (2015)

Ellis et al. (2015) explored TGD experiences of UK mental health services and GICs from survey data of a national report of TGD people's health and wellbeing. This included a mixed-methods approach including primarily quantitative data and limited qualitative data from open-response questions. The data related to mental health services collected 621 responses, representing a large range of gender identities from predominantly White British backgrounds (86%). 66% of the survey sample had accessed mental health services, showing that TGD people frequently use mental health services. Ellis et al. reported that 33.8% of participants were dissatisfied with their care. TGD people spoke to experiences of lack of clinician knowledge, their gender identity not being respected and fear about their gender identity being seen as a symptom of a mental health issue. It was unclear in the study whether these issues were simply perceptions held by TGD people about services or if they had experienced these difficulties.

The Trans Mental Health and Emotional Wellbeing Study national report (McNeil et al., 2012), the sample this study is based upon, focused broadly on TGD people's mental health, with mental health services being focused on as one of eighteen categories. The rest of the report focused on other avenues of TGD life including transition and GIC experience. As a result of this, the data collected for mental health services specifically was limited. Whilst difficulties were highlighted within mental health services, little is known about the impacts of these for TGD people, requiring further research to explore these issues. Only 74% of TGD people in this study said they would use mental health services again if they were unwell, speaking to the need for further research into the provision of mental health services for TGD people.

### 1.7.2 Hunt (2013)

Hunt's study aimed to examine the experiences of transgender individuals seeking counselling or psychotherapy outside of GICs. Hunt utilised a mixed-methods approach, with seventy-four TGD people completing a quantitative survey and five qualitative interviews. The survey collected a broad range of gender identities, but the participants interviewed reported binary labels of gender (e.g. transfemale). This small sample size may limit generalisability of interview data alongside a limited range of gender identities. The majority of the respondents in this study were over the age of 40, further limiting the results due to the differences in societal acceptance experienced by different age groups of transgender people.

Key themes were around fear of exploring gender identity for the first time or being discriminated against, this was explored in the interviews relating to accessing counselling. Transgender people sought counselling for various reasons, not exclusively related to their gender identity with participants feeling generally accepted by their counsellors, but less understood by them. The study did not further explore this finding within their qualitative interviews. When gender identity did come up, participants felt that some counsellors placed too much emphasis on it, and some ignored it completely. The scope of this study did not further explore these situations, including what participants found helpful or unhelpful in these situations.

There were mixed satisfaction rates reported in the quantitative data gathered and this was mirrored in the interviews with participants describing mixed experiences of counselling. The study would have benefitted from further investigation into the factors influencing satisfaction rates, including levels of counsellor competence with TGD patients. Whilst the study provides valuable insights into the experiences of five patients in counselling, it did not fully explore the impact of counsellor competence. In future mixed-methods studies, findings from the quantitative data could be better explored through interview questions based on the initial data captured.

The researcher and research assistant were both white, middle class, heterosexual females. This is likely to have impacted their understanding of the TGD community, being separate from the marginalisation experienced by people who are gender minorities. The researcher did not consult with any TGD people before conducting the study. This may have impacted the design of the study, questions asked, and interpretations made. However, the researcher did comment on potential biases and hold their position in mind in relation to this research. Future research should, where possible, include TGD people in the research process to improve cultural competence, ensure inclusive language and avoid assumptions or misrepresentations of the community. As this research was conducted in 2013, it is also important to note that there have been significant shifts in the political climate for TGD people and these results may no longer be relevant in the current contexts.

### 1.7.3 Applegarth and Nuttall (2016)

Applegarth and Nuttall interviewed six participants who mainly identified as female or as non-gendered. They used semi-structured interviews with open-ended questions to capture accounts of individual experiences of various types of talking therapy, including private therapy and therapy through charities and gender services. This study had a limited age range (32-48) and a limited range of transgender identities which may have narrowed the scope of the experiences collected and reduced the generalisability of the findings to the broader TGD community.

Fear was a prominent theme, encompassing concerns about judgment from therapists, disbelief about their gender and worries about their future lives. Safe spaces to explore their gender identity were highlighted as important for the therapy, with participants wanting to feel understood. Ability to "move on" from therapy, with mixed emotions regarding the end of therapy was a central topic of discussion, with some individuals experiencing distress and others, gratitude. None of the participants in this study utilised NHS therapy services outside of gender clinics, with participants opting for private or charity-led organisations. This was explored in relation to clients utilising LGBT organisations to lessen their fears, but it was unclear if this had led to better experiences within therapy.

This study utilised Interpretative Phenomenological Analysis (IPA) to gain a rich understanding of participants' lived experiences. Whilst this provides an in depth understanding of the perspectives of participants, it may have limited an exploration of wider socio-political context which is of importance when considering marginalised populations. As noted by Applegarth and Nuttall in their limitations, the narrow age range may have also limited the findings to a group who had benefitted from more progressive social attitudes at the time the study was conducted. However, these social attitudes have once again shifted, and it is important to understand the updated impacts of societal and political discourse on experiences of services.

### 1.7.4 Gaps in the Literature

Two of the studies used small sample sizes with narrow gender diversity and age ranges which decreases their generalisability to the TGD community. This is a common difficulty with research relating to TGD issues, with much of the research utilising small convenience samples. Two of three studies also had difficulty representing the spectrum of gender, with almost all participants in two of the studies identifying with a binary gender, which does not speak to the experience of people with non-binary labels. The studies presented are from 8, 9 and 11 years ago and as explored earlier, much has changed within the UK's political climate within that time. This suggests that TGD people's access and use of mental health services may also have changed over this time. It is important to assess whether there have been shifts within services and if so, how these are impacting TGD people.

Further research needs to explore TGD people's experiences not only in therapy, but within mental health services as a whole, including interdisciplinary intervention. Given the clear disparities in mental health outcomes for TGD people, there is little research into their experiences of accessing and using services and contacts with MHPs. Two of the three studies found are focused on experiences of counselling and therapy, rather than mental health services. There is only one study in the UK which explores TGD people's experiences with mental health services, utilising a mixed-methods approach through collection of survey data. This provided a helpful initial understanding of the topic area. However, their mixed-method approach through survey measures may have limited the length of response, potentially missing a depth of understanding of what may be happening for TGD individuals in services.

There is a gap in our understanding of how accessing and using mental health services impacts on TGD people and what can be done to make their time in services easier and more beneficial. There are currently no studies looking specifically at access for TGD people to mental health services in the UK. Further qualitative research would be useful to collect richer data and a more nuanced insight into how TGD people access, use, and are affected by mental health services.

## 1.8 Current Research

### 1.8.1 Study Rationale and Aims

With the large quantity of literature looking at the poor mental health outcomes of TGD people, it is important to understand their experiences of using mental health services. No studies have been conducted into understanding the experiences of TGD people in mental health services in the UK for the last eight years. Three studies were found in total with two of these focusing specifically on counselling and therapy. Given the changing political climate for TGD people, it is important to understand the barriers they are currently facing in mental health services and with a variety of MHPs. Little knowledge is available about TGD people's experience of accessing mental health services, with no UK studies looking at this.

Currently, the only study available on experiences of mental health services in the UK utilises a mixed-methods survey design. Further research through interview data would be able to build upon themes in the data, allowing the researcher flexibility to adapt questions and explore unexpected or new themes. Interviews may also allow participants to gain a sense of the interviewer, developing a trust and rapport which could allow them to share more honest responses, allowing space for elaboration and sharing their authentic self. The subject matter is likely to be emotive for TGD people who choose to participate in research of this nature, as such it is important to have safe space for them to speak freely without judgement. This research aims to explore the views of transgender and gender diverse people in the UK today, prioritising their voices and insight into accessing and using mental health services.

This study will use the term treatment to refer to the care provided by services, using therapy only when specifically referring to counselling or psychological therapy.

### 1.8.2 Research Questions

1. What are transgender and gender diverse people's perspectives of accessing support from mental health services?
2. How do transgender and gender diverse people describe their experiences of care provided by mental health services?

### 1.8.3 Clinical Relevance

It has been well documented that both health and mental health outcomes for TGD people are worse than for cisgender people (Wanta et al. 2019). There is also evidence suggesting that there are many barriers to accessing services for TGD people, potentially leading to TGD people avoiding using services or experiencing further discrimination or stigma when they do (Panchal et al. 2022). This study aims to better understand what needs to be done within these services to provide better care to TGD people and where services are currently failing them. It will seek to inform what training needs exist within services and provide ideas for progressing understanding and knowledge of TGD issues. It will also seek to inform ideas for better service design and provision for TGD people; to improve the care they receive from services.

# 2 METHOD

## 2.1 Overview

This chapter will consider the epistemological position of the research, outlining the underlying theoretical framework of guiding the study. This position will underpin the design, methodology and ethical considerations of the study. The analytical approach used will be outlined to ensure transparency of data analysis. The reflections of the author on carrying out this research will also be considered.

## 2.2 Epistemology and Ontology

Epistemology is the study of “the nature of knowledge” and how this knowledge is acquired, if it can be acquired (Burr, 2003). Ontology refers to the study of the nature of what exists and the knowledge of reality (Crotty, 1998). The understanding of the philosophical positions and assumptions of the researcher facilitates a better insight into the position that has influenced the aims, methodology and analysis undertaken (Mauthner & Doucet, 2003).

This research is underpinned by a critical realist position. Critical realism, as described by Bhaskar (1978), provides a framework for understanding the experience of TGD people who have used mental health services. This theory by Bhaskar states that there is an objective reality, which exists independently of the perceptions or conceptualisation of individuals. Critical realism utilises a realist ontology to acknowledge the limitations of human knowledge and the complexities of understanding objective reality, which are always mediated by personal perceptions and theories (Willig, 2016). It encourages a critical and reflexive approach to the study and interpretation of the world.

A critical realist approach seeks to provide deeper explanations for the accounts of individuals, considering the social, cultural, and historical construction of gender and societal structures which influence TGD people’s experiences (Willig, 2019). Critical realism falls between positivism and constructionism as an epistemological paradigm, with positivism considering reality to be discoverable through research, observable and measurable and constructionism as the belief that the world is fully constructed through human interaction (Willig, 2013). Critical realism posits a reality which exists independently of individual conceptualisation, which may be difficult to access due socially constructed aspects of existence (Sullivan, 2019).

Mental health services are influenced by societal norms and values which can lead to bias, discrimination, and stigma against TGD people, through biased service design and provision. Service delivery by MHPs is also influenced by training offered, systemic constraints and service values, which can perpetuate discriminatory service delivery through MHP’s practice. Critical realism is useful in highlighting how these beliefs can impact the quality, accessibility, and cultural competency of people delivering care and designing care provision in mental health services. Critical realism also acknowledges underlying structural factors such as power dynamics and institutional policies within mental health systems which may impact on TGD people’s experiences of care. These structures dictate which trainings are funded, which staff are hired and how organisational hierarchies are constructed.

This research focused on the experience of TGD people, which will be a different experience from those who identify as cisgender, due to different cultural and political contexts of their identities. In this research the experiences of participants were understood as their reality, living in a society where their gender identity has placed them outside of expected societal norms. A critical realist approach aims to understand how TDG people describe their experiences of mental health services as they exist in an objective reality, whilst acknowledging that this reality exists in the contextual worlds of TGD people. TGD people exist within their own personal, social, and cultural contexts which will influence their view and understanding of their experiences. The assumption was made that TGD people’s experiences are “real” and that these experiences have had a real effect on them. The study aim was not to find an objective truth but to interpret the experiences offered by the participants within their contexts. The researcher also must consider their own context in the analysis and interpretation of the data collected. It is possible that the participant’s reality was affected by the researcher and that the experience and reality of the interview varied for both researcher and research participant (Willig, 2016).

## 2.3 Design

### 2.3.1 Approach to Data Collection

With the research questions in mind, a qualitative approach was chosen to gather detailed and rich data. This research aimed to gain an insight into the lived experiences of TGD people, allowing them to directly speak to their own memories and feelings when accessing and using mental health services. Interviews allow for more nuanced and deeper exploration of the topic, with an ability to delve into any issues that arise throughout (Smith et al., 2009).

Individual semi-structured interviews were chosen as most appropriate, keeping in mind the need to centre the voices of the participants and ensure their inclusion in their own accounts of their time in services. Surveys and focus groups were also considered but were not chosen for this study. Survey data has been used to research TGD people in the past, relying on them to divulge sensitive information without any further discussion or meaningful debrief (Ellis et al., 2015). The researcher aimed to give TGD people an outlet to express their experiences and stories in their own words and to have these inform the basis of the research. Focus groups were not chosen as it was important to enable as much anonymity as possible for the participants. Furthermore, the group setting would have provided a differing perspective, with participants co-creating meaning rather than being able to speak to their own specific experiences (Smithson, 2008).

The study aimed to recruit a minimum of 8 participants over the recruitment period. The researcher aimed to recruit as many participants as possible from the sample population, not using data saturation guidelines. Data saturation, thought of as the point at which no new themes or codes emerge from the data, aligns with a “neo-positivist” position which is inconsistent with the position taken in this research (Braun & Clarke, 2021). A focus was maintained on the generation of meaning through the data collected, including the stages of recruiting, interviewing, transcribing, coding, thematic mapping, and interpretation. The data was collected and analysed in a way which aimed to elaborate meanings generated through interpretation of the data, with construction of new meanings always being theoretically possible (Low, 2019).

### 2.3.2 Rationale for Thematic Analysis

Thematic Analysis (TA) is a process to identify patterns and themes within qualitative data, with Braun and Clarke (2006) arguing that TA should be a foundation for qualitative analysis. It helps to identify, analyse, categorise, define, and report themes found within qualitative data (Braun & Clarke, 2006). King (2004) notes that TA can provide a highly flexible approach to data analysis which can be applied for the needs of many studies and approaches. This can include a rich and thorough account of the data, including the intricacies of what is being analysed.

TA was chosen in this study as it lends itself well to the research questions, looking at themes and commonalities across individuals rather than individual experiences. There was a focus on capturing the experiences of participants; their own experiential truth of their encounters with mental health services. This research will describe patterns of meaning in experience across a group of individuals and will use these to inform and improve clinical practice, service provision and service development in mental health services. TA has been considered less rigorous than other qualitive methods such as Grounded Theory and IPA, due to a more flexible approach. However, this can be helped by a specific choice of epistemology to anchor the consistency and cohesion of the analysis and study (Holloway & Todres, 2003). Other methodologies which may seek to examine power and privilege were not chosen for this study, as the study aimed to provide a broader initial understanding of themes and patterns across TGD people. This was an exploratory study, aiming to begin to inform a research basis for this topic rather than specifically seeking to unpack the construction and maintenance of systems of power and privilege.

An inductive approach to TA was used, with the researcher using the data to guide identification of themes and interpretations. This allowed coding and theme development to be guided by the data. However, it is important to note that the researcher curated the interview schedule and was also guided by their own experiences, beliefs, and assumptions in the analysis of the data. There will likely have been an impact of engagement with the literature, meaning a level of deductive TA will also have been utilised.  Braun and Clarke (2012) noted that an entirely inductive approach to TA is unattainable due to the bias of the researcher in the research process. A reflective journal of the process was kept, to consider these processes, the lens of the researcher and how the interaction between researcher and participant may shape the telling of their experiences (Willig, 2016).

## 2.4 Consultation and Pilot Phase

Prior to starting recruitment, consultation was undertaken individually with a small group of individuals who met the inclusion criteria. Four TGD people were sent a draft of the interview schedule and invited to comment on the questions and prompts. They were asked to specifically consider the language used, clarity of questions and any areas that may be missing from the questions. The consultants were able to identify some changes to language for clarity and indicated that they felt the questions covered a good range of topics relevant to TGD people’s use of mental health services.

The researcher and consultants discussed what information would be helpful to disclose at the beginning of the interview. Following this, it was decided that addressing the researcher’s identity as part of the LGBTQ+ community might be beneficial to the interview. As the TGD community have faced high levels of transphobia and stigma, it was thought that having an LGBTQ+ identified researcher may increase a sense of safety for participants and make the experience more comfortable. Following this, a short preamble about the researcher, their identity, and reason for the research was included in the beginning of the interview.

Following this consultation, pilot interviews were conducted with two members of the TGD community. This allowed the researcher to get a sense of interview duration, clarity of questions and how to ensure comfort and safety for the participants during their interviews. Participants of the pilot interviews suggested a reminder about taking a break if needed in the middle of the interview, as well as at the beginning. Due to the sensitive nature of the information discussed, it was thought that people may forget or be unaware that they need a break. Wording and structure of questions were rethought for clarity and further prompts were added.

## 2.5 Ethical Considerations

### 2.5.1 Ethical Approval

This study was registered with the University of East London (UEL). Ethical approval was sought and approved from UEL before the commencement of data collection (see Appendix C). The research complied with the British Psychological Society (BPS) Code of Human Research Ethics (2014) and the Ethics Guidelines for Internet-mediated Research (2017). As the study did not recruit through NHS services, no NHS ethical approval was needed.

### 2.5.2 Informed Consent

Participants were provided with a Participant Information Sheet (PIS) (see Appendix D) upon an expression of interest in being involved in the study. They were also provided with a consent form (see Appendix E) to be returned before the interview. The PIS provided information about the purpose of the research, that it would be recorded, themes explored, expectations of them, and benefits and disadvantages related to taking part. It outlined their ability to withdraw from the research without consequence, how confidentiality would be maintained and how their data would be protected. Consent was sought before the interview with the consent form and verbally before beginning. It was revisited at the end of the interview, with a reminder to participants that they could withdraw at any time during the interview and change their mind up to three weeks after taking part in the interview (i.e., withdraw their data).

### 2.5.3 Confidentiality and Anonymity

Confidentiality and anonymity were outlined initially in the PIS and discussed with the participant before the interview. Participants were aware that no identifying information would be used, and they would remain anonymous in the write up and any subsequent publications. Confidentiality and anonymity were a priority for this community and processes were outlined and followed to minimise the risk of any data breaches. Video interviews were transcribed, at which point the researcher anonymised the data, assigning a number to every participant. Consent forms were stored on UEL OneDrive, separately from transcripts to ensure they could not be used to identify participants. All documentation was completed online and there were no paper forms involved.

### 2.5.4 Data Management and Storage

A full data management plan was submitted and approved by the UEL Research Data Management Team (see Appendix F). Identifiable participant information such as contact details and consent forms were stored separately from video recordings and transcriptions to ensure confidentiality. Video recordings were stored on a password-protected Microsoft Steam account until transcriptions were completed, at which point they were deleted. Transcriptions were auto-created by Microsoft Teams which were reviewed and amended for accuracy by the researcher, at this time all identifiable information, including names and places, was anonymised (Thompson & Chambers, 2012). Anonymised transcriptions were only accessible to the researcher, supervisor and examiners upon request. During the research, anonymised transcripts were stored securely on UEL OneDrive. These will be stored by the supervisor for up to three years on UEL OneDrive. Participants consented to extracts from their anonymised interviews being used, ensuring that no identifiable information was included.

### 2.5.5 Potential Distress

The PIS outlined possible disadvantages to taking part in the study, namely the potential for distress at recalling difficult memories or upsetting situations from their past. It also mentioned the potential discomfort of disclosing personal details about their identity. Participants were reminded that their participation was voluntary, and they would be able to withdraw at any point or take a break at any time if needed without explanation or disadvantage.

During the interview, the researcher asked questions relating to how the participants were engaging with the experience. No participants asked to end or pause the interviews and no visible distress was noted on the video calls at any points. After interview, a question was asked about how participants had found it, with all participants stating they had a positive experience.

### 2.5.6 Debrief

Informal debrief at the end of the interview allowed for discussion about any potential emotions that had arisen during the interview. At this point, participants were also provided with a debrief sheet containing a list of support services and the researcher and supervisor’s contact details (see Appendix G). All participants returned their consent forms by email, some sending positive feedback about their experience of the interview. Whilst it is possible that some participants may have experienced some distress and used the support services provided, the researcher and supervisor were not made aware of any distress caused by the interview (i.e., request for meeting post-interview).

## 2.6 Participants

### 2.6.1 Recruitment Strategy

The research was advertised across social media platforms (e.g. Twitter and Instagram) by creating a new account solely designed to recruit for the study. Participants were recruited mainly through a snowballing approach, with participants being involved in recruitment of new participants. Social media was the main platform for recruitment as it is well placed to recruit the target community (Miller-Perusse et al., 2019). Multiple charities and organisations were contacted but of the few that responded, none agreed to advertise the study.

### 2.6.2 Inclusion Criteria

The inclusion criteria were kept broad to recruit a representative sample. The participants included anyone:

- 18 years of age or older
- Identifying as transgender or gender diverse
- Living in the UK
- With past experience of accessing mental health services in the UK

### 2.6.3 Exclusion Criteria

Exclusion criteria was anyone currently in contact with mental health services.

## 2.7 Procedure

### 2.7.1 Initial Contact

Participants viewed and engaged with study advertisements (see Appendix H) on social media platforms and either contacted the researcher through these platforms or via email. The researcher then emailed a copy of the PIS. Participants were able to ask any questions they had about the study and then a date and time was offered for the interview to take place. Written consent was gained before the interview and further verbal consent was gained after the interview, to remove any pressure to continue to consent after the interview had ended.

### 2.7.2 Remuneration

Remuneration was discussed with the consultants who supported with the design of the interview schedule. The group suggested that a prize draw would be a fair way of offering gratitude for the time of participants, with the acknowledgement that participation might be emotionally upsetting. Participants were able to opt-in to a prize draw to win one of two £50 Amazon vouchers. This was deemed appropriate as a token of appreciation for the time and effort of the participants. Participants were made aware that their entry or absence from this prize draw would not affect their participation in the interview in any way.

### 2.7.3 Individual Online Interviews

Brief demographic information was collected from participants before the interviews commenced, including age, gender, and ethnicity (Appendix I). A semi-structured interview schedule had been drafted by the researcher and supervisor (Appendix J) and amended following consultation with a group of 4 TGD people and a pilot phase with 2 TGD individuals. This served as a guide for the interviews, with the questions being asked flexibly in response to topics introduced by the participants. This approach was used to give participants space to discuss their experiences as broadly or specifically as they wanted, bringing in personal memories and reflections. Prompts had been developed for each question to facilitate further discussion if participants were having difficulty describing their experiences.

Interviews lasted from 59 – 87 minutes and took place online over Microsoft Teams. All interviews were audio and video recorded on Microsoft Teams. Following each interview, the participants were asked about their experience of the interview and if they had any feedback for the researcher about how the interview was conducted. Each participant was given a verbal debrief, including what to expect next and consent was revisited, with participants completing their consent forms (see Appendix E). Participants were then sent a follow up email with a written debrief including contact details of support services.

### 2.7.4 Transcription

Transcription was carried out by the researcher following conclusion of the first interview. This allowed the researcher to immerse themselves in and familiarise themselves with the data and material collected. This also allowed the interviewer to reflect on the process of interviewing and their role as interviewer to inform subsequent interviews. MS Teams transcripts were used as a starting point for transcription. Braun and Clark (2012) proposed that an orthographical style of transcription be used for Thematic Analysis (TA). This style was used, following guidelines for transcription by Banister et al. (2011). Banister et al. (2011) suggested that pauses are of little value to analysis of this kind, and as such, only pauses longer than one second will be recorded using (…). Participants names were replaced by numbers, any identifying information was replaced and put in parenthesis. Numbers were chosen over pseudonyms to reduce any potential bias in the process, representing all participants equally without underlying assumption or association. Punctuation was included by the researcher for ease of reading. Transcripts were revisited and reread on multiple occasions to ensure accuracy and guarantee anonymity of any participant information (Gibbs, 2018).

## 2.8 Analytic Approach

The analysis was guided by Braun and Clarke’s (2006) six-phase approach to TA to maintain a level of consistency throughout the analysis of the data.

1. Familiarisation with Data:

Immersion and familiarisation with the data began when then researcher conducted and transcribed the interviews, making notes and comments during transcription. Following this, the researcher became immersed in the data by reading and rereading the transcripts. Through this, the researcher aimed to gain a deeper understanding of the content, continuing to note comments during each rereading of the transcripts.

2. Generating Initial Codes:
   Codes in qualitative research typically consist of a word or brief expression used to represent noteworthy, collective, or evocative characteristics of a data sample (Saldana, 2009). NVivo 14 software was used to identify and label meaningful sections of the data. This allowed the creation of initial codes which represented concepts, patterns and themes in the data. The reflective journal kept by the researcher was used to inform the analysis process.

3. Searching for Themes:
   Codes were grouped into clusters of potential themes which captured similar patterns or significant aspects of the data. The researcher utilised visual mind maps to create a visual representation of the data when capturing the patterns.

4. Reviewing Themes:
   The researcher and supervisor reviewed the themes together alongside the original data. This meant that both the researcher and supervisor were able to ascertain the coherence and consistency of the themes to ensure they accurately represented the data. Extracts were reviewed considering the themes and subthemes developed and rearranged where necessary to create an initial thematic map (Appendix K). Transcripts were revisited to ensure that the themes represented the data and the thematic map.

5. Defining and Naming Themes:
   Themes were refined, defined and given clear names and descriptions that captured the “essence” of the data. Concise names were chosen with the supervisor to accurately represent each theme identified from the data.

6. Producing the Report:
   The researcher wrote the final comprehensive report, with support from excerpts from the data, to present the analysis, themes and the researcher's interpretation in the context of the research questions. The report was written to bring a coherent and cohesive story of the data together, capturing the essence of the identified themes in a clear narrative.

### 2.9 Reflexivity: The Researcher's Position

Reflexivity in psychological research is the recognition and consideration of the researcher's personal background, beliefs, values, and biases in the research process, situating the research within the social context of the researcher and the biased interpretive lens (Patnaik, 2013). This allows the researcher to acknowledge their participation in the research, not as an objective outsider, but playing an active role in construction of themes and meaning making from these.

I write as an adult cisgender woman with no experiences of gender diversity or transphobia. However, I do hold an LGBTQIA+ identity and as such, have experience of belonging to a minority group with experience of marginalisation and homophobia. I hold personal and professional relationships with people who identify as TGD. This was likely to have an impact on how the research was conducted, as I have had personal and professional conversations about the treatment of TGD people in mental health settings prior to the study. It was important for me to do this research for a variety of reasons, including the social and political climate for TGD people in society currently. As someone who identifies as a queer woman, I have benefitted from historical political movements which have afforded me my freedom. In the past, my identity was politicised and socially unacceptable, but I have had the luxury of other people fighting for my freedoms. As a queer person, I now have the responsibility to continue the fight for my queer family and ensure that we continue to fight until all of us have equal and equitable rights and can live our lives without fear of judgement, discrimination or violence. I cannot speak for TGD people but I do have the ability to platform and share their voices, which I hope to do in this piece of work.

I kept a reflective journal during the process of the research, noting thoughts and observations throughout the research process. This enabled me to capture personal attitudes and responses to each part of the process. The journal was used during the write up to increase awareness of bias and consider possible impact of this on the interviews, interpretations of the data and subsequent conclusions drawn. It is likely that my identity played a part in the design and all processes of this research. I attempted to involve TGD people as much as possible, within the confines of a doctoral thesis.

I have worked in mental health settings, with a vested interest in the treatment of LGBTQIA+ clients which is likely to impact on my views and opinions throughout the process. This will have impacted the questions asked, both from the interview schedule and in following up particular topics and themes with participants. I have had both personal and professional experiences of unhelpful and discriminatory processes within mental health services. This may have created bias, as I may hold assumptions that experiences may have been more unhelpful than helpful in services. I held this in mind in relation to the interview schedule and conducting the interviews.

I noted the power imbalance between researcher and research participant. Power imbalance was further influenced as I hold a position working in mental health services. This may have left some participants feeling unable to fully explain difficult experiences for fear of being met with similar attitudes from previous mental health professionals. Also of note regarding power imbalance is the position held by TGD people in society at the time of this research, with media and government scrutinising TDG people’s identities and right to exist. This context may have placed the participants in an even more vulnerable position. I chose to disclose my LGBTQIA+ identity at the beginning of interviews, to attempt to combat some of these power imbalances. This was discussed with consultants, as outlined in Section 2.5. It was hoped that this would allow participants to have a sense of who was interviewing them before disclosing very personal, and at times very difficult, experiences.

# 3 RESULTS

## 3.1 Chapter Overview

This chapter begins with presentation of participant characteristics to locate the sample and contextualise the results. Thematic Analysis (TA) was used to explore data in relation to the research questions. A thematic map is presented to provide an illustration of the themes and subthemes generated. Extracts from the transcripts will be used to support interpretations made by the researcher. Minor changes have been made to transcript extracts to improve readability. This includes removal of repeated words or curtailing of sentences.

## 3.2 Sample Characteristics

Between July - September 2022, 17 TGD people were interviewed. One participant verbally consented but did not return the written consent form, consequently, this interview was excluded from the data set. The final sample included 16 participants, with varying gender identities including transmasculine and non-binary (Figure 2). To protect participant anonymity, demographic data will be presented at group level. Participant ages ranged between 18-34 years. Participant pronouns varied from using he/him, they/him, they/them and she/her (Figure 3). Fourteen participants identified themselves as White British, with two describing themselves as White Scottish and Pakeha. Participants' last contact with mental health services ranged between contact in 2010-2023, (14 years ago to less than a year ago). Participants' first contacts with mental health services ranged from age 8-29 years old.

**Figure 2**

*Self-identified Gender Identity of Participants*

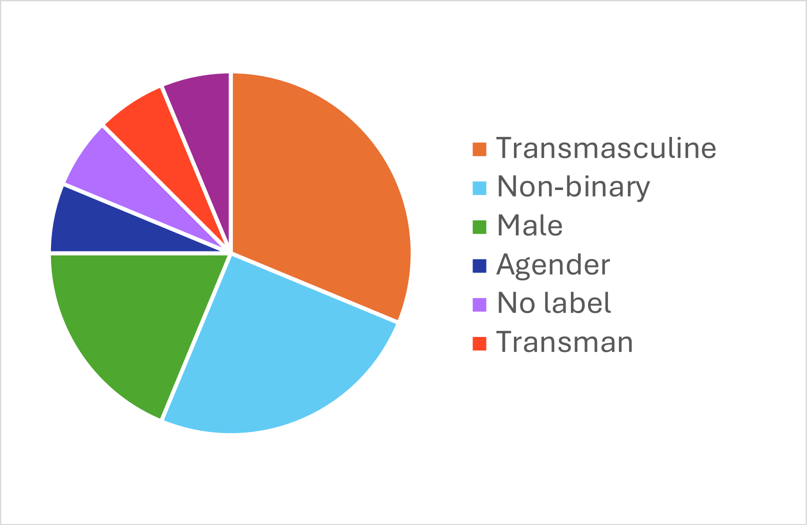
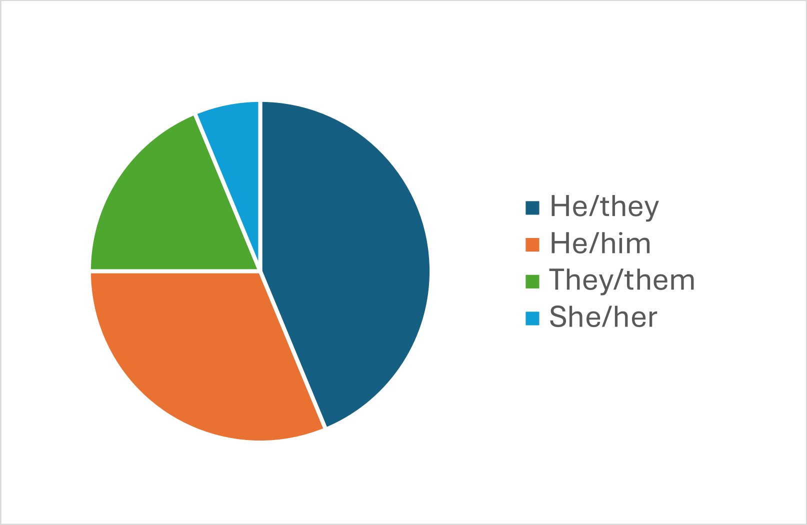


**Figure 3**

*Pronouns of Participants*



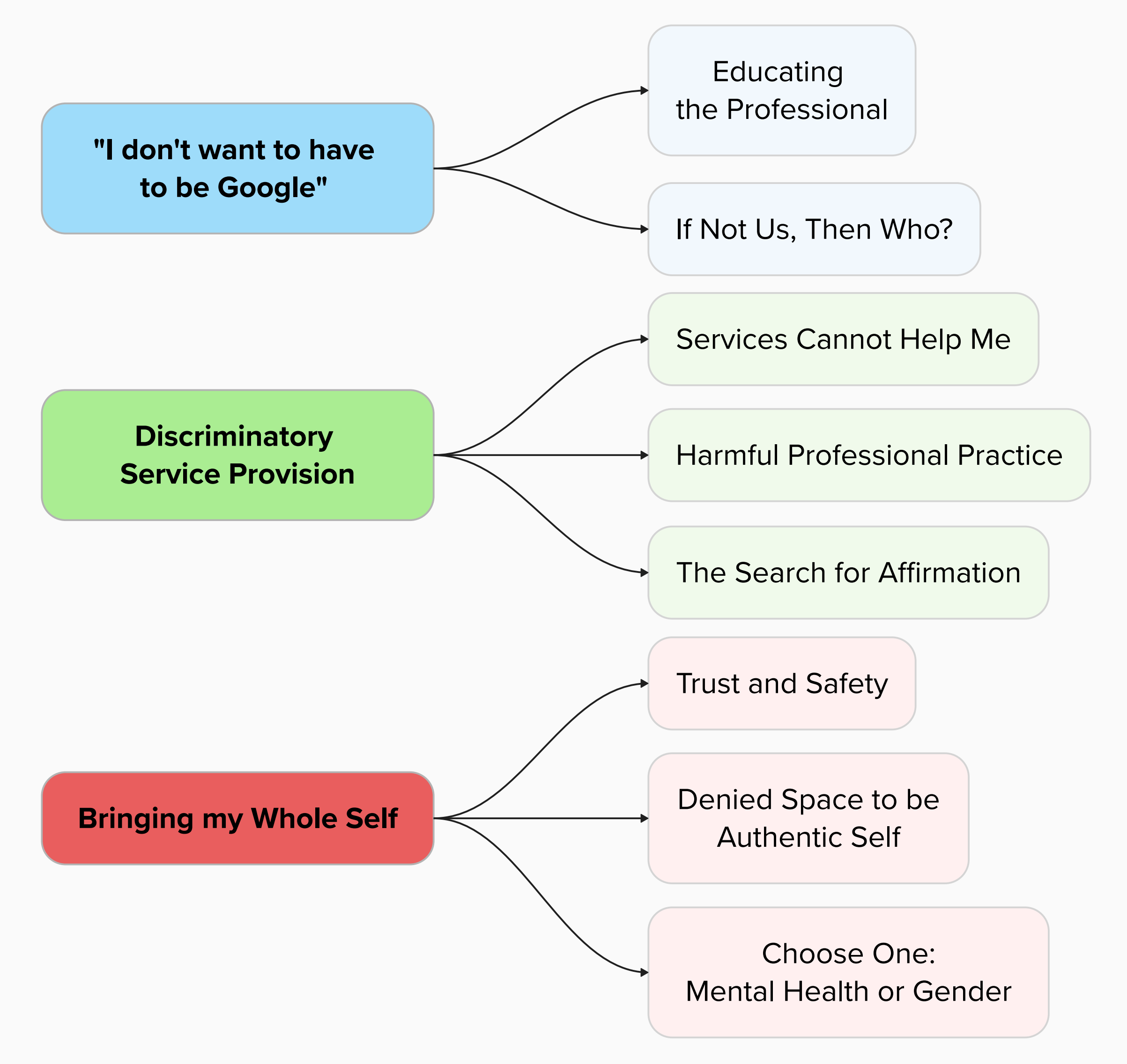
## 3.3 Thematic Map

Using TA, codes generated were grouped into an initial large thematic map (see Appendix K). From there, further thematic maps were constructed and refined to produce the final thematic map including main themes and subthemes (see Figure

4). Final themes created were “I don’t want to have to be Google”, Discriminatory Service Provision and Bringing My Whole Self.

**Figure 4**

*Final Thematic Map*



## 3.4 Theme One: “I don’t want to have to be Google”

As captured by Participant 10, the first theme speaks to the education of mental health professionals (MHPs) on issues relating to TGD identities, health, language, and terminology. Participants described the nuances of the expectation to educate staff on these issues. They discuss the complexities of having more TGD-related knowledge than their MHPs in settings where they are supposed to be receiving care. Participants described discomfort and disappointment at having to educate staff on issues related to their care in the Subtheme 'Educating the Professional'.

Staff educating themselves came up as an important factor for participants who wanted to be able to seek treatment like anyone else in the Subtheme 'If Not Us, Then Who'. Participants  discussed the potential challenges of staff educating themselves, instead of directly learning from their TGD patients. The subtheme explores the complexities of who educates MHPs and the importance of the source of the education.

### 3.4.1 Educating the Professional

Participants spoke to complex experiences of educating their MHPs about various aspects of TGD lives. Some participants described this as a burden to bear whilst trying to seek help which added a layer of difficulty in what is supposed to be a therapeutic environment. Internal perceptions of obligation and pressure to educate MHPs added to an already heavy load when dealing with mental health issues. This pressure highlights the power imbalance between patients and MHPs, with patients forced to educate their provider to receive competent care despite coming to services to be helped.

> *"I want someone to tell me something and be able to give me information that I don't know and be able to look after me. It's like, oh, I've gotta take on the responsibility now, right? So more stress, that as a patient in mental health services, you don't want to have."* (Participant 15)

Some participants said their MHPs' lack of knowledge wasted their time in services. This was especially challenging with repeated experiences of having to educate, leaving participants feeling exhausted when attempting to receive care from services *"it can get exhausting educating people"* (P3). They were unable to spend time talking about issues important to them, when they had to educate MHPs on basic TGD information which was, at times, irrelevant to their care. It is a possibility that TGD patients are not getting sufficient time to explore their issues with MHPs, instead having to educate and guide them. TGD people are potentially receiving inferior services from MHPs who are uneducated about TGD lives, reinforcing experiences of invalidation and marginalisation.

> *“But the person that I ended up seeing, I don't think like, didn't know anything really about trans people. So, it wasn't very helpful because a lot of like, what I was having to talk about was sort of like educating the therapist, you know, which meant that it wasn't actually super helpful in terms of me progressing how I felt.”* (Participant 6)

These experiences began to feel like the norm for some, with participants speaking to their own expectations that MHPs would not know about what being TGD meant. In some cases, this prevented participants from even bringing up their gender identity with MHPs or avoiding services completely. Participants recognised that negative expectations could prove unhelpful when using mental health services. This also likely serves as a defence for TGD patients, to protect them from the possibility of needing to do more laborious teaching or the possibility of being dismissed by MHPs. This likely alienates TGD people from mental health services, creating a barrier to accessing care for people who may not want to educate professionals.

> *“I didn't tell him about my gender identity because I thought “you're not even gonna understand it”. I don't wanna have to be Google and quite often that's what holds me back.”* (Participant 10)

Participants also spoke about the difference between MHPs who were resistant to efforts to educate them and MHPs who were willing to learn. Participants were able to understand the necessity of educating MHPs on specific TGD issues at times and found this easier when MHPs were eager to understand. There was greater difficulty for participants when there was a perceived *“lack of willingness to learn”* (P4) from MHPs. This included MHPs dismissing, ignoring or refuting what their patients were telling them. This leads to not only the burden of educating professionals, but the burden of attempting to have their identity validated.

Participants acknowledged their beliefs that mental health professionals cannot always know everything. Some participants wanted MHPs to be more transparent when they did not know something and said if they approached the situation with honesty and a commitment to doing better, that would have been more useful. This highlights a simple need for open communication between TGD people and MHPs. It is possible communication breakdowns happen due to uncertainty or insecurity held by MHPs about their lack of knowledge. It is also likely TGD patients are vigilant because of past negative experiences, which means MHPs will need to be mindful of and sensitive to this in their communication.

> *"If they didn't know the answer like or what they could have done, they could have been like, I don't really know what to do, I can go away and find out for you."* (Participant 2)

This lack of education on what TGD patients might need from MHPs has an impact on TGD people, with some feeling *"vulnerable"* (P2) and unable to *"speak openly and freely"* (P6). MHPs who lack knowledge about TGD people left participants *"deflated"* (P7) about not getting the help they expected as these MHPs were incapable of offering useful support.

### 3.4.2 If Not Us, Then Who?

Participants spoke about the need for professionals to take responsibility for their education on important TGD matters, but also explored the reasons this can be difficult. Some participants believed professionals educating themselves would create an environment where patients are not held responsible for this and can focus on what matters to them. Participants suggested professional training would be useful in allowing MHPs to gain a better understanding of TGD people, creating a better therapeutic environment for their patients. It also raises the question of whether MHPs are seeking out training to become better educated on TGD health. This potentially speaks to systemic difficulties relating to training for MHPs, including which trainings are being funded and why TGD trainings may be limited or outdated. Are professionals trying to learn but finding a lack of resources or are they avoiding the topic?

> *"If they took some time to have some training or something, it probably would help, because then they'd be more aware of it. So, the way they bring themselves or the way they broach questions would make it easier for me to feel like there was a space for [bringing other issues]."* (Participant 10)

Participants discussed the dichotomy of needing help from professionals but professionals being unaware of how to help or being able to provide any avenues of where to go for help. Participants spoke to the delays experienced in gender-related care due to inexperienced or uneducated MHPs, with people not being referred on for GIC care or having any guidance on how to access further support *"an uphill battle to get any care"* (P8). They knew to get referred, they would have to do their own research and present it to their MHPs as there was no one else to support them. The impact of this is twofold, allowing the patient to be the patient and removing the burden of education from them, but also allowing them to feel supported and understood. TGD patients are extremely vulnerable to their MHP, relying on the MHP's understanding and opinions of TGD-related healthcare issues to get support. This bolsters systemic inequalities in care provision for TGD people, with them relying on chance to get a professional who can provide the necessary care or needing to teach the MHP how to provide care for them.

> *"He had a son that was trans. He had really sensible knowledge and he had practical solutions, practical suggestions. That was really helpful. That was really, really fantastic. It was, yeah. Yeah, quite a novelty to have someone that seemed to get it or seemed to understand."* (Participant 4)

Some participants indicated a preference for a lack of knowledge from their MHPs, as they thought this may make them less likely to experience hate or discrimination from MHPs. This was seen for participants who had experienced prejudiced treatment from MHPs in the past, but also for participants who lived in fear of these attitudes, finding themselves relieved that they were only facing ignorance. This highlights the significant levels of fear experienced by TGD people and the worries about what may happen if professionals already hold prejudiced views about TGD people.

> *“I'm lucky that the most I've experienced have been shoddy organisation and misinformation. I am lucky that I haven't experienced direct aggression from a mental health professional so far.”* (Participant 16)

Participants discussed the complexities of staff educating themselves, and expressed worries at times about the potential for MHPs to find resources which may not be affirmative in nature for TGD people *“there's so much hatred and transphobia at the moment”* (P12). Participants thought there was a danger, especially in the current political climate, that MHPs may find anti-transgender research which is becoming more prevalent with the current *“anti-trans media”* (P3) and *“anti-trans decisions being made by the government”* (P6) around TGD identities.

> *“Are you going to be able to get this information from a reliable source? Because there's that concern with research of what were the intentions behind this? Can it be replicated? And who paid for it, if anybody?”* (Participant 11)

This also extended to ideas around long-held medicalised and stigmatised beliefs around TGD people and a lack of seeking out updated knowledge, using older sources with outdated information *“seemed to be very out-of-date, being transgender is no longer considered a mental disorder, it hasn't been for many years.”* (P14). This speaks to the levels of fear experienced by TGD people, as pervasive anti-transgender attitudes continue to infiltrate mental health services and affect their care.

Participants emphasised the importance of hearing from TGD people and relying not on generalisations but on individual experience. Participants remarked on the contradictory nature of this, holding both sides of the conversation. They thought that professionals should have a baseline knowledge of TGD issues but also be ready to be fluid and flexible with their understandings of individual TGD people and their experiences *“if you treat [people] with depression differently, why wouldn't you treat [people] with gender dysphoria differently*?” (P11). Individualised care is a necessity for all mental health support, whilst ensuring an understanding of the overarching issues a patient is facing. A lack of individualised care can affect minoritised groups more adversely than others, by perpetuating harmful stigma and a lack of safety.

MHPs providing care for TGD patients must understand the nuances of this and listen to TGD people without an expectation of being taught the basics.

> *"I think that not having time to treat people like an individual definitely affects minorities worse. When you've got the added identity layer that affects things, it feels more invalidating when you're being told to do something by someone who doesn't really understand where you're coming from, doesn't understand your situation, but talks as if they know how to fix things."* (Participant 15)

It is likely that TGD people feel unable to challenge why MHPs have not educated themselves on issues of gender identity. There are often internalised beliefs for TGD patients that TGD issues are too complex for mental health services, and professionals are not obliged to be educated about them. This idea, that being TGD is a niche issue and one which can only be dealt with by specialist services, is one which excludes and isolates TGD people from services which are supposed to care for them. This will be explored further in the following theme.

### 3.5 Theme Two: Discriminatory Service Provision

Theme two encompasses conversations about a lack of care, harmful practice and the costs of exclusion and rejection by these services. Seeking care at times felt impossible for some, with the impression there were no services available or that services did not want to help them *"there's nothing we can do for you"* (P7) as seen in the subtheme 'Services Cannot Help Me'. Participants described the impacts of direct discrimination when they were able to find mental healthcare, speaking to the harms experienced which often felt intentional *"he was really pathologising"* (P12). This was explored in the subtheme 'Harmful Professional Practice'.

Experiences of services were influenced mainly by MHPs, their behaviour and practice which contributed to participants feeling othered and as though their reality was being questioned by these professionals. This supported many pre-existing beliefs for participants that they would not be accepted by society *"reinforced my insecurity of being a weirdo"* (P1) and further strengthened their fears of rejection and isolation within mental health services, as described in the subtheme ‘The Search for Affirmation’.

### 3.5.1 Services Cannot Help Me

Participants shared their experiences of no services being for them, recounting going to their GPs and being sent away without support or further referrals. When support was given, it was often unrelated to what had been asked for. This included people being referred to mental health services when they had asked for gender-related care. This left people feeling frustrated and dismissed by services. It shows the continued stigma and discriminatory effects leftover from when being TGD was a mental health diagnosis. This highlights the attitudes that permeate health services and influence the care available to TGD people.

> *“I said “Oh I think I'm trans, I've read up on it and I want to be referred to the gender clinic” and he said “Umm, right, okay, here's a number”. I rang it and it was a suicide prevention team.”* (Participant 2)

Participants had described services as scarce, so when they were able to find treatment or therapy, it felt more important to utilise the opportunity when it came along. This created a sense of a *“pressurised trap”* (P5) where participants needed to see their treatments through, no matter the cost to them. This meant that some participants had to withstand treatments they believed were unsuitable or MHPs who were creating harmful situations for them. Participants conveyed a sense of worry that they would not find another MHP or that the service would penalise them for leaving. This “trap” keeps TGD patients stuck in harmful situations, continuing to reinforce ideas that they cannot be helped in mainstream mental health services. It emphasises the attitudes of services and MHPs to TGD issues which persistently harm patients, making them lose hope and feel alone. This treatment creates a sense of misplaced gratitude to services as TGD patients are led to believe they are lucky to have received any form of treatment.

> *“I had to keep going back and trying. I knew I didn't have a choice, so I kept trying to stick it out and she would consistently manage to say something, often gender related, often not, that managed to make me feel dirty and grim.”* (Participant 14)

Participants spoke to a feeling of inconveniencing services, as though they were asking for too much. Some participants were made explicitly aware they were not a priority by MHPs, but others sensed it even when it went unspoken. This included an incident of a participant being told that they could not change therapists, even though they were experiencing issues with their MHP’s understanding of their gender identity *“It was made clear - “You'll be on a waiting list for years. You'll never get seen.””* (P3). Service providers seemed to imply that TGD people were creating problems for services, rather than utilising something available for them. Participants thought it pointless to try to access services in the future, believing there would be nothing available. This accounts for some of the difficulties faced by TGD people, as even when services are available, they are left with the impression that they are not welcome. Even in TGD-led charity organisations, there was still a sense of asking for too much due to a lack of TGD therapists and resource. One participant spoke to feeling as though he was taking time and resources away from other TGD people who may need it.

> *“He said you can go back on the waitlist for more sessions, but I felt pretty guilty about it because I figured there'd be people using that service who couldn't afford to pay. So, I didn't go back on the wait list.”* (Participant 6)

Participants generally felt unwelcome in services, as though they were not the people these services were intended to help. Participants mentioned MHPs explaining waiting lists in a way that seemed like they wanted to dissuade them from seeking help *“When people tell you the waiting list, I feel like it's almost to put people off”* (P5). Participants discussed service forms and online systems not being set up to recognise anyone outside of a binary cisgender identity. Participants discussed the difficulties of engaging with services when they already know from the first form that the service does not account for TGD identities. These barriers to mental healthcare serve to instil a sense of exclusion for TGD people as these services, systems and even MHPs tell them there is nothing for them.

> *“You have a form to fill out your progress and it asks “What's your gender?” And it says male or female. You just think, Oh my God, how hard is it to just add an extra box?”* (Participant 10)

Services contributed to a fear of taking up space and these experiences left participants feeling *“deflated”* (P7) about seeking care and using mental health services. They described the difficulty of realising that the services which are supposed to be for everyone, are not for them *“it felt really awful, it felt pretty hopeless”* (P4). This was a powerful message, which left little hope for participants that they would be able to navigate services in a way that was meaningful and productive for them. TGD people should be cared for within mental health services, but instead are made to feel as though they sit outside of their remit or that they are wasting resources. This lack of access to services contributes to continued higher levels of negative mental health outcomes. With the shortage and prohibitive waiting lists of TGD-specific services, TGD people must be allowed and welcomed to use mainstream mental health services without discrimination.

### 3.5.2 Harmful Professional Practice

Participants spoke to MHPs’ directly harmful behaviour. Participants described overt homophobia and transphobia experienced from MHPs. They relayed overhearing discriminatory and derogatory comments made in conversation between members of staff, but also having transphobic comments directed at them.

> *“I was showing up to appointments in leggings and sweatshirts because I was incredibly depressed and barely able to function. And he would sort of make comments and like, “Are you really sure you're a man when you’re dressed like that?””* (Participant 15)

These attitudes and comments contributed to participants inability to discuss how pervasive transphobic attitudes in the UK have affected their mental health. Participants’ thought they would not be believed, or the effects of this would be minimised by MHPs due to their discriminatory attitudes. Participants named feeling othered by MHPs, as though they had less value as human beings and their difficulties would not be taken seriously. TGD people have been historically pathologised and shamed by mental health services, leaving them unable to discuss the impacts of discrimination in their lives with people involved with these systems. When MHPs display transphobic attitudes, this serves to silence TGD people who are fearful of further harm.

> *"It was just making me feel more like weird about my own situation, like uncomfortable. You know weird in the sense of feeling like I was the different one."* (Participant 6)

Professionals asked invasive questions, making participants uncomfortable and at times, distressed. Participants were reluctant to disclose their TGD identity to MHPs when they had previous negative experiences. They described being asked intrusive questions about their bodies, their genitals, which surgeries they have had and questions about sexual preference "*they want to ask questions that they wouldn't be comfortable answering"* (P10). Participants understood that in some settings, these questions may have relevance *"so long as it's relevant to my care"* (P13). However, participants felt that some MHPs abused their positions to ask out of curiosity rather than clinical necessity. Some participants relayed having told MHPs they were uncomfortable with their questioning, but MHPs continued to ask. These experiences shame and embarrass TGD people following violations of their privacy and dignity. This continues to perpetuate ideas about TGD people's identities, lives and bodies being abnormal, reinforcing existing stigma about TGD people. This intrusive questioning raises ethical concerns about patient consent and ethical boundaries, with MHPs failing to prioritise the wellbeing and autonomy of their patients.

> *"It was like an interrogation for them to decide whether I actually was who I feel I was. They asked me really direct questions like "how do you feel about your genitals?" And it's like, I am a child sat in front of you. It was humiliating."* (Participant 14)

Participants also discussed MHPs not respecting their identity markers. This included being ‘deadnamed’ or having their birth name used rather than their chosen name, incorrect pronouns being used and being misgendered in sessions. Participants thought this may be a small thing for professionals but could *“cause further mental anguish”* (P3) for already vulnerable patients struggling to deal with mental health issues. Some spoke to MHPs simply forgetting to use their correct name or pronouns, but more often MHPs actively refused to use them, with this continuing to happen months into treatment. It is important for MHPs and services to be aware and respectful of their patients, particularly within a vulnerable community. TGD people have elevated rates of mental health disorders, stemming from a variety of stressors including non-affirmation of identity. When MHPs cannot afford their TGD patients the basic respect to call them by their chosen names or pronouns, they continue a cycle of abuse that TGD people experience in their daily lives. This is often part of the reason why TGD people seek support from mental health services. To be met with further invalidation, discrimination and rejection can cause further harm and re-traumatisation for TGD patients.

> *“I had been seeing her for several months at that point. There were times like she'd use the wrong pronouns for me or refer to me as my parents’ daughter. It was really demoralising.”* (Participant 4)

This disrespect for patients’ chosen identities can have a detrimental effect for some, including losing trust in services. Patients felt their identities were being questioned or rejected and the legacy of these feelings were evident in further interactions with their next MHPs. Participants carried fear and uncertainty through their interactions with services, continuing to seek help for their mental health difficulties but navigating their worries about what may happen if they disclose their gender identity.

> *“When it's something that is hugely part of me and is emotional, in terms of being misgendered and having someone deny your identity... Yeah, it's harder. I don't feel that I've got the resources to deal with the high chances of them being like that.”* (Participant 12)

Participants remarked on MHPs actively denying their reality and questioning their understanding of themselves. This was evident in MHPs denying transphobic interactions in services for their patients *“they are doubting my reality and my integrity and my knowledge”* (P15). It was also evident in more direct transphobia and explicit denials of participants’ TGD identity. This doubt from MHPs means that TGD patients often feel the need to prove themselves, or in some cases, they withdraw from services entirely. A worry hung over this conversation, with participants saying that if they had been less confident and sure of themselves, this might have had a detrimental effect on their mental and physical health.

> *“He told me that he didn't think I was trans. When I asked him to elaborate, he said nothing. And I don't just think about myself in this situation, I think about other people. For somebody that could have been a catalyst, and that's quite dangerous.”* (Participant 8)

### 3.5.3 The Search for Affirmation

Participants discussed the impacts of discrimination and harm within services on their understanding of their mental health. In treatment, some participants outlined that lacking TGD affirmative care left them questioning themselves and their understanding of what might be happening for them. Met with scepticism and invalidation, participants’ senses of self were undermined, and their experiences were discredited by MHPs who did not affirm or even directly denied their identities. This can lead to the internalisation of discriminatory beliefs, causing TGD people to disconnect from their own understanding of their identity. This disconnect from their gender identity can negatively impact their sense of self, leading to internalised transphobia and may affect their ability to engage with MHPs and their treatment.

> *“Well, it made me feel like the idiot, weirdly enough, because you think “Am I wrong?”. It makes you question yourself. “Am I the only one feeling this way? Is this really not that normal?” You start questioning your own self, really, you feel like you're just gonna be in this place forever.”* (Participant 7)

Participants spoke to the impact being given a diagnosis without follow up, specifically referencing diagnoses of personality disorders and schizophrenia. A lack of support from MHPs to understand what these diagnoses meant for their lives, led to a reinforcing of harmful stereotypes. For some participants, this resulted in internalisation of the diagnosis and further stigmatisation of their gender identity. Participants had doubts or worries about their gender identity being problematic or disordered due to a lack of understanding and support from MHPs. Participants did not have faith that their MHPs could help them, and some acknowledged that they felt they would have to go to TGD specific services to receive care. This conflation of gender identity and mental health can leave TGD people feeling misunderstood and alone. This may lead to TGD people receiving incorrect treatments or disengaging from treatment entirely due to an erosion of trust.

> *"If I was just signposted somewhere, it would have probably saved me a good number of years questioning whether I was deluded or not, due to schizophrenia."* (Participant 8)

In other cases, prejudice and misconceptions from MHPs left participants feeling rejected by services and that professionals they were working with were unable to meet their needs. Participants discussed opening up to MHPs about their gender identity, but being left unaffirmed, misunderstood and dismissed *"Why have I bothered in the first place, this is awful?"* (P14). Participants felt let down by MHPs and mental health services, thinking they were alone and nothing could be done for them *"no help from anyone that, you know, their job is to help"* (P5). This rejection and isolation can be detrimental to TGD people who are seeking support, acceptance, and a sense of safety from services. TGD people who approach services are likely to have faced discrimination in their lives. Re-experiencing this in mental health services can reinforce pervasive negative attitudes towards TGD lives, leaving them with no places to be understood and cared for. Services which are supposed to support, protect, and validate are simply another place to solidify their feelings of marginalisation and isolation from society.

> *"I think it somewhat reinforced my insecurity of being a weirdo, a bit of an odd one out. In terms of like self-acceptance, I wasn't there yet. Like, "Am I just gonna be a freak in society?" They could have helped with that a little bit more."* (Participant 1).

Participants credited themselves with the resilience to get through these times, but also spoke to connection with others as a source of comfort and affirmation for them, being helpful when MHPs were not. They spoke to strong family connections, supportive partners and understanding friends, especially friends who were part of the LGBTQ+ community. *"If I hadn't had friends who knew where to look for information and knew what to do, I would have got so stuck, because it feels really hard to find information and know what to do, particularly if you're already in a place of "I don't have the energy to do it.""* (P4). This differed for every participant, but the overwhelming sentiment was that participants' may not have survived the discrimination and alienation by services without their supportive networks "*Luckily my partner was like "This isn't OK. Go back, see another doctor, because if you don't go back straight away, you're never gonna go back""* (P10). Online communities of other TGD people are an important factor, especially for TGD people who have a difficult time with their personal connections due to rejection or a lack of understanding. Connecting with people who could understand and affirm their experience was vital for navigating mental health services and life as a TGD person.

> *"[Online TGD groups were] like really helpful. Just knowing that I wasn't like the only trans person. They had a map and you just put your location on it and then other guys in the area popped up and you could speak to these people and hang out with them if you want. I'm really glad that I did that because a few of my closest mates were from that site and so it was really good."* [Participant 2]

### 3.6 Theme Three: Bringing my Whole Self

The final theme described the ways participants felt able to engage with services, depending on how services interact with them. Participants spoke about the differences they experienced when environments of trust and safety were not created, in the subtheme 'Trust and Safety'. In the subtheme 'Denied Space to be Authentic Self', participants outlined how this impacted authentic engagement with MHPs and services. Participants wanted to address their mental health concerns and feel secure enough to engage in meaningful exploration of gender dysphoria or societal stigma on their mental health. The subtheme 'Choose One: Mental Health or Gender" explores the complexities of addressing gender identity affirmatively within mental health services.

### 3.6.1 Trust and Safety

Trust and safety are important elements in any therapeutic setting. This was discussed with emphasis on the difficulty of finding trust and safety in mental health services for TGD people. Participants addressed the challenges of navigating treatment with professionals who lacked understanding of their TGD identity. They spoke to the resulting lack of trust with professionals they were working with and services they were accessing.

> *"It just kind of left me with a little distrust for mental health services or counselling. It made me feel like it wasn't gonna work for me."* (Participant 1)

Participants recounted difficult past experiences with professionals that informed their negative expectations of future professionals and services *"she would say something related to transness and it would make me hate myself for being trans"* (P14). They spoke to holding these experiences in mind when interacting with new therapists. Even when new therapists seemed understanding of them and their identity, the legacy of past discriminatory treatment and a lack of trust of services in general proved difficult for establishing trusting relationships with new professionals. The impacts of bad practice can make TGD people fearful and unable to trust MHPs, which should be considered by MHPs who are hoping to create safe environments for their patients.

> *"I started therapy with a new therapist. And I met her and she was really nice. And I thought "I probably can tell you", but I felt a bit uncomfy because of what happened before. It took me a bit of time to build up the confidence to do it."* (Participant 10)

Assessing their safety with professionals became a necessity for participants to understand if they would be able to disclose their identity. This became an active practice for some, with participants withholding parts of themselves until they had established if it was a safe space for them *"It'd probably take me a few visits, let me just get a feel of how this individual is before I say anything."* (P7). Participants emphasised that this was not paranoia, but a necessary exercise for TGD patients in most services. TGD people have often experienced a lack of safety in mental health services or know someone who has, leaving them worried to be their true selves. Many TGD people have reasonable fears about what may happen to them if they do not tread with caution in their appointments.

> *“It's difficult to know that you're okay to be yourself in front of these people and be accepted and not face any discrimination because of it. It's about knowing that you are safe to be who you are and not have somebody say, “Well, I'm not gonna give you this treatment or I'm not gonna help you with this because I think you're disgusting. Or I think that your way of living is wrong.” or anything like that.”* (Participant 3).

Participants discussed the difficulties experienced when they had liked and trusted a therapist, only to find their trust had been misused or broken. Participants found it complicated to untangle the complex interactions between building trust with a person, only to find out later in sessions or on reflection years later that the therapist held views which proved damaging to participants. This was, at times, more difficult for participants than professionals who were outrightly discriminatory or prejudiced. This is dangerous for TGD people who place their trust in MHPs, considering the power dynamic which may influence patients’ own views of themselves in a negative manner.

> *“Hearing those opinions from the therapist kind of reinforced some of my own worries about [medical transition]. When you like someone and trust them and then you're like, “Oh, this is strange”. At the time I was like “Oh this feels… not great but OK…” Rather than actually being like, hang on a second. This is bullshit and I shouldn't continue.”* (Participant 6)

Despite their past experiences, participants still believed it was possible for professionals to cultivate trust and safety for them. They discussed simple ways that some professionals have been able to ensure the space is safe for them. Participants outlined open conversations about identity, professionals offering their gender identity and pronouns first and professionals being able to ask questions rather than make assumptions as helpful markers for safer spaces. Some participants mentioned visible LGBTQ+ markers, such as inclusive signs, rainbow lanyards and pronoun badges, as a helpful indication that the service was knowledgeable and accepting. Participants preferred professionals who were *“chill”* (P16) with their gender identity and did not make it a bigger issue than necessary. In these cases, TGD patients are more able to be themselves and do not need to hold back.

> *“She's not going to make assumptions or judgments, and that she would just ask if there was anything she was wondering about. She would ask that rather than assuming so that makes me feel safer.”* (Participant 12)

Mental health services and MHPs need to work on establishing levels of trust and safety for TGD people to feel heard, respected, and validated. When these conditions are not met, it has detrimental effects on building therapeutic relationships and TGD patients being able to authentically express themselves in services.

### 3.6.2 Denied Space to be Authentic Self

Participants described the struggle of knowing when and how to disclose their gender identity to professionals, with some deciding to never disclose this. Participants explained the build-up of getting to know a professional and starting to feel safe with them. Participants recounted moments they felt able to be vulnerable and share their identity, which did not always go well. Some professionals responded with a lack of understanding or care for the information being shared, with others not responding at all. This resulted in participants being unable to share themselves with some retreating further from professionals and services. This impacts TGD people’s ability to engage with services and have a meaningful experience in treatment.

> *“It really shut me down because it felt like rejection. Not only did you not care enough to try and understand, when I then explained there was nothing. And then, why should I give any of myself to you if I've tried to share something with you and like this is the response that I've got? It was already such a difficult thing to be doing.”* (Participant 10)

TGD people's experiences of mental health services are often relayed as rejecting. The effects of past non-affirmation amplified participants' inability to engage with services. They were left with an assumption that their identity would be misunderstood or denied with no space to explore this. These past harms were evident from participants' descriptions of their interactions with MHPs and services. This serves to worsen TGD mental health outcomes, leading to TGD people avoiding services or receiving further harm and re-traumatisation from services.

> *"Now every time I go into an NHS appointment, I sort of have fight or flight and I feel like I'm not going to be believed, that issue of mistrusting them and sort of having trauma from NHS staff."* (Participant 15)

Participants spoke to feeling shut down, like they were holding back and unable to fully engage in with services. They could not bring their full authentic selves, meaning they were unable to get the care they needed from services. Participants felt they had to hold back from saying too much about their gender, needing to suppress themselves in a space supposed to be for them. This left a part of their identity separate from their treatment, leading to limited engagement with their care. MHPs leaving their TGD patients with a sense that their identities are not understood serves to continue to silence this group, essentially denying them the treatment they are seeking.

> *"Every time I'd be like "Oh, you know that that trans experience" they're like, "no, we don't really get that". So I just don't know how to talk with them. I didn't wanna overshare with them like I should have, cause they were a therapist, because they just couldn't handle it."* (Participant 9)

Participants wanted to be heard and understood by MHPs they were working with, feeling that this would enable them to be their authentic selves and get the most out of treatment. When participants felt listened to and cared for, they were able to let their guard down. Participants could better engage with treatment when they were safe to express themselves. The ability to discuss gender identity freely without fear of denial or repercussions is an important factor in treatment, allowing TGD people to be who they are.

> *“It’s just been nice to be understood and have someone tell you “there is something we can do” and you know, you won’t be in this boat forever”* (P7).

Participants wondered what the benefits of more LGBTQ+ professionals in services would be. They spoke to ideas of TGD specific mental health services and how different care might look for them *“they’re not gonna spend the whole time asking me a million questions”* (P5). Some participants had better experiences of private therapy with TGD therapists. This included a shared understanding of the worries that TGD people are facing, allowing them space to be themselves and get treatment without having to hide. Mental health services with a more diverse workforce may be able to more thoughtfully understand the difficulties faced by the TGD community, leading to more meaningful engagement.

> *I think if I'd had like a counsellor who was also part of the LGBT community in some way, they might have understood.”* (Participant 1)

Participants discussed instances of having space to disclose their gender identity and be themselves but found that the disclosure could consume their appointments. They felt like MHPs used their gender identity as the source of their difficulties and did not look further or try to understand them as a person outside of this. MHP’s assumptions about the cause of TGD mental health difficulties continues to leave TGD people feeling misunderstood. MHPs seeing TGD patients only through the lens of them being TGD can conflate issues in an unhelpful way which hinders their treatment.

> *“As soon as I disclosed that I was trans, it was “Oh, well, it's because you're trans that you’re feeling the way you’re feeling”. And every time I brought up something going on, that was the reason I was depressed. I didn't feel as though I was actually being listened to. It was more like a blame game.”* (Participant 5)

### 3.6.3 Choose One: Mental Health or Gender

This subtheme focuses on the interaction of mental health difficulties and gender and how this is explored by professionals. Understanding how mental health and identifying as TGD interact is a complex and multifaceted discussion, and different for each individual case. Participants spoke to their fears about discussing their gender identity with MHPs, feeling overwhelmed by having to navigate a mental health condition as well as considering the impacts of gender identity. This should be explored at a pace dictated by the client and with sensitivity and compassion.

> *"I was going for, like depression, but also OCD. I was terrified enough to discuss those things, I couldn't do that."* (Participant 14)

Some participants explained that exploring their gender identity did not always seem necessary in treatment. Participants spoke to their understandings of the causes of their mental health difficulties, which were not always related to their gender or transition "*I don't think it was completely triggered by gender stuff*" (P9). Participants who felt as though MHPs had decided that their issues were related to their TGD identity without discussion experienced this as being misunderstood by professionals. TGD patients should be able afforded the agency to explore this in a nuanced manner with care rather than being pathologised. Professionals who hold pathologising assumptions alienate their TGD patients and discount their identities.

> *"If I felt like somebody was asking it, making a point to say, maybe it's the trans thing, that's your mental health issue or anything like that... I would probably just leave the service and say it wasn't for me."* (Participant 13)

In contrast, some participants felt that MHPs placed too much emphasis on their mental health, neglecting the impact of gender dysphoria *"at this point it was mainly just down to the whole trans thing"* (P7). Participants felt that if they had been able to understand the impact of their gender dysphoria and societal difficulties relating to their TGD experience, that would have given them a better insight into the mental health difficulties they were experiencing. This shows the importance of patient-led care and building rapport, understanding each individual patient's complex relationship to their gender and mental health.

In some services, participants felt like they needed to keep their gender and mental health separate. As discussed in previous themes, for some this was for their own protection from discriminatory professionals or to avoid wasting time with MHPs excessive questioning. For others, their MHPs were unable to offer any support to explore what may be happening for their mental health in relation to their gender identity. When TGD people are forced to keep these issues of gender identity and mental health separate, it means they are unable to explore their difficulties as their whole selves. This felt unhelpful for participants, as they could not get what they wanted from services because of this.

> *"It didn't feel like a space that I could talk about gender stuff and given that was pretty much - I know now - the main thing. If you untangle that, most other things slot more or less where they need to be. And because I couldn't talk about that, I could only talk about things around the outside, I didn't really get anywhere."* (Participant 4)

This lack of space to explore these intersections exacerbated participants' difficulties, leaving participants in ambiguous and unclear treatment situations. When specific disorders which have interactions with gender identity were an issue, this became an even more complicated situation. In the context of eating disorder services, participants had limited opportunity to meaningfully explore the impacts of gender on their body image. Whilst gender identity was not seen as the cause of mental health difficulties, it is useful for TGD people to have place to explore the impacts gender diversity on their presenting issues. This allows for a conversation about the physical, psychological and societal impacts of gender diversity without TGD people feeling pathologised.

> *"I didn't have a way of making sense the difficulties I experienced in that context. When I had my eating disorder it was more around trauma, but also was quite a bit about my body because it linked to going through puberty, like my body changed and that was quite triggering, and I didn't really understand why."* (Participant 12)

There was an impression in the interviews that services simply had no idea how to manage TGD issues and MHPs felt unable to address them with patients. In some cases, this led to patients misunderstanding their own mental illness and wondering if wanting to transition was simply another symptom of that illness. They spoke to missing out on exploring the effects of gender dysphoria and transphobia and how helpful that would have been in their mental health journey "*I thought for a long time that it was to do with my mental health rather than actual identity."* (P3). When patients attempted to raise these issues, they were met with no awareness or helpful discussion. This leaves TGD people forced to figure out challenges for themselves, rather than exploring potential connections between their gender and mental health in treatment *"When you start unpicking things and make them connections, [MHPs] are just… blank. And they're like "So moving on…", like cool, okay." (P2).* Participants believed services could not manage the complexity that TGD patients brought and did not have the knowledge to facilitate nuanced exploration of the intersections of mental health difficulties and gender dysphoria.

> *"I remember always feeling like I could only go to CAMHS people with like fully formed ideas. I couldn't go to them and be like "I want to explore this, I'm beginning to think about this". had to go with full ideas of "This is a fact.". It didn't feel like a safe space to explore because it felt like if I showed any uncertainty, it would be shut down."* (Participant 4)

A thread through many participants' interviews was this complex understanding of needing to speak about the impact of their gender identity on their life and mental health difficulties. They wanted to understand the impact of dysphoria, societal prejudice, and discrimination on their own relationship with their gender and themselves. However, participants were often protective of discussing or exploring this as past experiences had been harmful. Their expectations were of more harm through a lack of knowledge, having their time wasted or through discrimination and transphobia, whether accidental or intentional. Participants spoke to a lack of safety which overshadowed many of their interactions with professionals and services. When participants were afforded safety and space to think about these things with MHPs who respected them and their identity, it proved incredibly helpful. Participants were able to utilise treatment to the fullest when they trusted that they could bring their whole selves.

> *"She was amazing. She was really understanding of how my transness interacted with things. She wouldn't bring it up unless I did. A lot of mental health professionals are really keen to like to blame a lot of things on [being trans] and overstate how much of an impact it has. Like if I weren't trans, I would still have OCD. I'd still have endured emotional abuse and have been suffering the effects of that. Yes, dysphoria has an impact, but those things would still be there."* (Participant 14)

MHPs building affirmative spaces meant patients were able to get what they needed from therapeutic settings. Participants described working collaboratively with the MHP to gain insight and awareness into themselves and their lives. It allowed participants to begin to unravel things that had seemed impossible to understand before. Participants expressed gratitude for MHPs who listened, understood and wanted to ensure their safety and comfort in their recovery. The impact of adapting and creating safer spaces for TGD people in mental health services is huge, with TGD people feeling grateful and lucky to be afforded these spaces. This should be a certainty for anyone using mental health services and TGD people should not have to rely on luck to find affirmative, knowledgeable, and caring professionals.

> *"I became uncomfortable with one of the grounding exercises because it was forcing me to be present in my body, which I don't do because my body isn't me. So, she adapted it, and she devised a new grounding exercise where I visualise being somewhere else, which I find a lot more pleasant and I'm glad for the adaptability that she has."* (Participant 16)

# 4 DISCUSSION

## 4.1 Chapter Overview

This chapter will consider the findings of this research, in the context of the research questions and the existing literature base. The implications of the research will be discussed in relation to clinical practice, training, and future research. A critical review of the study will be included, noting the strengths and limitations of the research. The chapter will end with the researcher's reflections and a conclusion.

## 4.2 Contextualising the Research Findings

### 4.2.1 What are transgender and gender diverse people's perspectives of accessing mental health services?

Participants gave detailed accounts about accessing support from mental health services, speaking to the barriers for TGD people. The three themes '"*I don't want to have to be Google*"', 'Discriminatory Service Provision' and 'Bringing my Whole Self' capture the difficulties faced by TGD people as they attempt to seek care. This can be understood through the GMSR model, encompassing distal and proximal stress factors and resilience factors (Testa et al., 2015). In accessing services, participants discussed instances of discrimination, rejection, and non-affirmation. In line with the GMSR model, feelings of internalised transphobia and negative expectations were evident for participants. Some participants noted community connectedness as protective against stressors caused by lack of access to services.

The subtheme 'Services Cannot Help Me' spoke to services feeling non-existent or impossible to access for TGD people. Hunt's (2014) participants mentioned cost and affordability of services, with Ellis et al.'s participants speaking to long waiting times as the problem. Participants in this study discussed the lack of services available, with most participants having used free NHS services. They also commented on waiting times for the NHS creating barriers to access. Participants felt forgotten about or as though waiting lists were used to discourage them from accessing services. Participants felt that NHS services were the hardest to access, with many relying on charities or LGBTQ+ organisations for support and guidance. One participant doesn't attempt to access NHS care anymore, after repeated failed attempts to get mental health support. This leaves a vulnerable community with no way to receive support which is likely to impact mental health outcomes.

Ellis et al. (2015) commented that MHPs are the "gatekeepers to gender identity treatment" (p. 12). Participants in this study spoke to the delays for accessing gender-affirming services, due to no support from MHPs. When appointments could be made, MHPs were uncertain or unwilling to make referrals, as seen in physical healthcare contexts (Persson-Tholin & Broström, 2018). Participants were often left unable to access the services they needed. This left TGD people feeling hopeless about the prospect of accessing any type of care.

In 'Services Cannot Help Me', participants discussed feeling outside of the service remit. Treatment of TGD issues was considered a specialist subject that services could not account for.  Participants felt unwelcome and misunderstood from the outset in accessing services, creating difficult ongoing relationships. Ellis et al. (2015) found that TGD people held perceptions that MHPs would be poorly informed about TGD issues, and that accessing support would prove difficult. Theme One '"*I don't want to have to be Google*"' highlighted participants' beliefs that mental health services would lack knowledge about their identity, waste their time and leave them feeling unwanted or rejected.

Participants in this study spoke to the internalisation of narratives that told them they were an inconvenience for asking for support. They were made to feel like they were creating problems for services by attempting to access mental health support. These fears created psychological barriers such as internalised transphobia, making seeking and accessing mental health support more difficult. According to the GMSR, distal stressors such as discrimination and rejection can cause further proximal stressors for TGD people, such as internalised transphobia and negative expectations.

Internalised transphobia was evident in participants' worries and shame that their TGD identity would be pathologised, as discussed in 'The Search for Affirmation'. This often arose due to MHPs failing to discuss or consider the impact of diagnosis with the patient, with no access to services post-diagnosis. Whilst this is an issue happening within service provision, it also speaks to the lack of follow up care. In the present study, some participants disengaged from services entirely before receiving support, due to expectations of a lack of affirmative care. White-Hughto et al. (2015) identified potential consequences of internalised stigma, including negative expectations.

Participants who had attempted to access services lost their confidence when unsuccessful, creating an ambivalence about accessing care and negative expectations about services. Redcay et al. (2021) recounted experiences of TGD people avoiding physical healthcare services due to expectations of rejection. One participant in the present study was directed to a suicide prevention hotline when attempting to access psychological therapy. This participant had sought support and space to explore their issues, with no mention of suicidal thoughts. The discriminatory assumption that a TGD person is suicidal highlighted how TGD people experience barriers created by services themselves. Past personal experiences of being discriminated against or rejected had shaped the negative views of participants in this study about accessing services.

The subtheme ‘Trust and Safety’ spoke to how participants felt unable to trust MHPs and services, leading them to avoid seeking support. A distrust of services is linked to avoidance of services by TGD people in physical healthcare settings (Redcay et al. 2021). Participants in De Santis et al. (2020) felt that physical health services had violated their trust and were left under the impression that services were not for them. Participants felt they were not being referred to services or being taken seriously due to their gender identity. Participants in this study emphasised that breaches of trust were even more impactful as a minoritised person. This lack of affirmation of their identity and dismissal of their need for support served as further barriers to accessing services.

Friends, loved ones and other TGD people were sources of connectedness and resilience, discussed in “The Search for Affirmation’. This enabled them to seek necessary support. The GMSR model hypothesised that community connectedness was a source of resilience, which helped to negate the effects of stressors. This is also consistent with Sherman et al.'s (2020) conclusions that community connectedness is associated with increased ability to seek access to healthcare. Multiple participants remarked that they would have given up seeking access to mental health support without their support networks. Whilst this is a protective factor for some, it is worrying for TGD people who may lack a supportive network. This speaks to how mental health services can prove inaccessible for some due to systemic barriers and past harms. It also raises questions around communities that services deem "hard to reach" and how hard services are trying to reach them.

### 4.2.2 How do transgender and gender diverse people describe their experiences of care provided by mental health services?

Participant's accounts spoke to a variety of difficulties for them in mental health services, with few accounts of positive experiences. Participants recounted experiences of uneducated practice, discrimination, victimisation and difficult relationships with MHPs. They spoke to their struggles to be accepted as their true selves and the impacts of this on therapeutic relationships and engagement with treatment.

Instances of discrimination due to a lack of knowledge of MHPs was discussed in subtheme 'If Not Us, Then Who?' demonstrated by the use of out-of-date diagnostic labelling which reinforced pathologising views. This resulted in participants feeling uncomfortable and misunderstood. Despite the change in diagnostic terminology to reflect the feeling of dysphoria rather than a fault with the person, research has shown that the legacy of these attitudes persist within mental health services (Ellis et al., 2015; Mizock & Lundquist, 2016). Whilst out-of-date knowledge may seem innocuous, it can be a sign of MHPs' prejudiced attitudes and resistance to change. In this study, participants spoke about discrimination and victimisation by MHPs who held archaic perceptions of what being TGD meant. This speaks to the question of whether MHPs are willing to learn about TGD issues and if they can take accountability for their role in harms caused due to their lack of education and knowledge.

Participants of Ellis et al. believed they should not be the ones to educate practitioners. In this study, participants agreed that it was not their role to educate and discussed the burden of this. Interestingly, some participants preferred to educate professionals, as they feared that MHPs would find prejudiced sources of information from their own research. The subtheme ‘If Not Us, Then Who?’ showed a level of fear and negative expectations which may have motivated participants to take on the responsibility of educating their MHPs. An internalisation of transphobic attitudes from services who ignore or reject their TGD patients shows the impact of the lack of education.

The subtheme ‘Harmful Professional Practice’ describes the harms experienced by participants in their interactions with MHPs. These spanned discriminatory, victimising, rejecting and non-affirming experiences, aligning with distal stressors in the GMSR. Participants described occasions where MHPs were homophobic or transphobic, impacting their ability to speak to instances of discrimination outside of services. They felt rejected and invalidated in services that were supposed to be safe for them. Simeonov et al. (2015) found their TGD participants were more likely to stop using mental health services after experiencing transphobia. There can be a secondary traumatisation that happens when TGD people seek support from services for transphobia or transphobic crimes and are met with a lack of understanding or blame from the service supposed to help them (Testa et al., 2012). One participant experienced discrimination from their MHP but was told they would not get another MHP if they quit their current treatment. They worried that trying to access another service would be impossible, with them being left alone or experiencing further harm. An Australian study by Cronin et al. (2023) reported similar concerns amongst TGD patients, finding a shortage of psychologists, social workers, and counsellors to help them. This speaks to the harm caused, but also shows the impact of negative expectations created for accessing services, as discussed in the previous section.

Participants in this study experienced invasive questioning from MHPs, many of which felt irrelevant, discriminatory and victimising. Ellis et al. spoke to invasive questioning within GIC settings but did not find the same for mental health settings. In this study, participants reported questions about surgeries which felt intrusive and disturbing, including instances of minors being asked about their genitals. In ‘Harmful Professional Practice’ participants noted the necessity for MHPs to understand some aspects of their transition and journey. However, they were often left feeling humiliated and victimised by insensitive questions about deeply personal topics. Wall et al. (2023) spoke to the link in healthcare settings between invasive questioning and gender-related medical misattribution. Healthcare providers often misattributed gender identity as the cause of TGD people’s medical concerns. Participants in this study spoke to identity markers being misused, denial of their gender identity, and the feeling that MHPs were conflating their gender identity with their mental health diagnosis. In physical health settings, denial of identity and medical misattribution has led to incorrect diagnosis or treatments for TGD people. Participants in this study were often unable to get the treatment they needed. This is potentially linked to misattribution and the persistence of the medical model in mental health settings.

These experiences have significant costs for TGD patients, feeling othered and misunderstood by services. It the subtheme ‘Denied Space to be Authentic Self’ participants questioned their own reality and understanding of themselves, with harmful internalisations of stigma and negative stereotypes. Participants needed to keep their gender identity separate from mental health concerns in services to get treatment. This sentiment was echoed in Applegarth and Nuttall (2016) where one participant felt they needed to become their own therapist due to the MHP trying to “fix” their gender identity. Participants in this study felt let down by MHPs and services, also feeling like they would need to find a way to deal with issues on their own, needing to develop resilience and utilise their communities.

The theme of ‘Discriminatory Service Provision’ outlined experiences of a lack of service provision. This included discrimination, non-affirmation and difficulty finding acceptance within mental health services. The theme ‘Bringing My Whole Self’ is about the impacts of these encounters and how TGD people navigate treatment considering their past experiences. The first subtheme of ‘Trust and Safety’ spoke to an understandable lack of trust between TGD people and mental health services. Participants described the uncertainty of what would happen in appointments, never knowing if MHPs would hold discriminatory attitudes. Past harms led to negative expectations for MHPs and a period of assessment of safety was necessary within therapeutic relationships. Participants described withholding parts of themselves until the MHP was deemed safe. Hunt (2014) did not specifically speak to past experiences with mental health services or therapists but focused on past negative life experiences. Even in this instance, past life experiences were seen to impact on the relationship between participants and therapists.

Participants in this study believed that trust and safety could be earned back, by affirming their gender and taking their identity seriously. They mentioned visible markers of LGBTQ+ acceptance in services would be a helpful indication to create a sense of pride and acceptance of their identity. This corresponds with Braybrook et al. (2022) who found LGBTQ+ participants believed rainbow lanyards would be welcome markers of inclusivity. However, wearing lanyards or having pronoun badges does not necessarily mean that all MHPs agree with or are knowledgeable about TGD issues. In some instances, this may cause more harm by fostering a false sense of trust for TGD people which could be broken. If a service is to utilise these markers of acceptance and inclusivity, it should be backed up with training and education for all staff.

In the subtheme 'Denied Space to be Authentic Self', participants spoke to the internal battle of whether to disclose their gender identity to professionals. Past experiences of rejection or identity disclosures being ignored, left participants feeling shut down and unable to engage with MHPs and services. These non-affirmations and discriminations resulted in the GMSR proximal stressor of concealment. The concept of concealment of identity for TGD people is complex one, and can lead to increased sense of safety. The idea of 'passing' can help avoid discrimination or victimisation (Xavier et al., 2013). Ultimately, participants in this study described feeling like they were unable to get the care they needed as they could not be their whole selves. This was in line with findings by Rood et al. (2017a), in which participants described concealment as creating exhaustion and self-hatred due to feelings of inauthenticity. Participants in this study wanted to be seen as their true selves in treatment settings. Rood et al. (2017b) discussed the complex dynamics of identity concealment for people who are transgender. TGD people conceal aspects of their sex assigned at birth, therefore allowing them to reflect their authentic self. These practices can be empowering, affirming and an act of self-respect for TGD people. This shows that identity concealing must be understood in a more nuanced way than simply a minority stressor.

In the subtheme ‘Choose One: Mental Health or Gender’ participants discussed the struggle of finding the balance of how much to focus on their gender identity in the context of their mental health in therapeutic settings. This was mirrored in Hunt (2014) in experiences of counselling, with some participants feeling their gender identity was ignored. Others felt it was focused on too much and worried that their gender identity would be assumed to be the reason they were seeking counselling. In Hunt’s study and in the present study, there was no universal correct way to address gender identity. It is an individual process of understanding what is best for each patient. Participants in this study had the best experiences when MHPs were sensitive, curious, and tried to understand and affirm the participant’s identity and needs.

Participants discussed complex understandings of the interaction between their gender identity and mental health. Some participants were unwilling to discuss this in mental health settings. However, there was the sense that a different therapist or approach may have given them space to feel safe to talk about potentially difficult experiences. Ellis et al. (2015) suggested that the aftermath of gender identity being labelled a mental illness, lends itself to the treatment of gender dysphoria within a psychiatric model. Treatment in this manner may feel uncomfortable and pathologising for TGD people as their gender identity is not the problem. Services need to address the societal and political reactions to gender identity which cause distress for TGD patients. This may explain some of the difficulty in exploring gender identity alongside mental health concerns, with MHPs being unaware of how to approach these conversations in a nuanced way.

Providing a trusting and safe space for TGD people allows them to embrace vulnerability and be their authentic selves. They can fully engage in treatment in a way that feels meaningful and useful for them. This gave participants a safe place to talk about potential interactions between gender identity and mental health. They could consider how their gender identity may impact on how they exist in the world in a way which did not pathologise. This included consideration of societal and political discourse and the influence of this on their mental health. The difficulty comes in creating this space for TGD people in services that hold memories of discrimination, rejection, victimisation, and denials of their identity. MHPs need to hold this in mind when working with TGD people, who have experienced these stressors in multiple aspects of their lives.

Participants often sought out other avenues of affirmation and care, understanding that mental health services would not provide this for them. They wanted to connect with TGD people or visit TGD internet sites to explore their identity, where to access care or find information about transition. The literature speaks to affirmative relationships and support networks developed in the TGD community, which is a protective aspect of community connection (Sherman et al., 2020). However, this comes as a necessity due to poor care, lack of resource and general failings from mental health services for TGD people. It raises the question about what happens to TGD people needing care who cannot find this connection with their community.

MHPs and services need to find ways of alleviating negative expectations for TGD people. Participants in this study discussed ways their MHPs were able to do this for them. It was helpful when they felt listened to, cared for, and were accepted as themselves. MHPs must understand that trust needs to be earned within the therapeutic relationship and it cannot always be given freely by TGD people who expect to be hurt. Hunt (2014) noted the necessity of training for counsellors but identified the therapeutic relationship as the most important aspect of engaging and working affirmatively with TGD patients. A trusting relationship with the MHP can be the most affirmative and protective factor for a TGD person in mental health services. It helps to cultivate identity pride and connectedness. This can help to minimise of proximal stressors and their resulting distal stressors in services, as noted by the GMSR model.

## 4.3 Implications and Recommendations of the Research

### 4.3.1 Research

Further research on access and use of mental health services could focus on better understanding of differences for distinct groups within TGD identities, such as people who identity as non-binary or agendered. This study used the term TGD to cover broad experiences of all transgender labels due to the lack of research in the area, however this may have hidden differences within the TGD populations. As discussed in Section 1.2.3, research on TGD people is often condensed and hidden within general LGBTQ+ research. Taking this into consideration, it is likely that people holding different gender identities within the larger TGD umbrella will also have distinct experiences and difficulties within mental health services. Results offered should be understood within the context of TGD people as a wider group, with likely differences for different identities within this.

The literature speaks to the lack of TGD research which includes TGD people of colour. This was the case for the current study, with only white participants recruited. Further research should attend to intersectionality and individual demographic factors to begin to understand how further minoritised identities may impact on access and experience of services for TGD people. Representation from minoritised groups in research design may help with recruitment of more diverse participant group, particularly TGD people of colour whose experiences have been overlooked in TGD research. This could be addressed by using a more inclusive research design such as Participatory Action Research (PAR). This involves emphasising the inclusion and involvement of participants as active contributors to the research process from conception. This includes the choice of topic, research design, data collection, analysis and dissemination of findings. This approach can be particularly useful with minoritised populations to ensure that their voices and perspectives are central to all parts of the research process.

The choice to look at MHPs as a group, rather than focus on a specific discipline was due to the lack of research on mental health services as a whole. It allowed for an understanding of the common themes that occur throughout services, including psychiatry, nursing, psychology and more. However, it did not allow for comparison between disciplines and a better understanding of the differences between mental health professions when it comes to understandings of TGD healthcare needs. Future research should seek to understand if there are differences between mental health professions, and if so, this can better inform recommendations for practice within specific disciplines. The current research should be understood for general mental health services rather than specific recommendations for individual disciplines, accounting for the diversity of practices within MHPs.

Longitudinal studies would be beneficial to this population, tracking mental health outcomes over time and assessing the effectiveness of current mental health interventions for them. This research should involve the input of TGD people in the planning and undertaking of research, who can speak to their experiences and potentially improve the design and recruitment of studies targeting this population. While this study utilised the input of a consultation group of TGD people to advise on the interview schedule, language and pilot interviews, the initial conception was by the researcher. It will be important for future research to engage TGD stakeholders from the beginning, meaningfully integrating their participation and ensuring their voices are present throughout.

Dissemination is an important consideration for studies related to TGD issues. Any future research should ensure that it is reported back to the TGD community who have given their time and effort to contribute. Research should aim for publication in peer-reviewed journals but also in ways that will reach the TGD community. It is important to ensure that TGD people can see their voices and experiences represented within research and foster a greater sense of visibility and acceptance. Where possible, researchers should aim to disseminate their findings directly to any TGD participants involved in their study and find further inclusive methods of disseminating to the wider TGD community, potentially through non-academic writing and TGD organisations. Dissemination can also ensure that research contributes to observable change within services and organisations. This can be done through reports, presentations, or training to relevant services, ensuring the understanding is for work to be done within services and not the responsibility of TGD patients.

### 4.3.2 Clinical Practice

#### 4.3.2.1 *Individual MHP Practice*

MHPs must commit to informing themselves and ensuring that they are using the correct names, pronouns, and gender identity markers for their patients. They can also offer their own pronouns as a way of facilitating a conversation with TGD people who may be unsure if they are safe to disclose their gender identity. Some MHPs choose to wear rainbow lanyards, rainbow badges and pronoun badges to visibly show their allyship for TGD people. This is positive, but MHPs must have the knowledge and acceptance of gender diversity to back this up. These signs of allyship need to be earned and should be supported by appropriate TGD inclusive action. This will begin to create safer, more open spaces for TGD people to bring themselves authentically and allow them to actively engage in treatment.

Professionals should try to limit unnecessary gender-related questions with patients as these can be embarrassing or hurtful (Vermeir et al., 2018). When clinically necessary, it is helpful to explain the purpose of questions clearly and sensitively to the patient. Many TGD patients will have experienced harmful questioning and practices from health professionals. It is important to hold a trauma informed perspective and be open to discussion and explanation. This will require the MHP to do their own work to improve their competency for having these discussions. This may include reflective work on what may be relevant or what may be a result of curiosity or lack of knowledge.

MHPs must be actively committed to working to earn the trust of their TGD patients, with this burden needing to fall on professionals to create safety. Participants in this study described being listened to, being heard, and not being judged as extremely important in their interactions with MHPs. In the event of mistakes being made, participants simply wanted a short acknowledgement or apology. Overreactions can cause TGD patients to become uncomfortable and create pressure to comfort or reassure MHPs.

MHPs should aim to be aware of the current social, political and media contexts impacting on their TGD patients and how this may contribute to feelings of unease or fear in services. MHPs should be careful when looking for resources, especially online, ensuring that the sources they are learning from are not transphobic. The browser extension ‘Shinigami Eyes’ can be useful for distinguishing trans positive content from transphobic content online. MHPs should ensure they do not become embroiled in current political debates about the validity of TGD people’s lives.

#### 4.3.2.2 *Systemic Service Change*

MHPs need to be supported in their efforts to educate themselves by the organisations they work for. Baker and Beagan (2014) suggested that services do not have the cultural competency necessary for working with their TGD patients, which may account for the lack of education on gender identity and TGD lives. However, considering the poor mental health outcomes and poor access to services for TGD people, the importance of this topic should not be underestimated.

Services must take accountability for their MHPs, ensuring a provision of training and education that does not pathologise or discriminate. This should, where possible, be co-created and facilitated by TGD people to amplify the voices of this marginalised patient group. This could be improved by trainings facilitated by TGD people who are actively involved in the service. This may require services to develop more diverse hiring practices, ensuring that their staff can represent and understand their patient group. TGD people involved in staff training and service development should be paid for their time.

At an organisational level, services need to ensure that forms and documents are inclusive of gender identity. This will ensure correct reporting and recording of patient demographics whilst also ensuring that TGD patients are affirmed in their identity. As noted by participants in this study, this will lead to better engagement in services for TGD people from the outset. It will also enable services to have a better record of their TGD patients and understanding of their identities. Participants in this study suggested things as simple as providing an extra box for non-binary people to tick. Beagan et al. (2013) suggests listing various potential gender identities and including a self-report box for anyone who falls outside of the identities listed.

#### 4.3.2.3 *Clinical Psychology*

For Clinical Psychologists (CPs) specifically, supporting TGD patients can span a variety of areas. Clinically, CPs can ensure that their therapy practices are gender-affirmative and trauma-informed. This will allow for validation of identity and consequently, a more open and useful therapeutic intervention. In terms of trauma-informed working, this will allow CPs to address traumas which may stem from various places, including discrimination and victimisation by mental health services.

CPs can begin to think about how to develop services in a way which is meaningful, integrated and accessible for TGD people. This will include thinking about how services can support TGD individuals for their unique needs, including support with medical care and referrals for gender-related care. Even services specifically designed for TGD people are often inaccessible to them, CPs should consider how to integrate services which often seem fragmented and separate, so that TGD people can seek care from general services rather than needing to always seek specialised care. This will begin to push for services which are more holistic and equitable for TGD people.

CPs can use consultation to provide training for other professions to enhance their competence when working with TGD patients. This will promote better understanding of TGD issues and normalise working with this group within services. It will help to destigmatise and demystify TGD healthcare needs, enabling MHPs to improve their practice, removing layers of prejudice and discrimination. CPs can also do this through supervision of trainees and students.

CPs can advocate for and support better policies to ensure access to equitable and non-discriminatory care for TGD people. They can do this within healthcare settings and wider, aligning themselves with social and political movements which support the advancement of equal rights for all. CPs can also help through promotion of community organisations, working with local community organisations and leaders to create and support already existing programmes which continue to enhance the protective factor of community connectedness for TGD people. This will enhance TGD people’s engagement with wider services and their ability to build supportive community networks.

### 4.4 Critical Review

A critical review was carried out to appraise the research for rigour and trustworthiness (Williams et al., 2020). Yardley’s (2000, 2017) evaluative criteria for qualitative research were considered, alongside a discussion of the study’s strengths and limitations. Yardley's criteria were chosen as they offer a broad range of measures for the assessment of the quality of qualitative research.

### 4.4.1 Sensitivity to Context

This study was conducted with consideration of the current context as outlined in Chapter One. The researcher specifically kept in mind their own position to the research, considering the influence of bias and opinion through a reflective journal, utilising research supervision and personal therapy. The current discriminatory socio-political climate for TGD people has real consequences for the participants who may have been worried for their safety in the interview process. It was considered there may be hesitancy for TGD people to sign up, so the researcher emphasised acceptance and confidentiality in initial conversations with participants. The researcher and consultants considered how safety could be created in interviews including use of language, researcher identity and debrief.

### 4.4.2 Commitment and Rigour

The researcher has a longstanding commitment to the topic, which lent itself to a concerted effort to understand and represent the experience of participants. The researcher sought guidance from consultants to give the best representation of the TGD community in terms of language and content. Research supervision was used to discuss how to best be driven by the data, taking account of the literature and lens of the researcher. This supported methodological rigour, through an immersion of the researcher in the data and making data driven interpretations. The researcher engaged in cycles of coding, linking codes, and finding themes and quotations to ensure a rigorous analysis. The researcher attempted to prioritise the voices of the participants, with an open approach to interviewing and participant-led data collection. The use of direct quotes from all participants ensured all perspectives were included.

### 4.4.3 Coherence and Transparency

There is clear documentation of the research design, methodology and analysis utilised in this research, ensuring transparency of the procedures used. The theoretical underpinnings of the study were outlined in detail to anchor the research. Appendix K and L show the initial thematic map and an extract of a coded interview transcript. An extract from the researcher’s reflective journal is presented in Appendix M describing the pressure felt by the researcher to represent the participants of the study after completing transcription. These are provided for further transparency and coherency of the study.

### 4.4.4 Impact and Importance

This was the first study to explore access to and use of mental health services in the UK for TGD people, eliciting their voices and centring their perspective. It offers valuable insights into the experiences of TGD people in services and the impacts these experiences have on their ability to engage with treatment. It explored ideas of what is most helpful from MHPs and services and provides ideas of what could change to make mental health services in the UK a safer place for TGD people. The study aimed to avoid pathologisation by focusing on the experiences of participants in the context of the current social and political climate. At a time when TGD people’s safety is at risk, it is of the utmost importance that they can seek out the care and support of mental health services without fear of discrimination. Suggestions have been made for further research, including involving TGD researchers and utilising longitudinal studies. Recommendations have been made in relation to the importance of training and education for MHPs, systemic service changes and how MHPs can improve their interactions with TGD patients.

### 4.4.5 Strengths of the Study

Two pilot interviews were conducted prior to the study commencing. The researcher used the pilot interviews to practice their interviewing technique and test the interview schedule. Preliminary responses were captured, providing a clearer focus for the research topic. The interview process was refined based on the pilot studies prior to interviews, including prompts and clarifying the wording of some questions.

The advice of TGD consultants for the design of the interview schedule and write up of results was a strength of this research. Consultants were able to bring personal experience and knowledge to increase cultural competency, sensitivity, and meaningful engagement with TGD people in this research (Staples et al., 2017).

The use of interviews allowed TGD people to speak to their experiences and guide the conversation to what they felt was most important. Research on TGD people has often left them invisible, with research misrepresenting or misinterpreting them. It was important to strive to represent the voices of the participants as accurately as possible, whilst emphasising the individuality and heterogeneity of the TGD community (Nadal et al., 2021).

### 4.4.6 Limitations of the Study

The literature demonstrates that TGD people in the UK represent a small percentage of the population. Mainly online recruitment methods were utilised in this study, with many participants signing up through social media platforms. Research has shown that social media is one of the best ways of engaging TGD participants (Rosser et al., 2007). However, this may have affected the sample recruited, as people without access to social media will have been less likely to have the opportunity to sign up. This likely influenced the young age range of participants.

The perspective of a range of gender identities were captured, but the majority of these identified as transmen or non-binary. One hypothesis for this may be the context of the UK socio-political climate and current media vilification of trans women. This may have made it feel less safe for them to sign up to research for fear of discrimination or transphobia. Due to the current online culture of “TERFS”, it may have been that trans women did not feel safe talking online to a cisgender woman who may hold harmful beliefs about them or their identities.

All but two participants identified as White British, the remaining two identifying as White Scottish and Pakeha. This leaves the research with an incomplete understanding of the experiences of TGD people, with racialised TGD voices being invisible in the research. This is a common difficulty of TGD research, which leads to generalisations being made about this population that may not fit for perspectives outside of the perceived norm (dickey et al., 2016). Although effort was made to be inclusive, with advertisements on multiple platforms, in public spaces and wide inclusion criteria, the sample was not representative of non-White TGD people’s perspectives and experiences. It is possible that due to multiple marginalised identities, the research felt unsafe to take part in. Most participants were recruited online through social media, with research showing this routinely leads to majority white and highly educated participants (dickey et al., 2015).

The use of Thematic Analysis as a research methodology may have been a limitation of the current study. Future studies could utilise more in-depth analyses, which provide a better chance to unpack the construction of power structures and privilege with regards to the TGD population. This would allow for a more detailed and critical examination of power dynamics through a richer exploration of the complexities of how the themes are interconnected and sustained.

### 4.5 Researcher Reflections

Reflexivity was an important process for this research. Reflexivity is a form of critical thinking which considers the researchers' own values, biases and characteristics and considering how these may have influenced the conception, design, and analysis of the study (Lazard & McAvoy, 2020).

As a cisgender woman, the first question I asked myself about this study was "Should a cis woman be doing this research?". This formed the basis of my approach to this research, with an understanding that I am writing from an outsider perspective and writing about experiences I will never be able to understand. I believe that TGD people should have the opportunity to be involved at all levels of research about them. I also believe that my allyship includes actively supporting, advocating for, and standing alongside TGD people in achieving equal rights and ensuring they can live their lives safely and free from harm. As such, I did this research to inform and attempt to change clinical practice in the UK. Allies must continue to be active in the labour and process of achieving a society which is accepting and safe for the TGD community. However, it is likely that my methods of design, data collection, recruitment and analysis will have been through the specific lens of a cisgender woman. TGD researchers may have approached any of these areas differently, coming to and prioritising different conclusions.

The current political climate for TGD people had a considerable impact on my emotional state throughout the course of this research. This was an emotive topic for me, which led me to consider my TGD friends and colleagues and how they are navigating their lives, their work, and their research. The process of writing this thesis was deeply affecting as I felt a pressure to do it justice. This was also impacted by rampant anti-TGD media and an increasingly transphobic government. This further highlighted the need for research centring TGD voices and ensuring TGD people are involved in discussions about themselves. There are multiple ideologies which uphold transphobia, and these were important to note within this thesis, as these ideologies are present in our mental health services too. The experiences of TGD people are actively shaped by these societal discourses which seep into the running of public services. It is necessary to understand this to continue to question white, heteronormative and cisnormative narratives.

Gender critical attitudes have come into force over the last decade, potentially as a reaction to the increasing visibility and acceptance of TGD people. This speaks to broader reactionary movements against more progressive thinking, including feminism, racial equality and LGBTQ+ rights. This, in part, has been amplified by social media discourse on TGD lives which prioritises controversial and emotionally charged content. It is also likely that widespread economic and social insecurity has played a part in the rise of gender critical views, with people becoming fearful of change and returning to what they perceive as comfortable and familiar social structures. This has been influenced by politics, which has utilised a growing divide between progressive and conservative views on issues of identity to create frenzied and inflammatory debates about TGD lives. All of this impacts on TGD people in their everyday lives. They are subject to discrimination and violence, as well as having to listen to people in power debate their right to exist. For the purposes of this study, I had to prioritise the safety and comfort of the TGD people I was interviewing. This meant utilising my personal networks to recruit, which likely meant that the participant pool was smaller. This is one of the potential reasons for the sample being all white participants.

It is likely that my affiliation a university, as well as my identity, will have replicated barriers that TGD people experience in mental health services. TGD people may have felt unable to discuss these issues with someone cisgender, someone who is a mental health professional and who is white. This may have meant that parts of discussions felt off limits for some people, losing some of the nuance of the conversation. Whilst I attempted to keep the inclusion criteria broad, this may have ruled out people who wanted to take part. The study required access to technology, which may have ruled out someone without access.

I am a mental health professional, which was important to note throughout the interviews, as people discussed the difficulties and challenges faced when working with mental health professionals. I thought this may impact on the participants' ability to engage with the interview, build rapport and be truthful about their experiences. This was not the case. Participants were warm, open, and honest. I found it incredibly easy to establish a rapport with all of them and felt they trusted me enough to truthfully explain their experiences in our conversations. This may have been because I identify as a gay woman, with our shared community creating safety for them. However, it is also likely that TGD people can easily establish rapport with anyone who is interested in their lives and shows them kindness and respect.

## 4.6 Conclusion

To my knowledge, this was the first UK study of its kind to explore the experiences of transgender and gender diverse people when accessing and using mental health services in the UK. Three themes were generated using Thematic Analysis: '"*I don't want to have to be Google*"', 'Discriminatory Service Provision' and 'Bringing my Whole Self'. These themes build on previous research of physical healthcare settings and mental health settings globally, linking closely to the GMSR model (Testa et al., 2015).

Study participants gave raw and honest descriptions of their experiences, reflecting thoughtfully and carefully about how these experiences have affected them, their lives, and their expectations of mental health services. This study emphasised the need for MHPs and mental health services to do better for their TGD clients. TGD people should be afforded access to services in the same way as cisgender people. MHPs need to educate themselves and ensure their practice is sensitive and respectful of TGD identities. MHPs who do this will foster better therapeutic relationships with their TGD patients, offering them safe space to explore the complexities of mental health and gender identity.

MHPs must attend to the power they hold over TGD patients who are seeking care and seeking referrals to services which are highly gatekept. Mental health services need to implement better strategies to ensure empathy and care are at the forefront of their interactions with TGD people. This is important for TGD patients, many of whom have already had harmful experiences with mental health services. Care should be taken to not retraumatise this community, instead providing space for healing and reparation of their relationship with MHPs and services. Hiring more diverse clinicians would create an opportunity for TGD people to see themselves reflected in services and prove useful for shared learning among colleagues.

Through these findings, it is hoped that further research will explore the complexities of experiences of mental health services and its impact on mental health outcomes for TGD people. Research should continue to build a better understanding of what goes wrong for TGD people in mental health services, to do better next time.  This study serves as a testament to the resilience and bravery of TGD people who unwaveringly advocate for their community to have access to equitable and affirmative mental health care.

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# 6 APPENDICES

## Appendix A: Literature Search

Multiple electronic databases were used to search for relevant literature including Academic Search Ultimate, APA PsycArticles, APA PsycInfo, CINAHL Complete and SCOPUS. Google Scholar and references lists were also searched. The search included grey literature.

The literature search to identify relevant papers included the following search terms, based on recommendations by Booth et al. (2006):

- “transgender” or “trans” or “trans*” or “transsexual” or “gender variant” or “gender diverse” or “gender non-conforming” or “genderqueer” or “gender non-binary” or “nonbinary” or “tgd” or “tgnc”
- “client” or “patient” or "service user"
- “perspectives” or “views” or “perceptions” or “experiences” or “accounts”
- "mental health services" or "mental health care" or "psychiatric services" or “therapy” or “counselling”

Inclusion and exclusion criteria were used to reduce bias and aid identification of the relevant publications.

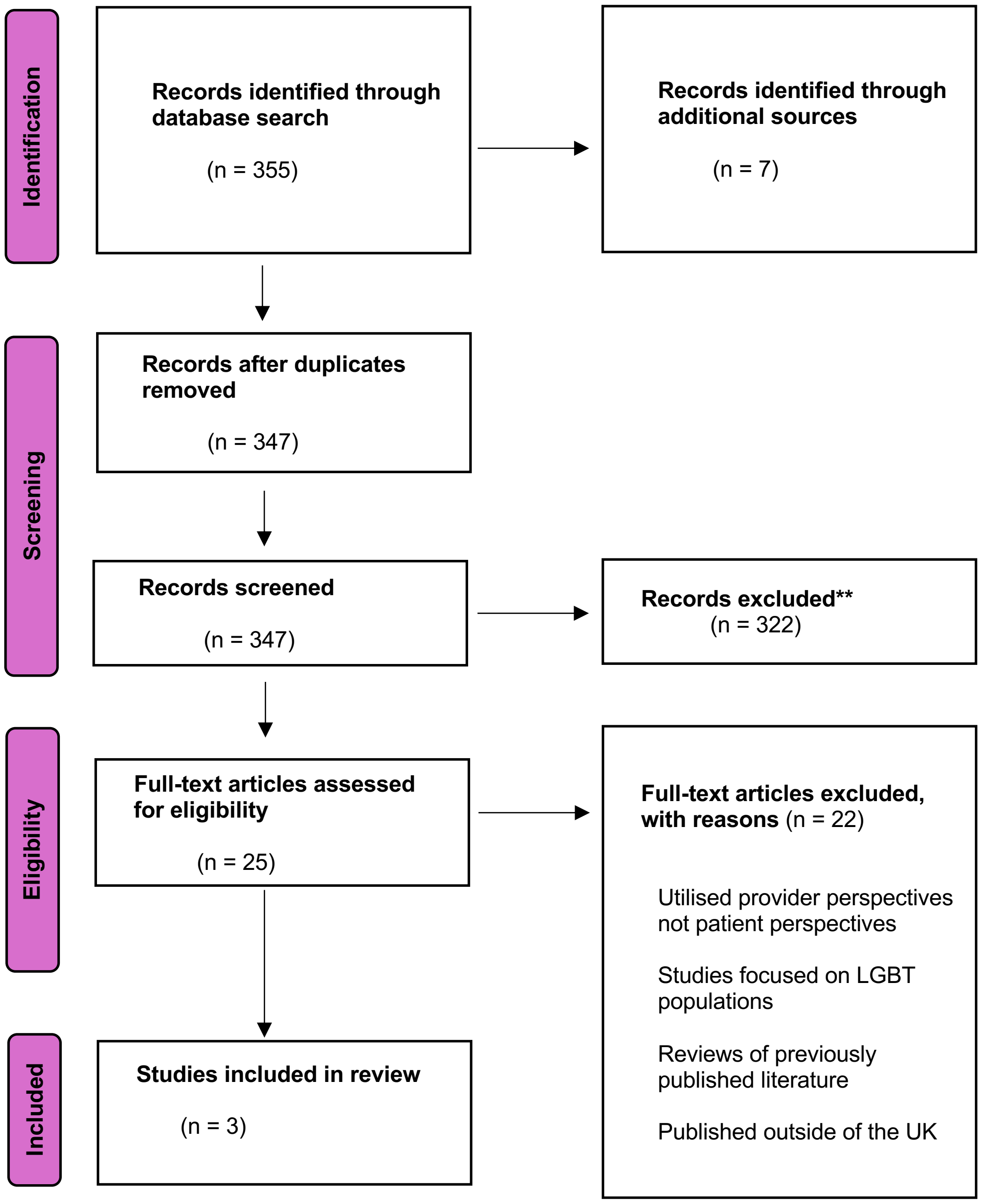
Inclusion criteria:

- Studies focusing on TGD people over the age of 18
- Studies that explored TGD experiences of mental health services

Exclusion criteria:

- Studies that were reviews, meta-analyses, or syntheses of the literature
- Studies focusing on provider perspectives
- Studies focused on LGBT populations, rather than TGD specifically
- Studies not written in English
- Studies not conducted within the UK

# Appendix B: PRISMA Flow Chart



## Appendix C: University of East London Ethical Approval and Ethics Form

**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:** | **Luis Jimenez** |
| **Supervisor:** | **Trishna Patel** |
| **Student:** | **Kayleigh Mulqueen** |
| **Course:** | **Prof Doctorate in Clinical Psychology** |
| **Title of proposed study:** | **Exploring transgender and gender diverse people's experiences of UK mental health services** |

| 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.<br>**Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., |

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| | 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.<br>**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** |
|---|
| Please clearly detail the amendments the student is required to make |
| |

| **Major amendments** |
|---|
| Please clearly detail the amendments the student is required to make |
| |

| | | |
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| **Assessment of risk to researcher** | | |
| **Has an adequate risk assessment been offered in the application form?** | **YES**<br>☒ | **NO**<br>☐ |
| | 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:**<br>(Typed name to act as signature) | Dr Luis JImenez |
| **Date:** | **22/05/2023** |
| ***This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee*** | |

## 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)

| | |
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| 1.1 | Before completing this application, please familiarise yourself with:<br>▪ British Psychological Society's Code of Ethics and Conduct<br>▪ UEL's Code of Practice for Research Ethics<br>▪ UEL's Research Data Management Policy<br>▪ 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:<br>▪ 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.<br>▪ Useful websites:<br>https://www.myresearchproject.org.uk/Signin.aspx<br>https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/<br>▪ 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 |

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| | separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required.<br>▪ 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.<br>▪ 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:<br>https://fadv.onlinedisclosures.co.uk/Authentication/Login<br>You may also find the following website to be a useful resource:<br>https://www.gov.uk/government/organisations/disclosure-and-barring-service |
| 1.7 | Checklist, the following attachments should be included if appropriate:<br>▪ Study advertisement<br>▪ Participant Information Sheet (PIS)<br>▪ Participant Consent Form<br>▪ Participant Debrief Sheet<br>▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5)<br>▪ Permission from an external organisation (see section 7)<br>▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use<br>▪ Interview guide for qualitative studies<br>▪ Visual material(s) you intend showing participants |

| Section 2 – Your Details | | |
|---|---|---|
| 2.1 | **Your name:** | **Kayleigh Mulqueen** |
| 2.2 | **Your supervisor's name:** | **Dr Trishna Patel** |
| 2.3 | **Name(s) of additional UEL supervisors:** | **Dr Matthew Jones Chesters**<br>3rd supervisor (if applicable) |
| 2.4 | **Title of your programme:** | **Doctorate in Clinical Psychology** |
| 2.5 | **UEL assignment submission date:** | **20/05/2024**<br>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 | Exploring transgender and gender diverse people's experiences of UK mental health services |
| 3.2 | **Summary of study background and aims (using lay language):** | People who identify as transgender and gender diverse (TGD) are more likely than cisgender people to need help from mental health (MH) services with the prevalence of psychiatric diagnosis being 44% higher in people who are transgender than cisgender control populations (Wanta et al., 2019). They experience higher rates of chronic illness, mental health conditions and substance misuse (Reisner et al., 2016). This may also be due to dealing with issues stemming from holding a minority identity (Choate, 2019). Studies of mental health issues frequently show that people who are transgender experience high rates of depression, anxiety than people who identify as lesbian, gay or bisexual (Higgins et al., 2016). TGD populations are at higher risk levels of suicidal ideation and suicide attempts in comparison to cisgender youth (Perez-Brumer, Day, Russell, & Hatzenbuehler, 2017).<br>However, there is a lack of understanding and training amongst MH professionals regarding issues of being TGD which can lead to further distress for these clients (McNeil et al., 2012; Bauer et al., 2009). Ellis, Bailey & McNeil (2015) found that 40% of transgender people would not report mental health difficulties due to previous negative experiences with mental health professionals.<br>Studies have shown professionals do not feel fully competent to deal with this client group, leading to difficulties for TGD people within MH services such as having to educate professionals on TGD identities (Bauer et al., 2009).<br>Research has not fully involved the voices of people who identify as |

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|  |  | TGD and their experiences of using MH services, utilising theoretical stances or having a focus on service provider's perspectives (Holt et al., 2021). Involving the voices of the TGD community is important to empower them to be part of the research, and as such, part of the solution to some of the barriers to gaining acceptable health care (Safer et al., 2016).<br>This study aims to use semi-structured interviews to explore TGD people's experiences of using MH services and if there are any barriers to seeking help for them. |
| 3.3 | **Research question(s):** | How do transgender and gender diverse people view accessing support from mental health services?<br>How do transgender and gender diverse people describe their experiences of mental health services? |
| 3.4 | **Research design:** | This study will adopt a qualitative methodology, using semi-structured interviews on Microsoft Teams to explore the views of participants, allowing them to discuss their experiences of MH services openly.<br>An interview schedule has been developed following consultation with members of the proposed sample population. Attached is a draft interview schedule (Appendix 4) which was developed following consultation with 5 members of the proposed sample.<br>The interview schedule will first be piloted and further revised before a final version is produced. Any data gathered in the pilot interview will not be used in the study but will be used to inform the approach and content of the interview schedule. If possible, the interview schedule will be revised after the pilot interview in consultation with members of the proposed sample. |
| 3.5 | **Participants:** Include all relevant information including inclusion and exclusion criteria | Participants will be anyone who is 18 years of age or older, identifies as transgender or gender diverse, lives in the UK, has had experience of accessing mental health services in the UK.<br>Exclusion criteria will be anyone who is currently in contact with mental health services. |
| 3.6 | **Recruitment strategy:** Provide as much detail | The study will be primarily advertised through a number of social media platforms such as Twitter and Instagram, as online platforms are well placed to reach TGD populations (Miller-Perusse et al., 2019). The researcher will also utilise online forums. The researcher |

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| | as possible and include a backup plan if relevant | may also use flyers in LGBTQ+ groups in the community in order to reach a wider group of people.<br>The researcher will not use personal social media accounts to advertise the study, instead setting up social media accounts specific for the study. The study will be advertised on Facebook, Instagram, Twitter and LinkedIn social media platforms.<br>Permission will be sought from any forums where the study will be advertised before any posts are made. Forums focused on will be UK LGBTQ+ specific forums.<br>Due the minority status of the proposed participant group, recruitment may prove challenging (Bush & Blackwell, 2022). If initial recruitment proves unsuccessful, the researcher will interview MH professionals who have experience of working with TGD people. |
| 3.7 | **Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc. | This study requires a password-protected computer with access to the researcher's MS Teams account and NVivo software.<br>Interview schedule as in Appendix G. |
| 3.8 | **Data collection:** Provide information on how data will be collected from the point of | Informed consent will be clearly sought from the intended population by consent form before the interview. Consent forms will be collected for the study and any personal information in an electronically signed form will be password protected and saved on OneDrive for Business.<br>Demographic information will be collected prior to the interview. Any demographic information collected will be stored separately to any transcripts in a single .docx file. |

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| | consent to debrief | Video and audio recordings will be generated from MS Teams interviews (eight to fourteen approximately one hour recordings).<br>Anonymised transcripts will be created from these audio/video recordings. Once the transcripts have been completed the audio and video recordings will be deleted.<br>An interview schedule will be developed so that a standard format is followed.<br>Participant email addresses may be collected in order to offer an entry to win an Amazon voucher after participation. This will be voluntary and will not be necessary to take part in the study. | |
| 3.9 | **Will you be engaging in deception?** | **YES**<br>☐ | **NO**<br>☒ |
| | 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**<br>☒ | **NO**<br>☐ |
| | If yes, please detail why it is necessary. | Participant email addresses may be collected in order to offer an entry to win an Amazon voucher after participation. This will be voluntary and will not be necessary to take part in the study.<br>This is necessary in order to reimburse this protected and vulnerable population for their time and effort in contributing potentially upsetting or emotive information to the study. | |
| | How much will you offer? | 2 x £50 Amazon vouchers | |

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| | Please note - This must be in the form of vouchers, not cash. | |
| 3.11 | **Data analysis:** | Thematic Analysis will be used to collect a cross-sectional views and experiences of TGD people. Interpretative Phenomenological Analysis was ruled out as the study will not explore the internal world of individual people. Thematic Analysis will be used to explore the themes which emerge from the interview data representing the views of TGD people's experiences of MH services following the methods outlined by Braun and Clarke (2006). This is in line with the study's adherence to a critical realist epistemological position. |

## 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.

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| 4.1 | **Will the participants be anonymised at source?** | **YES**<br>☒ | **NO**<br>☐ |
| | If yes, please provide details of how the data will be anonymised. | The participants will all be given a participant number and all identifiable information will be pseudonymised in the transcripts. A document will be created containing a key linking the participant's pseudonym and their identifying information. The key will be saved on the UEL OneDrive in the following folder and file structure: KM Thesis Documents > Participant Key > [interview pseudonym key]. | |
| 4.2 | **Are participants' responses anonymised or are an anonymised sample?** | **YES**<br>☒ | **NO**<br>☐ |
| | If yes, please provide details of how data will be | During transcription, confidentiality will be ensured by changing names to pseudonyms and altering any identifiable information. Transcription will be done only by the researcher in order to maintain | |

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| | anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.). | confidentiality. Any recordings will be deleted immediately after transcription. |
| 4.3 | **How will you ensure participant details will be kept confidential?** | During the recruitment process, all potential participants will be provided with an information sheet detailing how their data will be stored securely and anonymised and how their data will be used for the thesis write up and the possibility for future dissemination. This will be done in order to gain fully informed consent. All data will be securely stored in UEL OneDrive for Business in separate password-protected folders. Any demographic information collected will be kept to a minimum and only information deemed directly relevant to the study will be collected.<br>The participants will all be given a participant number and all identifiable information will be pseudonymised in the transcripts. A document will be created containing a key linking the participant's pseudonym and their identifying information. The key will be saved on the UEL OneDrive in the following folder and file structure: KM Thesis Documents > Participant Key > [interview pseudonym key].<br>Electronic consent will be gained from participants prior to their interview. They will be informed of their right to withdraw from the study at any time, as well as prior to data analysis once their data will have been anonymised. Participants will be informed of a likely timeline of approximately three weeks after interview to withdraw consent. They will have the researcher's contact details if they wish to withdraw consent.<br>During transcription, confidentiality will be ensured by changing names to pseudonyms and altering any identifiable information. Transcription will be done only by the researcher in order to maintain confidentiality. Any recordings will be deleted immediately after transcription. After data collection has been completed and data analysis commenced, the Participant Key document linking participant numbers with their contact information will be deleted. |

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| | | The data will not be shared with any other researchers for any other purposes. |
| 4.4 | **How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security | All data will be stored on the UEL OneDrive for Business. This includes electronic consent forms and any other identifiable data.<br>However, video and audio recordings from MS Teams interviews will be stored by default on the UEL Microsoft Stream Library. Automatic transcriptions will be made by MS Teams, once these are checked and amended accurately, all original video recordings will be deleted.<br>A copy of the anonymised interview transcripts will be backed up in a different storage location using Sharepoint or an external hard drive. These will be deleted after up to three years.<br>Participant email addresses and any information for the reimbursement of the Amazon voucher will be stored on OneDrive for Business. This will be stored in a separate file from other information and will be password-protected. |
| 4.5 | **Who will have access to the data and in what form?** (e.g., raw data, anonymised data) | Only the researcher and research supervisor will have access to the anonymised transcripts which will be stored securely on UEL OneDrive for Business. UEL OneDrive utilises password-protected multi-factor authentication and the data will only be able to be accessed through this.<br>Anonymised transcripts will be shared with the research supervisor via OneDrive for Business secure links. No further information will be shared with the research supervisor. The research supervisor will not have access to any data that has not been anonymised.<br>Examiners may request to see anonymised interview transcripts. Video and audio recordings will be immediately deleted once they have been transcribed. |
| 4.6 | **Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases) | Any audio or video files created from the MS Teams interviews will be transcribed and immediately deleted from the secure OneDrive server.<br>Electronic copies of consent forms will be kept until the thesis has been examined and passed. After this they will be immediately deleted.<br>Anonymised transcripts from the interviews will be retained for up to three years by the research supervisor on UEL OneDrive for future |

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| | | dissemination purposes. After this time, all research data will be deleted. | |
| 4.7 | **What is the long-term retention plan for this data?** | Any MS Teams recordings will be deleted immediately after they have been transcribed for analysis.<br>Anonymised data and transcripts will be deleted by the researcher after the thesis has been examined and passed, at which time they will be deleted from the researchers account. The thesis supervisor will store any anonymised data and transcripts for up to three years on their UEL OneDrive in order to keep this data for possible publication. After three years, all data will be deleted.<br>Personal data will only be kept for the necessary time period i.e., until the thesis has been passed and the winners of the Amazon vouchers have been contacted.<br>The thesis, which will include write ups of the transcripts, will be stored in the Research Open Access Repository (as outlined in the UEL Research Data Management Policy). | |
| 4.8 | **Will anonymised data be made available for use in future research by other researchers?** | **YES**<br>☐ | **NO**<br>☒ |
| | If yes, have participants been informed of this? | **YES**<br>☐ | **NO**<br>☐ |
| 4.9 | **Will personal contact details be retained to contact participants in the future for other research studies?** | **YES**<br>☐ | **NO**<br>☒ |

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| | If yes, have participants been informed of this? | **YES**<br>☐ | **NO**<br>☐ |

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| 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, emotional distress, intrusion, etc.) | **YES**<br>☒ | **NO**<br>☐ |
| | If yes, what are these, and how will they be minimised? | There is a risk of harm to participants through recall of potentially upsetting experiences. There may be previous difficult experiences with MH professionals, and this will need to be taken into account. It will be important for the researcher to be mindful of not reinforcing any potential stigma and to use correct language and terminology with each participant.<br>To minimise this, the researcher will outline the topic area from the outset in order to allow participants to make an informed decision about their participation. As a Clinical Psychologist in training, I am skilled in managing upsetting or emotive conversations. I will closely monitor participants during the interview and will take appropriate action if someone becomes upset.<br>Participants will be able to stop the interview at any point without reason. Participants will be informed that they can withdraw completely at any point before data analysis. Participants can also | |

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| | | choose to take a break during the interview or reschedule the interview for another time. Participants will have time to debrief with the researcher at the end of the interview. They can also contact the researcher or research supervisor following participation in the research.<br>There is also a risk of harm through continuing to research minoritised groups without the voice of the group. The research will attempt to minimise these effects by involving a consultation group early in the research process and ensuring dissemination of the research back to the community.<br>A list of support services will also be provided to each participant should they need it. | |
| 5.2 | **Are there any potential physical or psychological risks to you as a researcher?** | **YES**<br>☒ | **NO**<br>☐ |
| | If yes, what are these, and how will they be minimised? | Hearing about difficult or emotive experiences may be upsetting for me as a researcher. I will use supervision to discuss this and manage my own emotions. | |
| 5.3 | **If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a** | **YES**<br>☒ | |

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| | **GRA form as an appendix:** | | | |
| 5.4 | **If necessary, have appropriate support services been identified in material provided to participants?** | **YES**<br>☒ | **NO**<br>☐ | **N/A**<br>☐ |
| 5.5 | **Does the research take place outside the UEL campus?** | **YES**<br>☒ | **NO**<br>☐ | |
| | If yes, where? | Online only | | |
| 5.6 | **Does the research take place outside the UK?** | **YES**<br>☐ | **NO**<br>☒ | |
| | 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 form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment | **YES**<br>☐ | | |

| | | |
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| | 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:**<br>▪ 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.<br>▪ 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).<br>▪ 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).<br>▪ 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** | **YES**<br>☒ | **NO**<br>☐ |

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|  | **adults (*see below for definition)?**<br>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 |  |  |
|  | * You are required to have DBS or equivalent clearance if your participant group involves:<br>(1) Children and young people who are 16 years of age or under, or<br>(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**<br>☒ | **NO**<br>☐ |
| 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**<br>☒ | **NO**<br>☐ |
| 6.4 | **If you have current DBS clearance, please provide your DBS certificate number:** | **001731752627** |  |
|  | 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:**<br>▪ 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).<br>▪ 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**<br>☐ | **NO**<br>☒ |
| | If yes, please provide their details. | Please provide details of organisation | |
| | 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**<br>☐ | |
| 7.2 | **Additional guidance:**<br>▪ 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.<br>▪ 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**<br>☒ |
| 8.2 | **Student's name:** | **Kayleigh Mulqueen** |

| | | |
|---|---|---|
| | (Typed name acts as a signature) | |
| 8.3 | **Student's number:** | **2195622** |
| 8.4 | **Date:** | **05/05/2023** |
| ***Supervisor's declaration of support is given upon their electronic submission of the application*** | | |

## Appendix D: Participant Information Sheet

Exploring transgender and gender diverse people’s experiences of UK mental health services

**Kayleigh Mulqueen**

**U2195622@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 Kayleigh Mulqueen. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and I am studying for a Doctorate in Clinical Psychology. 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 interviews to do a piece of research into transgender and gender diverse people’s experiences of mental health services. There is a distinct lack of research in this area which has actually included the voices of the transgender and gender diverse population. I would like to hear directly from the people who have been affected by their use of mental health services, in a positive, negative or neutral way. I would like to do this by interview (i.e., an informal conversation) so that you can have a chance to talk about how you have experienced using mental health services in your own words rather than ticking boxes or using rating scales.

I would also like to give space to think about the impacts of service limitations and mental health professional’s attitudes on the experiences of transgender and gender diverse people using mental health services. The goal for this research is to provide some information on what services are doing well, what they could do better and to think about ways to improve services in the future for you and this population.

### Why have I been invited to take part?

To address the study aims, I’m inviting people who identify as transgender or gender diverse in any way to take part in my research. If you identify as transgender or gender diverse, are over 18 years of age, live in the UK and have had an experience of accessing mental health services in the UK, you are eligible to take part in the study. If you are currently using a mental health service, unfortunately, you are not eligible to take part.

It is entirely up to you whether you take part or not, participation is voluntary.

**What will I be asked to do if I agree to take part?**
If you agree to take part, you will be asked to take part in an online interview (informal conversation with me) relating to your experiences of using mental health services. This will likely involve speaking about your gender identity and the amount this has (or has not) had an effect on your use of mental health services.

The conversation will take place on Microsoft Teams and will last approximately one hour. This conversation will be recorded, this is so that I will be able to accurately type up your words to include within the thesis write up. It is important for the study (and to me) that your words are not misinterpreted or changed in any way. You can choose whether or not you would like to have your camera on.

The interview will involve a number of open questions. You will be able to choose to skip some questions if you would like. These questions will relate to your gender identity, your experiences of mental health services, your experience with mental health professionals and the impact that these have had on you. It will be more like a guided chat than an actual interview with the questions serving more as prompts for the conversation.

If you would like to be entered into a prize draw for one of two £50 vouchers as a thank you for your participation, you can provide your email address and you will be contacted after the study if you have won. If you would like to be entered into the prize draw, you will be asked for your full name, date of birth, address and National Insurance Number. You do not have to enter this prize draw and this will not have any impact on your participation in the study.

**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 for any reason, you can do so by sending me an email at u2195622@uel.ac.uk. If you withdraw, 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 been interviewed, as long as 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?**
This study may require you to call upon potentially difficult or upsetting memories. This may include times where you were feeling unwell or times where you were not treated as you would have liked by professionals, services or other people also using mental health services. Recalling these times may be difficult and lead to feelings of

upset. It may also feel uncomfortable to discuss intimate and personal details relating to your identity with me.

With this in mind, we can end the interview at any point without any explanation or issue. You can refuse to answer a question or multiple questions if you do not wish to discuss a certain experience. You can also take a break at any point during the interview. In relation to any difficulties you may have discussing aspects of your identity, you will be able to choose how much you share and how much you would like to discuss about that.

I will be available to debrief with you at the end of the interview and hear about your experience of being interviewed and how this has felt for you. Information for support services will be provided, if you feel you need further support.

**How will the information I provide be kept secure and confidential?**
After the interview, your recording will be transcribed (typed up) within three weeks. Once typed up, the recording of your interview will be immediately and permanently deleted to protect your anonymity. All of the interview transcripts will be anonymised, pseudonymised (you will be given a fake name) and any potentially identifying information from the interview will be carefully changed (locations etc.).

The recordings will be stored on a secure UEL server and will be password protected. No one else will have access to these recordings. They will be deleted immediately after transcription. The anonymised transcripts will also be stored on a secure UEL server and these will only be shared with my research supervisor (Dr Trishna Patel). These will be stored for up to three years by the research supervisor and permanently deleted after this time.

Any contact details or consent forms provided will be stored in a separate password protected folder to protect your anonymity. These will not be shared with anyone. These will only be kept until the end of the research project and after that they will be permanently deleted.

Parts of your anonymised interview transcript (i.e., short quotes) will be included in the write up of the thesis. This will be published on the UEL Research Open Access Repository and may be further disseminated in the future. Any quotations or excerpts used from your interview will be monitored carefully for identifiable information and this will be changed or deleted prior to submission.

The only time your confidentiality and anonymity may be broken is if I am concerned about your safety or the safety of someone else. Where possible, I will discuss this with you first.

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, Registry of Open Access Repositories, ROAR. Findings may also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) 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. Any personally identifying information will be removed or anonymised in the transcripts (for example, any locations or names mentioned) and you will be given a pseudonym (a fake name) within the write up.

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 Trishna Patel 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.
Kayleigh Mulqueen
u2195622@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: t.patel@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 E: Interview Consent Form

Exploring transgender and gender diverse people's experiences of UK mental health services

**Kayleigh Mulqueen**

**U2195622@uel.ac.uk**

| | **Please initial** |
|---|---|
| I confirm that I have read the participant information sheet dated 24/02/2023 (version 1) for the above study and that I have been given a copy to keep. | |
| I have had the opportunity to consider the information, ask questions and have<br>had these answered satisfactorily. | |
| I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage. | |
| I understand that if I withdraw during the study, my data will not be used. | |
| I understand that I have 3 weeks from the date of the interview to withdraw my data from the study. | |
| I understand that the interview will be recorded using Microsoft Teams. | |
| I understand that my personal information and data, including 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. | |
| It has been explained to me what will happen to the data once the research has<br>been completed. | |
| I understand that short, anonymised quotes from my interview data may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me. | |
| I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to. | |
| I would like to enter the prize draw for a chance to win a £50 Amazon voucher and agree to provide my details to be contacted about this. | |
| I agree to take part in the above study. | |

Participant’s Name (BLOCK CAPITALS)

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Participant’s Signature

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Researcher’s Name (BLOCK CAPITALS)

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Researcher’s Signature

……………………………………………………………………………………………………………………………………………

Date

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

## Appendix F: Data Management Plan

**UEL Data Management Plan**
**Completed plans must be sent to researchdata@uel.ac.uk for review**

*If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).*
Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

| **Administrative Data** | |
|---|---|
| PI/Researcher | Kayleigh Mulqueen |
| PI/Researcher ID (e.g. ORCiD) | 0000-0003-3892-1166 |
| PI/Researcher email | u2195622@uel.ac.uk |
| Research Title | Exploring transgender and gender diverse people's experiences of UK mental health services |
| Project ID | N/A |
| Research start date and duration | January 2023 – September 2024 |
| Research Description | People who identify as transgender or gender diverse are statistically more likely to seek support from mental health services, however it has been seen that there is a lack of understanding and training for mental health professionals regarding the mental health needs of this client group. The proposed study aims to gain an understanding of the experiences of adults (age 18+) who identify as transgender within mental health services.<br>Individual semi-structured interviews will be conducted with eight to fourteen participants over MS Teams for |

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| | approximately one hour. Participants will be recruited mainly on popular social media platforms or LGBTQ+/transgender specific forums. Interviews will be recorded on MS Teams and transcribed and analysed using thematic analysis.<br>Gaining more insight into the experiences of transgender and gender diverse people within mental health services may provide more understanding of what is needed within services to better support them and improve their experiences of mental healthcare. |
| Funder | N/A |
| Grant Reference Number (Post-award) | N/A |
| Date of first version (of DMP) | 22/03/2023 |
| Date of last update (of DMP) | |
| Related Policies | Research Data Management Policy<br>UEL Data Protection Policy<br>UEL Data Backup Policy<br>UEL Statement on Research Integrity<br>UEL Statement on Research Ethics |
| Does this research follow on from previous research? If so, provide details | N/A |
| **Data Collection** | |
| What data will you collect or create? | Video and audio recordings will be generated from MS Teams (eight to fourteen approximately one hour recordings).<br>Anonymised transcripts will be created from these audio/video recordings. This will be stored as a .docx file with all potentially identifiable information removed. Once the transcripts have been completed the audio and video recordings will be deleted.<br>Any demographic information collected will be stored separately to the transcripts in a single .docx file. This will include special category data. |

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| | Consent forms will be stored separately to this again, in .docx format. This will include personal category data. |
| How will the data be collected or created? | All data will be collected through interview recordings on MS Teams – between eight and fourteen video or audio recordings will be saved UEL Microsoft Stream Library. Recordings will be stored following the file naming convention: [ProjectCode]-[InterviewerInitials]-[ParticipantNumber]-[Location]-[Date].Ext. An interview schedule will be developed so that a standard format is followed.<br>Participant email addresses may be collected in order to offer an entry to win an Amazon voucher after participation. This will be voluntary and will not be necessary to take part in the study.<br>Consent forms will be collected for the study and any personal information with an electronically signed form will be password protected and saved on OneDrive for Business. |
| **Documentation and Metadata** | |
| What documentation and metadata will accompany the data? | Participant information sheets, debrief sheets, consent forms, recruitment advertisements, interview schedule, list of support services for interview follow up. |
| **Ethics and Intellectual Property** | |
| Identify any ethical issues and how these will be managed | Ethical approval will be sought prior to any recruitment processes from the University of East London School of Psychology Research Ethics Committee (SREC).<br>During the recruitment process, all potential participants will be provided with an information sheet detailing how their data will be stored securely and anonymised and how their data will be used for the thesis write up and the possibility for future dissemination. This will be done in order to gain fully |

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| | informed consent. All data will be securely stored in UEL OneDrive for Business in separate password-protected folders. Any demographic information collected will be kept to a minimum and only information deemed directly relevant to the study will be collected.<br>The participants will all be given a participant number and all identifiable information will be pseudonymised in the transcripts. A document will be created containing a key linking the participant's pseudonym and their identifying information. The key will be saved on the UEL OneDrive in the following folder and file structure: KM Thesis Documents > Participant Key > [interview pseudonym key].<br>Electronic consent will be gained from participants prior to their interview. They will be informed of their right to withdraw from the study at any time, as well as prior to data analysis once their data will have been anonymised. Participants will be informed of a likely timeline of approximately three weeks after interview to withdraw consent. They will have the researcher's contact details if they wish to withdraw consent.<br>During transcription, confidentiality will be ensured by changing names to pseudonyms and altering any identifiable information. Transcription will be done only by the researcher in order to maintain confidentiality. Any recordings will be deleted immediately after transcription.<br>After data collection has been completed and data analysis commenced, the Participant Key document linking participant numbers with their contact information will be deleted.<br>Due to potentially distressing content given the nature of the study, participants will be informed that they can ask to end the interview, take a break or skip a question if needed. A list of support services will be provided upon debrief.<br>The data will not be shared with any other researchers for any other purposes. |
| Identify any copyright and Intellectual Property Rights issues and how these will be managed | N/A |
| **Storage and Backup** | |

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| How will the data be stored and backed up during the research? | All data will be stored on the UEL OneDrive for Business. This includes electronic consent forms and any other identifiable data.<br>However, video and audio recordings from MS Teams interviews will be stored by default on the UEL Microsoft Stream Library. Automatic transcriptions will be made by MS Teams, once these are checked and amended accurately, all original video recordings will be deleted.<br>A copy of the anonymised interview transcripts will be backed up in a different storage location using Sharepoint or an external hard drive. These will be deleted after up to three years.<br>Participant email addresses and any information for the reimbursement of the Amazon voucher will be stored on OneDrive for Business. This will be stored in a separate file from other information and will be password-protected. |
| How will you manage access and security? | Only the researcher and research supervisor will have access to the anonymised transcripts which will be stored securely on UEL OneDrive for Business. UEL OneDrive utilises password-protected multi-factor authentication and the data will only be able to be accessed through this. Anonymised transcripts will be shared with the research supervisor via OneDrive for Business secure links. No further information will be shared with the research supervisor.<br>Video and audio recordings will be immediately deleted once they have been transcribed.<br>Anonymised data will be stored separately from any identifiable data and deleted as soon as transcription is completed. These will be stored in secure and encrypted separate files on UEL OneDrive for Business. All file names will be anonymised. |
| **Data Sharing** | |
| How will you share the data? | The thesis will be publicly available through the UEL Research Open Access Repository. Consent for this will be gained prior to interview.<br>Anonymised full transcripts will not be shared in order to protect participant confidentiality as it is likely to contain sensitive information. |

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| | Excerpts and quotations from the transcripts will be shared within the thesis, however, these will be monitored carefully for identifiable information and this will be changed or deleted prior to submission. |
| Are any restrictions on data sharing required? | Only anonymised data will be shared. Only anonymised data will be included in the thesis write up and any subsequent publications or presentations resulting from this. No identifiable data (MS Teams recordings) will be shared.<br>Data will only be shared where informed consent has been gained. Consent can be revoked at any time and if any participant revoked their consent, their data will not be shared. |
| **Selection and Preservation** | |
| Which data are of long-term value and should be retained, shared, and/or preserved? | Any audio or video files created from the MS Teams interviews will be transcribed and immediately deleted from the secure OneDrive server.<br>Electronic copies of consent forms will be kept until the thesis has been examined and passed. After this they will be immediately deleted.<br>Anonymised transcripts from the interviews will be retained for up to three years by the research supervisor on UEL OneDrive for future dissemination purposes. After this time, all research data will be deleted. |
| What is the long-term preservation plan for the data? | Any MS Teams recordings will be deleted immediately after they have been transcribed for analysis.<br>Anonymised data and transcripts will be deleted by the researcher after the thesis has been examined and passed, at which time they will be deleted from the researchers account. The thesis supervisor will store any anonymised data and transcripts for up to three years on their UEL OneDrive in order to keep this data for possible publication. After three years, all data will be deleted.<br>Personal data will only be kept for the necessary time period i.e., the duration of the project or for those who consent to being contacted for future research, for up to three years after the completion of the project. This includes consent forms. |

|  |  |
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|  | The thesis, which will include write ups of the transcripts, will be stored in the Research Open Access Repository (as outlined in the UEL Research Data Management Policy). |
| **Responsibilities and Resources** |  |
| Who will be responsible for data management? | Kayleigh Mulqueen<br>Dr Trishna Patel |
| What resources will you require to deliver your plan? | UEL OneDrive for Business<br>Microsoft Office Software<br>MS Teams |
|  |  |
| **Review** |  |
|  | **Please send your plan to researchdata@uel.ac.uk**<br>**We will review within 5 working days and request further information or amendments as required before signing** |
| Date: 22/03/2023 | Reviewer name: Joshua Fallon<br>Assistant Librarian RDM |

## Appendix G: Debrief Sheet

### PARTICIPANT DEBRIEF SHEET

Exploring transgender and gender diverse people’s experiences of UK mental health services

**Kayleigh Mulqueen**
**U2195622@uel.ac.uk**

Thank you for participating in my research study on the experiences of transgender or gender diverse people with mental health services. This document offers information that may be relevant in light of you having now taken part.

**How will my data be managed?**

The University of East London is the Data Controller for the personal information processed as part of this research project. 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. 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 may also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) 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. Any information that may be personally identifying will be amended or deleted when the interview transcripts are typed up.

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 Trishna Patel 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 upset or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, upsetting 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:

| **Organisation** | **About the Organisation** | **Contact Details** |
|---|---|---|
| The Beaumont Society | UK registered charity – "We are the largest and longest established transgender support group in the UK, and have developed a support network which has been at the forefront of the transgender, transvestite, transsexual and cross-dressing community since 1966!"<br>Their information line can provide "the telephone numbers of all the societies regional organisers who are available to speak to for advice, details of where to go for a good night out – even a friendly ear to listen". | Telephone:<br>**01582 412220**<br>*24/7 365 days a year information line*<br>Website:<br>http://www.beaumontsociety.org.uk/<br>Enquiries or emails via contact form:<br>http://www.beaumontsociety.org.uk/contact.html |
| The Clare Project | UK registered charity based in Sussex.<br>"The Clare Project provides a variety of support options for the trans, non-binary, and intersex (TNBI) community in Brighton and across Sussex. Over the years, we have welcomed thousands of TNBI people through our doors, regardless of their gender identity, gender expression, or biological sex variation."<br>They run socials in person and online, workshops, trainings and creation of resources. | Telephone:<br>07464 229395<br>Website:<br>https://clareproject.org.uk/<br>Email:<br>info@clareproject.org.uk<br>Address:<br>The Clare Project,<br>c/o Dorset Gardens<br>Methodist Church<br>Brighton<br>BN2 1RL |
| Gendered Intelligence | Gendered Intelligence, established in 2008, is a registered charity that works to increase understandings of gender diversity and improve the lives of trans people.<br>Our vision is of a world where diverse gender expressions are visible and valued, and where trans, non-binary, gender diverse and gender questioning people live healthy, safe and fulfilled lives. | Telephone:<br>**0330 3559 678**<br>For anyone who is personally impacted (including family and friends) by the NHS gender care waiting list and is in need of support and information. |

| | | |
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| | We are a trans-led and trans-involving grassroots organisation with a wealth of lived experience, community connections of many kinds, and a depth and breadth of trans community knowledge that is second to none. | Website:<br>https://genderedintelligence.co.uk/<br><br>Enquiries or emails via contact form:<br>https://genderedintelligence.co.uk/contact/contact.html<br><br>Address:<br>**VAI,**<br>**200a Pentonville Road,**<br>**London**<br>**N1 9JP** |
| Mermaids | Mermaids has been supporting transgender, nonbinary and gender-diverse children, young people, and their families since 1995.<br><br>Mermaids has evolved into one of the UK's leading LGBTQ+ charities, empowering thousands of people with its secure online communities, local community groups, helpline services, web resources, events and residential weekends.<br><br>They also seek to educate and inform wider society on gender identity by helping professionals accommodate and reassure gender-diverse young people. | Telephone:<br>08088010400<br>Monday to Friday 9am – 9pm<br><br>Website:<br>https://mermaidsuk.org.uk/<br><br>Email:<br>**info@mermaidsuk.org.uk**<br><br>WebChat:<br>https://mermaidsuk.org.uk/contact-us/<br>Monday to Friday 9am – 9pm<br><br>TextChat:<br>Text **MERMAIDS** to **85258** for free 24/7 crisis support all across the UK. |
| Mindline Trans+ | Mindline Trans+ is an emotional and mental health support helpline for anyone identifying as transgender, non-binary, genderfluid.<br><br>Also support family members, friends, colleagues and carers. | Telephone:<br>0300 330 5468<br>Mondays & Fridays 8pm-midnight<br><br>Website:<br>https://mindlinetrans.org.uk/ |
| Stonewall | **"At Stonewall, we stand for lesbian, gay, bi, trans, queer, questioning and ace (LGBTQ+) people everywhere. We imagine a world** | Website:<br>https://www.stonewall.org.uk/<br><br>Email: |

| | | |
|---|---|---|
| | **where all LGBTQ+ people are free to be themselves and we can live our lives to the full.**<br>We are part of a vibrant global movement for change made up of LGBTQ+ people, our allies, families and friends. Since day one, we've fought for freedom, for equity and for potential.<br>Over the last 30 years, we have helped create transformative change in the lives of LGBTQ+ people in the UK. Today, we have equal rights to love, marry and have children, and our lives, families and relationships are represented as part of the national curriculum in most of the UK." | Info@stonewall.org.uk<br>Information service – not a support line<br>Address:<br>Stonewall,<br>192 St. John Street,<br>London,<br>EC1V 4JY |
| Switchboard LGBT Helpline | "At Switchboard we provide an information, support and referral service for lesbians, gay men and bisexual and trans people and anyone considering issues around their sexuality and/or gender identity." | Telephone:<br>0300 330 0630<br>Open 10:00-22:00 every day<br>Website:<br>https://switchboard.lgbt/ |
| Further information and support services can be found here: https://www.gendergp.com/support-services/<br>However, if you are in a crisis and in need of immediate assistance, you can call the Samaritans on 116 123 who offer free and immediate confidential support from trained workers.<br>In an emergency please call 999 or attend your nearest Accident and Emergency department. | | |

**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.

Kayleigh Mulqueen
Email: U2195622@uel.ac.uk

If you have any questions or concerns about how the research has been conducted,
please contact my research supervisor Dr Trishna Patel, School of Psychology,
University of East London, Water Lane, London E15 4LZ,
Email: t.patel@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 H: Study Advertisements

University of East London

# Exploring Transgender and Gender Diverse People's Experiences of UK Mental Health Services

People who identify as transgender or gender diverse utilise mental health services for a variety of reasons. However, research has shown that service providers have little knowledge about this population.

We want to find out about transgender and gender diverse people's experiences of UK mental health services. We hope that by hearing from the people affected, we can understand how to change practice to make experiences of mental health services better.

We want to speak to people who identify as transgender or gender diverse, are over 18, living in the UK and have experience of using UK mental health services.

Interviews will be on Microsoft Teams for around 1 hour. You can also enter a prize draw to win a £50 Amazon voucher for your participation.

**To participate in this study or for more information, please email Kayleigh Mulqueen at u2195622@uel.ac.uk**

**All contact will remain confidential.**

University of East London

# Exploring Transgender and Gender Diverse People's Experiences of UK Mental Health Services

We are hoping to study the experience of transgender and gender diverse people who have used UK mental health services.

We hope that by hearing from the people affected, we can find ways to make your experiences of mental health services better.

We want to speak to people who identify as transgender or gender diverse, are over 18, living in the UK and have experience of using UK mental health services.

Interviews will be on Microsoft Teams for around 1 hour.
You can also enter a prize draw to win a £50 Amazon voucher for your participation.

**To participate in this study or for more information, please email Kayleigh Mulqueen at u2195622@uel.ac.uk**

**Any contact will remain completely confidential.**

## Appendix I: Demographics Information

What is your age?

How would you describe your gender?

How would you describe your ethnicity?

Are you currently in contact mental health services?

When was the last time you were in contact with mental health services?

What age were you for your first contact with mental health services?

## Appendix J: Interview Schedule

**[Before turning on recording]**
Confirm consent for recording following signing of the consent form. Checking participant still consents to this. Brief explanation about the content of the interview and explanation of right to withdraw or pause or reschedule at any point.

**[Once recording has begun]**
Thank you for agreeing to take part in this research. As you already know, this research will be focused on your experiences of mental health services as someone who identifies as [transgender or gender diverse]. Anything you discuss with me today will remain confidential and there will be no judgement based on any of your responses. My hope is that we can have an open and honest conversation about your experiences. Firstly, can I ask…

1. Could you tell me what terminology you prefer to identify yourself by?

2. Could you tell me about how you came to be in contact with mental health services?

   Prompts:
   *How did you decide to contact mental health services?*
   *How many times have you been in contact with mental health services?*
   *Which mental health services have you been in contact with?*

3. What has been your experience of using these mental health services?

   Prompts:
   *How have you found the process of getting in contact with mental health services? Do you feel that mental health services have been equipped to meet your needs?*

4. If needed, would you feel comfortable to use mental health services again?

   Prompts:
   *Why or why not?*
   *What has impacted on this decision?*

5. How has your experience of mental health professionals been?

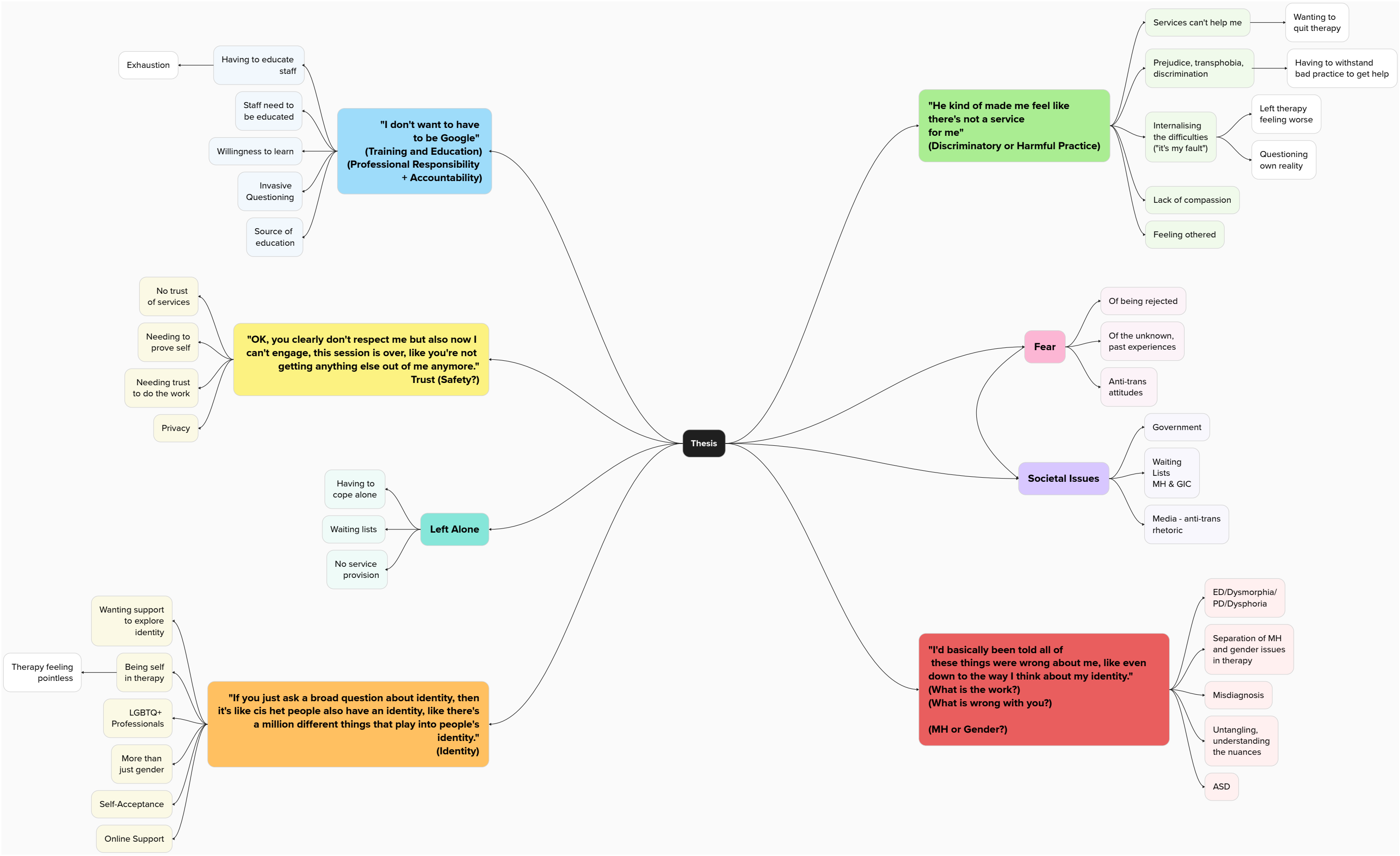
6. What would you change about your experiences of mental health services?

7. Has your experience of mental health services had any impact on your general wellbeing?

8. Is there anything that has stopped you from accessing mental health services?

9. Is there anything you would like to speak about with regard to your experience of mental health services that we haven’t spoken about?

# Appendix K: Initial Thematic Map



## Appendix L: Example of Coded Extract

KM: *That's really helpful. You've mentioned a few experiences – CBT, DBT. What was your first therapeutic experience?*

PPT 9: I think I had a bit of counselling first, so they kind of were like establishing, you know, like the, the, I don't know, like the building blocks. They were like, how is your eating? Like, how's your sleep? And like what actually are you? What? What is wrong with you? And I was like. I kind of had eating problems, but again, they stemmed from the gender. Like it literally was like everyone seems to be like- I had to lie, like it probably wasn't really a lie, but I used to just be like, oh, well, it's just a control thing. I just want some control over my life, but like it wasn't. It's because I wanted no tits and I'd read about it and I was like, if I just didn't eat like they wouldn't grow and that just didn't happen. And I didn't lose any weight, like I literally just didn't eat. And then I was just tired all the time and miserable and starving and nothing changed. And I mean like, my periods never stopped either, like in the- nothing that I did actually like changed the fact that I was literally just going through puberty, and no one would just notice that and give me puberty blockers. There was always a problem, always an obstacle, and I was like, they're reversible. I was like, if you just- it's like, it wasn't even like I was not gonna go on testosterone. I was like if you just given me puberty blockers rather than prescribing me, like weird medication and being like "ohh like you've got control problems" like then I probably would have just been fine. Like I literally would have just not had any of the problems that I did have. Like nothing would have stemmed from it. So they were like, "oh, well, well, we'll get you on some sort of eating program". And I was like my eating's fine. Like I'm choosing to not eat like I don't have any mental illness around my eating.

Eating problems due to gender dysphoria

Feeling unable to be honest with MHPs

Wanting to change their body

Not being listened to or understood

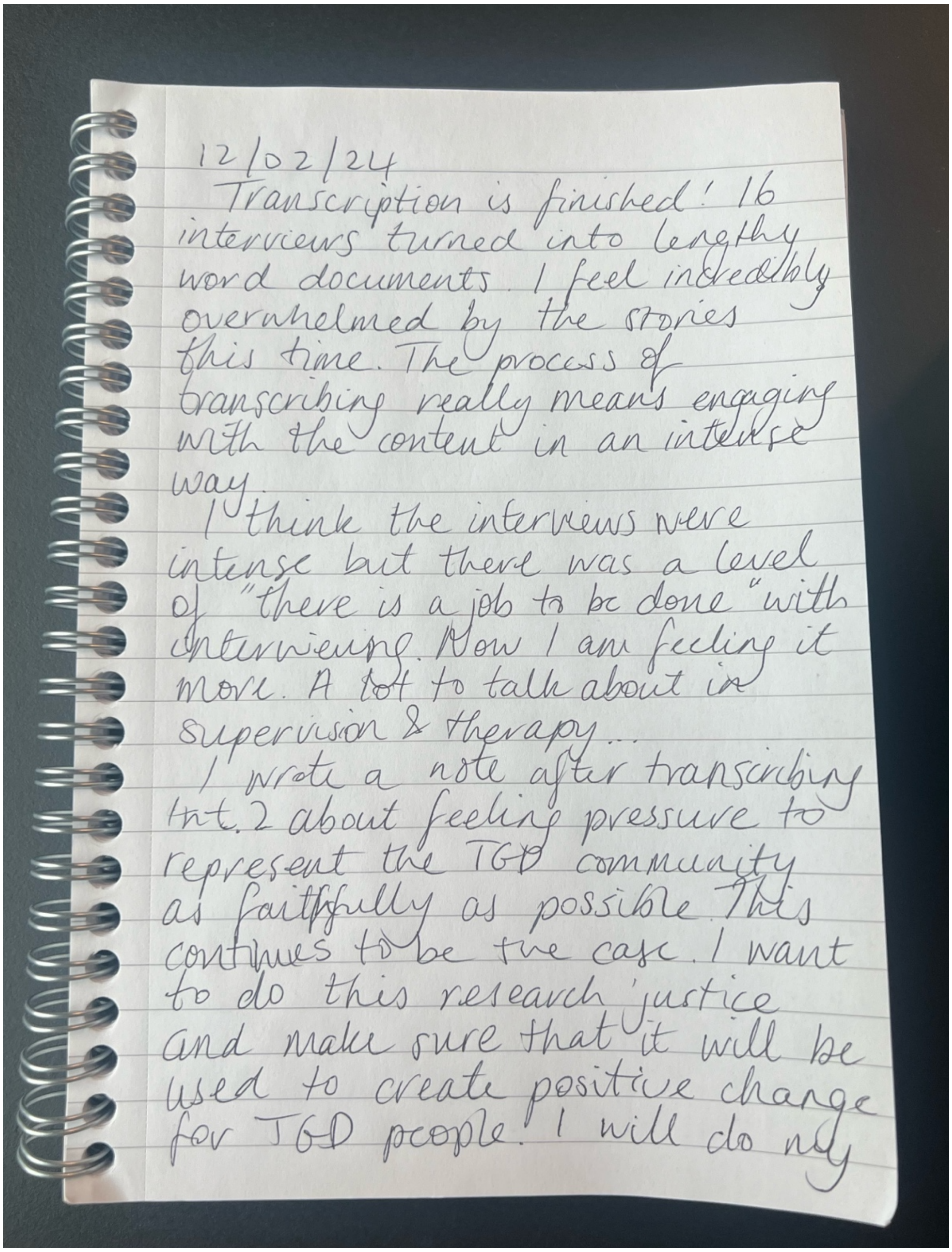
Things always feeling difficult

Getting the wrong treatment

MHPs not understanding what is going on

Gender dysphoria rather than mental health difficulties

## Appendix M: Extract of Researcher’s Reflective Journal



12/02/24

Transcription is finished! 16 interviews turned into lengthy word documents. I feel incredibly overwhelmed by the stories this time. The process of transcribing really means engaging with the content in an intense way.

I think the interviews were intense but there was a level of "there is a job to be done" with interviewing. Now I am feeling it more. A lot to talk about in supervision & therapy...

I wrote a note after transcribing Int. 2 about feeling pressure to represent the TGD community as faithfully as possible. This continues to be the case. I want to do this research justice and make sure that it will be used to create positive change for TGD people! I will do my