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Working with Gender and Sexual Diversity

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Declaration

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Glossary of Terms

Assigned gender refers to the gender a person was assigned at birth (or in utero).

Gender identity refers to a person's felt sense of their gender. A person's gender identity can be male, female, a mix of the two or neither.

Gender expression refers to the way an individual expresses their gender identity.

Gender presentation refers to a person's presentation of their gender e.g. through clothing or mannerisms

Sex refers to a person's biological characteristics i.e. chromosomes, hormones, genitalia and reproductive organs which are associated with being either male or female.

Gender variance refers to gender behaviour or expression which is seen to deviate from the 'conventional gender norms'. This is sometimes described as **gender nonconformity.**

Gender diversity refers to the fair representation of genders including trans and non-binary gender categories

Gender binary refers to the idea that there are two separate gender categories: male and female

Gender incongruence is when someone experiences their gender identity differently to the sex they were assigned at birth.

Transgender or Trans person is someone who experiences some degree of gender incongruence.

Transgendered is the noun of **transgender** but is widely considered to be inappropriate and viewed by some as offensive.

Cisgender or Cis person is someone who feels that the sex they were assigned at birth matches their gender identity.

Trans man refers to a person who was assigned female at birth but identifies as a man.

Trans women refers to a person who was assigned male at birth but identifies as a woman.

Non-binary person refers to someone who experiences their gender identity outside the binary terms of male and female.

Transition refers to the process of altering gender expression and presentation to match gender identity. This can involve social, medical and surgical changes, depending on the individual, but not necessarily all three.

Gender dysphoria refers to the distress experienced when an individual perceives a disparity between their biological sex and their gender identity. This term is used by some medical professionals as a diagnosis.

Real-life experience refers to a period of time during which a trans person lives full-time in their actual gender.

Actual gender (previously referred to as **preferred gender**) is used to describe a person's experience of their gender rather than their sex assigned at birth.

Affirmed gender (previously referred to as **acquired gender**) is used to describe a person's gender status post-transition.

Gender confirmation surgery refers to various types of surgery that trans people can undergo during transition.

Transsexual is an outdated term predominately used by medical professionals to describe people who transition, often (but not always) involving hormones and/or surgery. Although some people still use this term many see it as inappropriate and instead prefer either **transgender** or **trans**.

Transsexualism is the noun of **transsexual** and is used by some medical professionals as a diagnosis.

Transphobia refers to irrational fear or dislike of trans people resulting in prejudice and discrimination.

Gay relates to being exclusively attracted to people of the 'same gender'

Heterosexual relates to being exclusively attracted to people of the 'other gender'

Heternomativity refers to the belief that being heterosexual is 'normal' and other sexual orientations are ‘abnormal’.

Heterosexism refers to discrimination against non-heterosexual people

Cisnormativity refers to the belief that being cisgender is the norm.

Cisgenderism refers to the assumption that there are only two genders and that a person’s gender identity should match their biological sex.

Throughout this portfolio, I have endeavoured to use the language and terminology preferred by the LGBT community. Particularly within the transgender field, terminology is varied and constantly evolving, and keeping up with this continually shifting lexicon can be challenging (Burdge, 2007). I am aware that even with the best intentions, I may inadvertently offend someone or even a group of people (Richards & Barker, 2013). I have therefore sought feedback from as many people as possible regarding the terms I use and made adjustments accordingly. When referring to specific participants, personal pronouns were always used according to their individual preference.

Preface

This portfolio contains three pieces of work presented in fulfilment of the requirements for the Counselling Psychology Doctorate programme at City University London. It is primarily focused on the theory and practice of counselling psychology, with an emphasis on working with gender and sexuality.

This portfolio illustrates my journey on the road to becoming a counselling psychologist and my development as both a reflective-practitioner and a scientist-practitioner. It also reflects my developing passion for psychosexual and gender therapy, and my enthusiasm for work with LGBT clients. The experiences of LGBT people are often collated in the literature. However, it is important to acknowledge that although gender and sexuality are linked, they are also independent from one another.

I will outline each section of the portfolio and discuss some of the common threads that link the three parts together. I will also reflect on some of the personal and professional issues that motivated me to choose this research topic.

The first section presents my doctoral research project which investigates how trans people experience healthcare and psychological services during transition. This study aims to give the transgender community a voice, and to further inform counselling psychologists and other healthcare professionals of the needs of this client group with a view to informing future treatment in this area. Interpretative phenomenological analysis (IPA) was employed in order to capture the subject experience of the participants. Data was gathered through semi-structured interviews conducted in person by the researcher. Three master themes and 10 sub-themes emerged from the analysis of the data, which represent my understanding and interpretation of the lived experience of the participants. The results are discussed in relation to existing research and literature, and clinical implications are considered.

The second section presents an example of my clinical work within professional practice in the form of a case study. This study outlines my work with a gay client presenting with psychosexual difficulties. This case study illustrates how I link psychological theory to clinical practice whilst working within a cognitive-behavioural framework. It also demonstrates my ability to work reflexively and tailor therapy to the individual needs of the client.

I chose to present this particular client as it was a challenging yet rewarding piece of work that encouraged me to think creatively, and it illustrates my willingness to learn and expand upon my professional development. When I started working with this client, I was surprised by the lack of evidenced-based research for treating LGBT people with psychosexual difficulties. Elements from this client study are reflected in both the literature review and the results of the research project, particularly in relation to the importance of adopting an affirmative stance. Although I tend to think of myself as an integrative therapist – and my clinical practice is informed by person-centred, psychodynamic, and cognitive-behavioural theory – my primary approach is cognitive behavioural therapy (CBT). I believe my growing enthusiasm for this model is evidenced throughout the portfolio, and particularly in this case study.

The final section takes the form of a publishable paper summarizing the key findings from the research project, and focusing on the final master theme – "Survival" – which I believe has important implications for counselling psychology. I decided to focus on one master theme rather than trying to present a full summary of the findings, as I felt that this would allow me to represent the participants' experiences in more detail and to discuss the implications in greater depth.

The theme "Survival" highlights the importance of trans people developing specific coping strategies in order to manage the difficulties associated with transition and negotiating obstacles to treatment. Hearing how participants overcame challenges and fostered resilience is especially useful for counselling psychologists as it can help us understand how to better support trans individuals within therapy. This article is intended for submission to the *International*

Journal of Transgenderism, and therefore follows the guidelines for manuscripts set out by this journal.

My enthusiasm for gender and sexuality has grown and developed over the last 3 years. When I began my training at City University, I was eager to develop an interest across a broad range of areas within counselling psychology. My plan was to gain as much experience as possible working within a broad variety of clinical settings. I suspect that this was partly because I found the prospect of specializing somewhat daunting.

I started seeing a trans client in 2014 while I was in my first year of training. When we first started working together, I knew very little about trans issues, and neither did my clinical supervisor. Consequently, I had to do a substantial amount of reading and research around the topic. The individual in question was my first adult client on the course, and someone I worked with on a weekly basis for over a year. I was continually struck by my client's strength and determination. My work with this client had a profound impact on me. Above all it taught me the importance of developing a strong therapeutic relationship. He was surrounded by people who were ill-informed, and, despite my best efforts to educate myself, I often felt inadequate. I felt frustrated by the lack of understanding around trans issues – both my own and that of others – and I think this became one of the primary motivators for conducting this research. Additionally, my client had expressed dissatisfaction with the healthcare support he had received, and I was eager to learn more about the experiences of other trans individuals and their perceptions of healthcare and therapeutic services.

At the beginning of my second year, I started a placement at a psychosexual service. This service primarily treats persistent sexual problems, but also provides support for people with gender-related difficulties. I was therefore given further opportunity to work with trans clients. Towards the end of my second year, I decided to apply for a placement with a gender clinic, and began working there as a trainee a few months later. I thoroughly enjoyed my work at the psychosexual service, and I decided to stay on. By the end of my third year, I had become completely immersed in gender and sexuality, and I soon realized that this was an area I could see myself working in full time. I surprised myself, as I had not expected to specialize so early on and before I had properly begun my career. However, I found that the more I worked and the more I read, the more my interest and enthusiasm grew. I suddenly understood the attraction of focusing on one area, and was excited by prospect of one day becoming an expert in the field.

While working at the psychosexual service and the gender clinic, I began to realize how pervasive and damaging heteronormativity is in our society. Heteronormativity relates to the assumption that being heterosexual is the norm and therefore adheres to the traditional binary male and female gender roles. These notions are harmful, as they imply that people who are LGBT are somehow abnormal or unnatural. Although there is extensive literature on working therapeutically with LGBT people, this appears to be largely focused around the importance of adopting an affirmative approach. There seemed to be a lack of literature that explored adapting specific interventions for these clients. For example, most of the available resources on sexual dysfunction focus on heterosexual sex. When working with LGBT clients, I have had to make adjustments to the standard CBT and psychosexual interventions in order to make sure they were relevant and appropriate, as illustrated in the client study.

The main theme that permeates this portfolio is a commitment to understanding how to provide high-quality psychological therapy for LGBT clients that is tailored to their individual needs. I hope that the development of this portfolio will not only enhance my own clinical practice, but also, if disseminated appropriately, contribute to academic discourse, spark future research, and potentially initiate changes to therapeutic practice.

Section A: Research Project

How do trans people experience healthcare and psychological services during transition?

Abstract

This research project aims to explore trans people's experience of healthcare and psychological services in the UK, with a view to helping further inform counselling psychologists and other healthcare providers of the specific needs of this client group, with implications for improving future treatment and support in this area. In the past, trans people have frequently reported experiencing difficulties when accessing healthcare and psychological support. Much of the research carried out in the UK has involved large-scale studies conducted online. Consequently, there is a need for a project using a qualitative design to explore in depth the lived experiences of this population. Semi-structured interviews were conducted with 9 participants, and the data was analysed using interpretative phenomenological analysis (IPA). The sample comprised 4 trans men and 5 trans women between the ages of 18 and 62 years old. Three master themes emerged from the data: "Challenges of Living", "Negotiating Care", and "Survival". A further 10 sub-themes were also identified. These results represent my personal interpretation of the participants' subjective experiences. The findings were explored in relation to existing theory and literature. Implications for clinical practice and considerations for working therapeutically with trans people were considered. Specifically, recommendations aimed at helping trans people feel more visible and empowered were presented. The importance of helping trans clients build resilience and develop coping strategies was also discussed.

1. Introduction

1.1 Overview

This first section aims to explore and define issues around gender and what it means to be trans in western society according to literature resources. The historical context of gender variance and its relationship with the medical and psychiatric professions is considered. The impact of living as a trans person is explored in relation to mental health, minority stress, and stigma. The benefits of adopting a trans-positive therapeutic model is then briefly outlined. This is followed by a review of the recent and relevant literature regarding trans people's experiences of psychotherapy and healthcare. Finally, the aims of the study are summarized, and the clinical relevance is discussed.

1.2 Gender

Within western society, gender plays a significant role both in defining and restricting our social and personal identities (Bolich, 2007). Traditionally, gender has been thought of as binary, expressed as one of two distinct categories: male or female. People are labelled as either "male" or "female" according to their external genitalia. This gender label is assigned as soon as our genitalia become discernible, often before we are even born, and usually by a medical professional (Bornstein, 2013; Burdge, 2007). It has been argued that gender classifications are social constructs that can be both oppressive and disempowering (Burdge, 2007). Some theorists argue that gender is not simply a static classification, but a mode of activity, which people perform within the context of social interaction (Butler, 1990).

While "sex" refers to a person's distinctive biological characteristics – that is, chromosomes, hormones, genitalia, and reproductive organs – "gender" refers to a socially defined role, as well as position, and an individual's felt sense of who they are (Bornstein, 2013; Burdge, 2007; Wood, 2012). The distinction between sex and gender has only been widely acknowledged relatively recently and was popularized by psychologists and feminists in the late 1960s (Mikkola, 2016).

Writing in 2007, Bolich asserted that gender and sex are commonly viewed as interchangeable, and the notion that gender is determined by our biology is rarely questioned. While the majority of individuals experience their gender identity as aligned with their biological sex, some people experience their gender identity as incongruent with their natally assigned sex (Hendricks & Testa, 2012).

1.3 Transgender

"Transgender" is an umbrella term (Hunt, 2014; Lev, 2004; Stryker, 2006), which encompasses a wide range of individuals who experience their gender identity as different to their biological sex (Burdge, 2007). Some transgender people identify as male or female, while others feel that they do not fit within the traditional gender binary – for example, those who identify as "non-binary" or "gender queer". "Transgender" (or "trans") has come to replace other labels such as "transsexual" and "transvestite" (Carroll & Gilroy, 2002), the term "transsexual" in particular being viewed by some as inappropriate, since it is used as a psychiatric diagnosis, and can therefore be seen as pathologizing (Hale, 2007; Stryker, 2006).

Some transgender people seek to alter their gender expression so that their outward appearance matches their felt sense of who they are. This process is referred to as "transition", and usually, but not always, involves medical interventions such as hormones and/or surgery. In the UK, as with many other countries, trans people who wish to transition are required to undergo a formal assessment with a mental health practitioner in order to access hormone therapy or gender confirmation surgery (Ellis, Bailey, & McNeil, 2015). "Gender dysphoria" is a mental health diagnosis that refers to the distress experienced when an individual perceives a disparity between their assigned sex and their gender identity.

1.4 The Pathologization of Gender Variance

"Gender identity disorder" (GID) first appeared in the DSM (American Psychiatric Association) in 1980, not long after "homosexuality" was removed as a psychiatric diagnosis (Cooper, 1999). In 2013, GID was removed from the DSM-V and replaced with “gender dysphoria”. This new diagnosis was seen as preferable, since it seemed to carry less stigma. Unlike GID, gender dysphoria does not pathologize non-identification with the gender assigned at birth, but instead reflects the distress experienced by some trans people (Applegarth & Nuttall, 2016). “Transsexualism” is currently included as a diagnosis in ICD-10 (World Health Organization, 1992). However, it is likely that when ICD-11 is released, “transsexualism” will be replaced with “gender incongruence” (Drescher, Cohen-Kettenis, & Reed, 2016).

Mental health practitioners currently control trans people’s access to medical interventions and treatment (Bess & Stabb, 2009; Ellis et al., 2015; Rachlin, 2002). Clinicians who work with trans clients are often seen as “gatekeepers” and viewed with suspicion by many in the transgender community (Carroll, Gilroy, & Ryan, 2002). Trans people who wish to transition in the UK are first required to attend a number of appointments with a mental health professional, usually at a gender identity clinic (GIC). In order to be eligible for hormone therapy or surgery, they need to be endorsed by a clinician, who conducts a formal assessment and subsequently writes a letter of recommendation. This can often be a frustrating and disempowering process for trans people (Coolhart, Provancher, Hager, & Wang, 2008; Rachlin, 2002).

Some theorists believe that mental health diagnoses are unhelpful and disempowering. Foucault (1965) proposes that within western society, psychiatric diagnosis serves to position patients as deviants in order to exert institutionalized social control. Many have argued against clinical labels such as “gender dysphoria” and “transsexualism” as they pathologize, stigmatize, and dehumanize (Carroll et al., 2002; Hale, 2007; Lev, 2006). Furthermore, Burdge (2007) suggests that pathologizing behaviours that deviate from the gender binary reinforces gender stereotypes (Burdge, 2007). Gainor (2000) argues that the psychiatric profession has failed to take into account the impact of living in a society that oppresses gender non-conforming people. It therefore seems unsurprising that trans people experience distress and discomfort in relation to their gender when we consider the stigma and discrimination to which they are exposed (Gainor, 2000; Sennott, 2010).

However, receiving a diagnosis currently remains the only avenue available to trans people seeking gender affirmation (Burdge, 2007; Lev, 2006). According to Butler (2004), receiving a diagnosis simultaneously enables and restricts trans people. She argues that being labelled in this way can significantly alleviate distress by permitting access to the necessary treatment, while at the same time increasing distress by allowing one's gender experience to be defined as mentally disordered. Trans people must endure the stigma associated with mental illness in order to be eligible for medical treatment (Butler, 2004). However, it has been argued that continuing to allow gender variance to be pathologized is a small price to pay to ensure that gender affirmation interventions remain readily available to those who would be unable to afford private treatment (Lev, 2006).

1.5 Gender Variance Across Cultures

People who do not conform to the binary gender model have historically been pathologized and stigmatized in western society (Coolhart et al., 2008; Gainor, 2000; Lev 2004). However, there is evidence that other cultures have not always had such an intolerant attitude towards gender variance (Brown & Rounsley, 1996; Gainor, 2000; Lev, 2004). A range of atypical gender behaviour and expression has been documented across a variety of cultures and societies (Feinberg, 1996; Newman, 2002). India's mythologies and ancient texts demonstrate a tolerance for gender and sexual diversity (Kalra, 2012). *Hijra* individuals (transgender people) have been recognized and established within Indian society for thousands of years and are thought to possess special powers that allow them to bless others with luck and fertility (Kalra, 2012). In some ways, Hijra are similar to trans women. However, although they tend to adopt feminine roles, they do not identify with either of the sexes, and prefer to think of themselves as the "third gender".

Fa'afafine, literally meaning "in the manner of a woman", are accepted within Samoan society (Vasey & Bartlett, 2007). Fa'afafine are assigned male at birth, but tend to present as feminine (Vasey & Bartlett, 2007). In French Polynesia, there exists the gender variant *Mahu* and *RaeRae*. Mahu are not considered to be men or women, but rather "half-men/half-women" (Stip, 2015, p. 193). Zanghellini (2010) defines the Mahu as male-bodied, non-operative, transgender Polynesians, whereas the RaeRae might include those who undergo hormone therapy and/or surgery (Stip, 2015). Mahu are accepted in society as a distinct gender, and they play specific social roles, including parental practices of fostering or adoption. Cross-gender behaviour has also been noted within Native American cultures. Two Spirit people have gender identities that combine the masculine and feminine, and are therefore seen as spiritually blessed (Lang 2016).

1.6 Prevalence of Gender Variance

It is notoriously difficult to accurately estimate the UK transgender population. Burdge (2007) suggests that this may be because many trans people need to conceal their true gender identities due to fear of persecution and/or discrimination. In addition, most of the statistics on transgender people are gathered by counting the number of referrals to gender clinics (Reed, Rhodes, Schofield, & Wylie, 2009). Therefore, these numbers will only represent those trans people who wish to transition, and will not include those who experience gender variance, but do not seek medical intervention (Winter et al., 2016). Whittle, Turner, and Al-Alami (2007) report that estimates of the number of self-identified trans people in the UK vary considerably from 1 in 100 to 1 in 20. A study conducted by Wilson, Sharp, and Carr (1999) found that the prevalence of gender dysphoria in Scotland was 8.18 per 100,000. The results revealed that almost one-third (31%) of patients with gender dysphoria had presented within the past year. On the basis of this finding, the authors concluded that the number of individuals seeking medical care for gender dysphoria was on the increase (Wilson et al., 1999). The most recent study on gender variance in the UK estimates the transgender population to be approximately 300,000, of which 56,000 are estimated to be people with gender dysphoria (Reed et al., 2009). In 2007, 10,000 people had presented with gender dysphoria. According to Reed et al. (2009), the number of individuals presenting was then growing at a rate of

15% per annum. Since it appears that no further large-scale study has been conducted in the meantime, it is extremely difficult to establish a current estimate of the prevalence of gender variance.

1.7 Mental Health Problems

A number of authors have suggested that rates of anxiety and depression are particularly high amongst transgender patients (Bockting & Coleman, 1993; Gainor, 2000; Lev, 2004). Trans people are also recognized as an at-risk group for suicide attempts and suicidal ideation (Hunt 2014; Maguen & Shipherd 2010; McNeil, Bailey, Ellis, Morton, & Regan, 2012; Nodin, Peel, Tyler, & Rivers, 2015; Virupaksha, Muralidhar, & Ramakrishna, 2016). A recent study found that suicidal tendencies are significantly higher amongst trans people compared to the general population (Virupaksha et al., 2016). Newfield, Hart, Dibble, and Kohler (2006) found that trans men in the United States reported significantly diminished quality of life, particularly in relation to mental health. Similarly, Budge, Adelson, and Howard (2013) found that rates for anxiety and depression were considerably higher for transgender individuals in the United States than for the general population. Fifty-one per cent of trans women and 48% of trans men reported depressive symptoms; while 40% of trans women and 47% of trans men reported anxiety symptoms (Budge, Adelson, & Howard, 2013).

McNeil et al. (2012) conducted a large-scale survey on trans mental health. Of the respondents who answered the questions relating to rates of current and previous instances of mental illness, 88% described experiencing depression, and 75% described experiencing anxiety. Fifty-three per cent of respondents reported engaging in self-harm, 48% stated that they had attempted suicide at least once, and 84% reported that they had thought about suicide at some point. Similarly, a recent study conducted by Nodin et al. (2015) examined mental health risk and resilience amongst young LGBT people. The survey found that 48% of transgender respondents under the age of 26 had attempted suicide, with 30% of these occurring during the last year. These rates are considerably higher than those for cisgender young people, which were reported as 26% for overall suicide attempts, with 7% occurring during the last year. On the other hand, Cole, Boyle, Emory, and Meyer (1997) found that trans individuals are no more likely to have a comorbid psychiatric illness than the general population. The authors argue that while many trans people may experience transient bouts of depression or anxiety, they do not report higher instances of severe psychopathology, such as schizophrenia or major depression.

Cole et al. (1997) noted that participants perceived themselves as happier, more confident, and more productive once they had acknowledged their gender dysphoria and sought support. According to McNeil et al. (2012), both suicide attempts and suicidal ideation reduced considerably after transition. Similarly, 74% of participants felt that their mental health improved once they had transitioned, compared to only 5% who reported that it got worse (McNeil et al., 2012).

While early models of "transsexualism" view it as an illness with emotional and psychological consequences, more recent models regard such consequences as stemming from social rejection, discrimination, and lack of understanding, and emerging perspectives on gender variance are moving away from the transsexual model towards the transgender model (Denny, 2004). Similarly, Bockting (2009) describes a paradigm shift within transgender health away from a disease-based model towards an identity-based model. Virupaksha et al. (2016) argue that high instances of psychological distress and suicidal behaviour among transgender people appears to be greatly influenced by external factors such as lack of social support, discrimination, societal stigma, and violence-related issues.

1.8 Stigma

The negative impact of stigma is universally acknowledged. According to Goffman (1963), a stigma is an attribute that marks out an individual as "different from others in the category of persons available for him to be", and thus reduced in the minds of others "from a whole and usual person to a tainted, discounted one" (p. 12). In this way, the stigma creates a discrepancy between an individual's virtual – that is, normally anticipated – social identity, and his or her actual social identity. According to Goffman, "this discrepancy, when known about or apparent, spoils his social identity; it has the effect of cutting him off from society and from himself so that he stands a discredited person facing an unaccepting world" (Goffman, 1963, p. 31). As a result, the stigmatized individual is subject to various kinds of discrimination, which in effect reduce his or her life chances. Furthermore, Goffman (1963) argues that when the stigmatized person is continually discredited by others, the targeted individual can end up internalizing this lack of respect, coming to believe that it is somehow warranted.

1.9 Transphobia

Transgender people are not only discounted and misunderstood within society (Burdge, 2007), but they are also frequently exposed to transphobia and active hostility. This is regarded as a reflection of society's reluctance to re-examine established notions of sex and gender. According to Gainor (2000), "the mere existence of people who define their gender roles with greater flexibility may be experienced by those who do not have that flexibility as disquieting and even personally disruptive" (p. 133). Similarly, Butler (2004) argues that transphobic individuals see trans people as threatening, as they undermine their sense of world and sense of self. Butler proposes that these individuals hold "a profound desire to keep the order of binary gender natural or necessary, to make of it a structure, either natural or cultural, or both, that no human can oppose, and still remain human" (p. 35).

1.10 Minority Stress

Despite the fact that transgender awareness has increased and trans people are becoming more prominent in LGBT communities, they remain among some of the most marginalized individuals in society (Lev, 2004). Hendricks and Testa (2012) suggest that in addition to experiencing general life stressors, trans people are also especially susceptible to other stressful external and environmental events related to their gender identity or gender expression. As previously mentioned, it is well documented in the literature that trans people experience high levels of violence, stigma, discrimination, harassment, and social isolation

(Bockting, Knudson, & Goldber, 2006; Elder, 2016; Gainor, 2000; Lombardi, Wilchins, Priesing, & Malouf, 2002; Whittle et al., 2007).

Whittle et al. (2007) found that 73% of trans participants experienced one of the following while out in public: inappropriate comments; threatening behaviour; physical, verbal or sexual abuse. In addition, 64% of trans men and 44% of trans women experienced harassment or bullying at school, and 29% of trans respondents experienced harassment at work. Furthermore, 45% of participants reported that their gender identity or gender expression contributed to the breakdown of family relationships, and 36% mentioned that they had a family member who no longer spoke to them.

"Minority stress" has been defined as "psychological stress originating from marginalization in the social environment which potentially contributes to mental health conditions" (Ellis et al., 2015, p. 3). It has been argued that the higher rates of mental health problems reported amongst the transgender population are a result of minority stress (Hendricks & Testa, 2012; Kelleher, 2009). Hendricks and Testa (2012) offer a conceptual framework, based on Meyer's (2003) Minority Stress Model for LGB people, for understanding how minority stress factors affect trans individuals. Hendricks and Testa (2012) discuss three processes by which trans people may be exposed to minority stress. The first process relates to external events that occur as a direct result of an individual's minority status. The second process refers to anticipation or expectation that external stressful events such as violence or discrimination will occur. The third process occurs when negative attitudes and societal stigma are internalized resulting in internalized transphobia. The authors argue that it is important that healthcare professionals have a good understanding of how minority stress impacts trans people's mental health as well as their ability to gain access to and engage in care.

1.11 Trans Positive Models and Affirmative Therapy

There has been a recent shift away from a transphobic psychological paradigm towards a more trans-positive and trans-affirmative model (Raj, 2002). Research suggests that the therapist's ability to be flexible, open-minded, and comfortable is more important than their theoretical orientation (Brown & Rounsley, 1996). Trans-positive models emphasize the importance of building a respectful and supportive therapeutic relationship that affirms and validates all forms of gender and sexual diversity (Raj, 2002). Furthermore, this relationship should be collaborative not adversarial (Raj, 2002).

According to Carroll et al. (2002), therapists working with trans clients should listen attentively, demonstrate empathy, provide a safe environment, validate the client's feelings, and adopt an "informed not knowing" stance. They should refrain from asking invasive or inappropriate questions, and should leave it to the client to broach sensitive topics (Elder, 2016). It is also important to use affirming language, to clarify with the client how they define their gender identity, and to check what their preferred name and pronouns are (Chavez-Korell & Lorah, 2007; Hendricks & Testa, 2012; Raj, 2002).

Affirmative therapists understand that gender variance is natural and represents a normal variation of humanity (Coolhart, et al., 2008; Lev, 2004). Trans-affirmative approaches seek to validate the client's gender identity and gender expression without pathologizing them (Benestad, 2010; Benson, 2013; Chavez-Korell & Lorah, 2007; Lev, 2004). Therapists should support and normalize all types of behaviour (Chavez-Korell & Lorah, 2007) and help the client find an expression of gender that most fits their felt sense (Coolhart, et al., 2008). Benestad (2010) suggests that a therapist can facilitate positive gender belonging by assisting the client to explore their gender identity, while offering knowledge and insight regarding gender expression.

Benestad (2010) emphasizes the importance of being comfortable with gender diversity and developing a good understanding of transgender issues. Affirming therapists should be aware of the role that psychiatric and medical establishments have historically played in perpetuating the binary gender system that positions trans people as outsiders (Carroll et al., 2002). They must also be mindful that mental health professionals are often seen as "gatekeepers" and regulators, and understand that many trans people will view those working within this discipline with suspicion and even hostility (Carroll & Gilroy, 2002).

Trans-positive therapy involves considering the injustice and oppression that trans people are subjected to on a global level (Benson, 2013; Carroll & Gilroy, 2002), and understanding the impact that prior victimization, discrimination, and rejection has on this population (Hendricks & Testa, 2012). Clinicians need to examine thoroughly their own attitudes and assumptions around gender in order to ensure that they work through any biases they might hold in relation to gender variance or trans people (Carroll & Gilroy, 2002; Hendricks & Testa, 2012). They should be open to disclosing their level of knowledge regarding trans-related issues, and be willing to educate themselves and if necessary consult with others in order to increase their familiarity with this topic (Hendricks & Testa, 2012). Affirmative therapists should ask clients about their previous experiences in therapy in order to explore any negative assumptions they might have acquired as a result of prior negative experiences (Ettner, 1999).

Therapeutic support should be made available prior to and at any point during the transition process to those clients who want to engage in therapy (Lev, 2004; Raj, 2002). Therapists should adopt a client-centred approach that is tailored to the individual needs and stated goals of the client (Bockting, 1997; Ettner, 1999; Raj, 2002). Trans people present for therapy for a variety of different reasons, including but not limited to depression, anxiety, substance misuse, sexual/physical abuse, interpersonal difficulties, and problems functioning at work (Carroll et al., 2002; Lev, 2004). An affirmative therapist can assist trans clients with a range of therapeutic goals and aims. They can facilitate transition by encouraging self-acceptance, promoting gender pride, exploring client's difficult feelings, and providing information regarding treatment options (Benestad, 2010). They should also be prepared to help the client negotiate the reactions of partners, family members, and work colleagues, and be mindful of the potential risks associated with disclosure depending on the level of tolerance for gender variance (Chavez-Korell & Lorah, 2007).

A highly specialized level of expertise is required when working with trans people. Therapists should develop a good working knowledge of both the medical and psychosocial aspects of the transgender experience (Rachlin, 2002); they must familiarize themselves with the political, historical, and psychological contexts surrounding trans people (Carroll et al., 2002); and they should remain informed about various treatment options, new terminology, and relevant literature (Elder, 2016). Therapists should also ensure that they know how to signpost appropriately and are aware of relevant referral pathways, local resources, and support organizations (Carroll & Gilroy, 2002; Coolhart et al., 2008; Ettner, 1999).

1.12 Experiences of Psychotherapy

Much of the early literature suggests that trans clients have frequently reported negative or unhelpful experiences during therapy. Gagne, Tewksbury, and McGaughey (1997) observed that the majority of participants reported being encouraged, sometimes prematurely, by their therapists to come out and learn how to live and “pass” convincingly. Carroll et al. (2002), however, point out that pressuring clients to come out without taking into account whether the individual is psychologically and emotionally prepared for the transition may have negative repercussions. Additionally, focusing on passing reinforces the notion that to be “normal”, trans people must conform to the binary gender system (Gagne, Tewksbury, & McGaughey, 1997).

Ettner (1999) observed that some counsellors even attempted to dissuade clients from undergoing gender confirmation surgery, believing they had the wrong facial features or body types to pass as the opposite gender. It has been suggested that as a result of the power dynamics that are inherent in the gatekeeping role, trans clients may see therapists and medical professionals as their adversaries rather than sources of support (Fontaine, 2002). Applegarth and Nuttall (2016) reported that clients who receive therapy at GICs often feel that they have to persuade their therapist that they are mentally stable and genuinely “transgender enough” to transition.

However, recent research has indicated more mixed experiences with psychotherapy. Rachlin (2002) emphasized the value of psychotherapy in helping cope with life stressors, exploring options for living with one’s gender identity, facilitating decision-making, and providing support during the transition process. Rachlin (2002) conducted a survey to assess transgender individuals’ experiences in psychotherapy in the United States. The survey was completed by 93 participants, and a total of 150 contacts with therapists were reported. The majority of respondents (87%) described positive change occurring as a result of their experiences in therapy. Negative encounters tended to be associated with participants feeling that the therapist lacked sufficient knowledge and understanding of trans issues. Participants also reported feeling dissatisfied with therapists who were perceived as particularly passive or distant.

Participants identified the following four factors as particularly helpful in facilitating positive outcomes in therapy: acceptance, respect for the individual’s gender identity, flexibility in treatment approach, and connection to the trans community (Rachlin, 2002). The author emphasized the importance of distinguishing between psychological assessment and psychotherapy in order to ensure that the client has realistic expectations. She suggests that, although psychological assessment can help the client by providing them with a letter of recommendation, it will not assist with personal growth, psychological insight or making life decisions.

Chernicoff (2002) conducted a qualitative study on the coming-out experiences of 11 trans men in the United States. Based on her findings, she identified a number of therapeutic interventions that respondents had found useful, such as psychoeducation, helping separate facts from fears, undoing self-hatred of the body, and feeling accepted by the therapist. The major criticism made by participants focused on the role that mental health professionals play as “gatekeepers”. The participants resented having to have their transition approved, and reported feeling as though they were at the mercy of the psychologists and psychiatrists (Chernicoff, 2002). The importance of ensuring that psychotherapy is made available is highlighted by one participant in the following comment:

> If you experience yourself as transgendered the legacy you're left with is one of being poorly treated by people throughout your life. I really do think it's hard to get through all of these changes and such a profound transformation without therapy. (Chernicoff, 2002, p. 92)

Israel, Gorcheva, Burnes, and Walther (2008) conducted a study in the United States investigating the experiences of LGBT clients in therapy. The researchers interviewed 42 LGBT participants, including 9 transgender individuals. Respondents were asked to describe one helpful and one unhelpful experience in therapy. Helpful experiences were facilitated by therapists who were perceived as warm, respectful, trustworthy, caring, good at listening, non-judgmental, knowledgeable, and affirming of the client's gender identity. Participants also reported finding it helpful when therapists provided a structured approach, taught clients new skills (such as coping or communication skills), and helped clients gain insight. Unhelpful experiences occurred when therapists were perceived as cold, distant, disrespectful, disengaged, judgmental, or uncaring. Respondents found it particularly unhelpful when therapists imposed decisions or pushed their own agenda rather than focusing on what the client wanted to explore.

Bess and Stabb (2009) interviewed seven transgender people about their experiences of psychotherapy in the United States. The authors observed that participants largely reported positive experiences with their therapists, describing them as supportive, trustworthy, and empathetic. Therapists were also said to have facilitated self-acceptance, validation, and normalization. Several participants stated that their therapists were also particularly helpful with issues related to disclosure and coming out. When asked, all participants reported that they trusted their therapists and felt comfortable talking honestly with them. However, some participants also recounted negative experiences, particularly with therapists who had not specialized in gender issues. Therapists were criticized for being overtly hostile, disregarding participants' gender issues, and focusing on pathology rather than growth.

Participants suggested that helping professionals should receive specialist training as well as make an effort to establish connections with transgender people so that they could be seen for their “humanity rather than their novelty” (Bess & Stabb, 2009, p. 273). One unusual feature of this study was that the average number of sessions reported by participants was 65. Bess and Stabb (2009) assert that this finding suggests that facilitating gender identity development is a complex process, which is likely to require longer-term therapy. However, considering the cost of private psychotherapy and the fact that most NHS services only offer brief therapeutic interventions, it seems unlikely that many people in the UK would have access to long-term therapy.

Benson (2013) investigated seven transgender people’s experiences with mental health services in the United States. The findings indicated that participants identified a variety of reasons for accessing mental health services. Some participants expressed frustration at having to rely on endorsement from mental health professionals in order to access treatment. A major complaint related to the feeling that therapists were ill-informed about transgender issues, and participants resented having to pay for therapy, only to then spend time educating their therapist. Participants mentioned that they sought therapy so that they could feel listened to and supported, but often described feeling misunderstood and stereotyped. They explained that as a result of past negative experiences, they subsequently sought therapists who had experience working with transgender clients and were aware of gender issues. They described feeling safer with clinicians who identified themselves as transgender-friendly. Participants emphasized the importance of being able to acknowledge their gender identity and have it affirmed, even when it was not the focus of therapy. The author suggests that in order to adequately support trans clients, mental health professionals must receive specific trans-positive training. They should be encouraged to examine their own gender-related privileges, and to acknowledge the context of societal prejudice and institutional discrimination rather than focus on pathology (Benson, 2013).

Elder (2016) examined the experiences of 10 older transgender and gender non-conforming adults (aged between 60 and 83) in therapy in the United States. Nine participants reported positive, helpful, healing, or trans-affirmative experiences in therapy. Participants emphasized the importance of the therapeutic relationship, and valued therapists who were non-judgmental, empathetic, respectful, professional, and good listeners. However, all participants also recounted negative or transphobic experiences in therapy. They described unhelpful therapists as emotionally distant, silent, or blatantly transphobic. Participants recommended that therapists adopt an inclusive, respectful, and non-judgmental attitude, and advised that they should refrain from being patronizing, overly curious, or asking invasive questions. The author emphasizes the importance of providers keeping themselves informed about changes in the literature and language, as well as ensuring that they have a good understanding of the treatment options available to trans people (Elder, 2016).

There is limited research that has examined trans people's lived experiences of psychotherapy in the UK. When I initially embarked on this research project in 2014, I was unable to find a single UK study relating to this topic. However, a more recent literature search revealed two published studies and one unpublished doctoral thesis. This suggests that the importance of exploring trans people's attitudes and experiences in relation to therapy is finally beginning to be recognized.

Callen (2014) investigated six transgender women's lived experiences of one-to-one psychosocial support. According to the findings, all participants discussed the value of receiving individual support in relation to their well-being. They emphasized the importance of feeling listened to, understood and accepted by their therapist. Normalisation was also identified as a useful therapeutic intervention. Some participants felt that support services also fulfilled the role of "gatekeeper" and expressed concern about being denied medical treatment. This led to a fear of disclosing emotional distress, particularly when accessing therapeutic services within NHS gender clinics. Participants emphasized the importance of educating professionals and communicating with the trans community in order to ensure better support for others in the future.

Hunt (2014) explored trans people's experiences of seeking and receiving therapy outside of gender clinics within the UK. The study took a mixed-method design and involved an online survey completed by 74 participants, and five semi-structured interviews. Survey responses revealed that the majority of participants felt accepted by (61%) and able to trust (64%) their therapist. However less than half of respondents felt understood by their therapist (44%). Overall, the results indicated that satisfaction with therapy was mixed, with 43% of respondents feeling either extremely or very satisfied with therapy, and 54% feeling somewhat, slightly, or not at all satisfied (Hunt, 2014).

Four of the five interview participants recounted positive experiences in therapy, which were associated with feeling heard, understood, accepted, and affirmed. However, four participants also reported feeling either misunderstood or rejected by their therapist. These findings support the notion that a strong therapeutic relationship is more important than technique or modality (Hunt, 2014). Participants indicated that how therapists dealt with gender issues during therapy was a major concern. Only 35% of survey respondents felt that their therapist had a good understanding of gender identity issues. It was reported that while some therapists seemed unwilling to address the topic at all, others seemed to become overly focused on gender, even when it was not relevant. The author highlights the importance of therapists approaching gender concerns with clients sensitively and appropriately (Hunt, 2014). Most participants who took part in the study were white, British, and over the age of 40, therefore potential limitations relate to the lack of diversity within the sample.

Applegarth and Nuttall (2016) looked at six trans people’s experiences of talking therapy within the UK. Some of the participants had accessed therapy via specialist gender clinics, while others had received therapy privately or through a charitable organization. Their findings indicated that transgender clients often experience anxiety around transition and this can be intensified during therapy and subsequently affect the therapeutic relationship. The authors suggest that in order to help them overcome their anxiety, therapists should help trans clients to cultivate a sense of hope and acceptance (Applegarth & Nuttall, 2016). Participants described therapy as beneficial when it helped them rethink and accept their personal sense of gender. They emphasized the importance of a good working relationship, and explained that feeling connected to a therapist helped them feel safe, while feeling disconnected resulted in resistance, fear, and anger.

The importance of moving beyond therapy was also emphasized, as participants were keen to avoid getting stuck in ongoing therapy. Participants explained that successful therapy continued to have a positive impact even after it had ended. One possible limitation of Applegarth & Nuttall's (2016) study was the relatively narrow age range (32–48). Including younger participants who could have benefited from recent improvements in societal attitudes might have produced alternative findings.

1.13 Experiences of Healthcare

The existing body of literature indicates that trans people often experience difficulties when accessing primary, secondary, and specialist healthcare (Winter et al., 2016). A number of research projects have been undertaken in the United States investigating healthcare issues for trans people (Grant et al., 2011; Sanchez, Sanchez, & Danoff, 2009; Taylor, 2013; Wagner, Kunkel, Asbury, & Soto, 2016). Similar studies have also been conducted in Australia and New Zealand (Pitts, Couch, Mulcare, Croy, & Mitchell, 2009), Canada (Bauer et al., 2009; Coyle, 2011), Portugal (Murillo, Gómez, & Donat, 2007), Guatemala (Boyce, Barrington, Bolaños, Arandi, & Paz-Bailey, 2012) and Sweden (Linander, Alm, Hammarström, & Harryson, 2017). Previous research from other countries has identified a number of issues that prevent trans people from accessing adequate healthcare, such as provider ignorance (Bauer et al., 2009; Grant et al., 2011; Linander et al., 2017; Sanchez et al., 2009; Taylor, 2013), stigma and discrimination (Bauer et al., 2009; Grant et al., 2011; Wagner et al., 2016), fear of discrimination (Boyce et al., 2012), lack of social support (Boyce et al., 2012; Linander et al., 2017), financial constraints (Wagner et al., 2016), and waiting times (Murillo et al., 2007; Linander et al., 2017).

Whittle et al. (2007) released a report on transgender people's experiences of inequality and discrimination within the UK. This report was based on a quantitative analysis of 873 responses from an online survey, as well as a qualitative review of online postings and emails. At the time, this project was the largest study on transgender people living in the UK. Amongst other things, the study investigated trans people's experiences of accessing healthcare. Healthcare access is essential for transgender people looking to transition, since support from a range of healthcare professionals is required in order to access the necessary treatment (Whittle et al., 2007).

Findings from the qualitative analysis agreed that trans people often encountered discrimination and inequality when accessing healthcare. A number of instances were detailed where funding for treatment was refused by local health authorities who expressed personal prejudices towards transgender people. GPs were identified as particularly problematic. Survey results indicated that one in five trans people experience their GP as unhelpful. Of the 80% of respondents who felt that their GPs were willing to help, 60% reported that they lacked the appropriate information to do so.

The authors compared the responses of participants who had transitioned in the past 3 years to those who transition over 15 years ago in order to establish if access to treatment had become easier. They concluded that there had been little improvement in terms of waiting times, obtaining funding, delays with treatment and refusal of treatment. Overall, the results indicated that trans people continue to experience difficulties, and that one in three participants struggled to obtain appropriate support from healthcare professionals. Furthermore, one in seven respondents felt that they were treated adversely by clinicians because they were transgender. Based on their findings, Whittle et al. (2007) recommended that all healthcare providers receive specialist training to ensure that they have a good awareness and understanding of trans patients' rights, particularly in relation to dignity, decency, respect, and privacy.

Heredi (2013) conducted a phenomenological study into trans people's experience of living in a bi-gendered society. In her paper, she identified "dealing with medical power" as a key theme. Participants expressed dissatisfaction and frustration with the professional help they had received. They reported feeling as though they had been patronized and cross-examined by those who treated them, and one described feeling "failed by the system" (p. 67). Another respondent recalled feeling that his trans identity appeared to be in doubt due to the fact that he had long hair. This suggests that some practitioners are still influenced by outdated stereotypes. Based on her findings, Heredi (2013) suggested that more counselling support should be made available specifically to support trans people in the process of transitioning. She highlights the need for increased dialogue between clients and practitioners, and argues that “listening to transgendered people directly is the key to understanding and learning” (Heredi, 2013, p. 72).

Dundas (2016) explored 9 trans people’s experiences of stigmatization and shame using a qualitative discourse analysis. Participants reported a number of obstructive and shaming experiences when trying to access care. In particular, participants seemed to resent having to rely on health professionals in order to gain access to medical treatment, as it resulted in a shaming power asymmetry. Some participants described feeling under pressure to say “the right things”, rather than being able to communicate their actual experiences. Having to undergo psychiatric assessments and receive a psychiatric diagnosis was described as pathologizing and shaming. Furthermore, they reported that health professionals’ lack of knowledge, particularly at first point of contact, exacerbated existing feelings of invalidation and invisibility. Several participants also recounted experiences of clinical transphobia. Dundas (2016) emphasized the importance of increasing awareness of gender issues amongst all health professionals. He also suggested that gender care clinicians should be mindful of the potential shaming and stigmatizing impact of having to attend clinical settings.

Stonewall commissioned a survey to explore the treatment of LGBT people within social and healthcare settings (Somerville, 2015). The sample comprised 3,001 health and social care staff from a range of backgrounds, including nurses, psychologists, psychotherapists, social workers, doctors, receptionists, and senior managers. The results indicated that health and social care staff require further training in order to help them challenge any potential biases and feel better able to support trans patients. Seventy-two per cent of patient-facing staff stated that they had not received any training on the health needs of trans people, and one in four reported that they did not feel able to respond to the specific needs of this patient group. One in five patient-facing staff described hearing other colleagues talk negatively about trans people or use discriminatory language in the past 5 years, with one in ten stating that they had witnessed this in the last year. One in ten staff reported being aware of colleagues experiencing discrimination at work because they were trans, while one in fourteen respondents said that they would not feel comfortable if they had to work with a trans colleague. Somerville (2015) emphasizes the importance of having inclusive information available to patients and staff. Eighty-three per cent of staff had not seen any literature or posters that included trans people. Furthermore, it was recommended that health and social care organizations develop a campaign to raise awareness and tackle homophobic and transphobic bullying in addition to implementing a zero-tolerance approach to bullying and abuse (Somerville, 2015).

Davies et al. (2013) conducted a study investigating the levels of patient satisfaction within two of the main gender clinics in the UK. A Patient Satisfaction Questionnaire (PSQ-GD) was completed by 282 participants between April and May 2011. The questionnaire covered a range of concerns including clinical care, administrative issues, and experience of service provision from local psychiatric services and general practitioners (GPs). The findings revealed high levels of satisfaction for clinical care provided directly from the gender clinics, with 70% expressing that they were either pleased or very pleased with the clinic's supervision of their care. Rates of satisfaction were lower for local mental health services, with 54% reporting that they were either pleased or very pleased with the support they received. Contrary to previous research, satisfaction was high for provision of hormones from GPs, with 75% of respondents being either pleased or very pleased. However, the authors suggest that this could be due to relief of finally having a GP prescribe after previously experiencing difficulty in getting them to do so.

Open questions were also asked in order to give respondents the opportunity to expand on positive or negative experiences. In total, 222 positive comments and 131 negative comments were made by participants. Positive comments were largely related to satisfying experiences with clinic staff. Negative comments were predominately related to waiting times, administrative concerns, or clinical issues with the clinic, GPs, or local services. It is proposed that the findings add context for individual complaints and indicate that patient satisfaction can be achieved despite the inherent challenges in providing transgender care (Davies et al., 2013). One potential limitation of this study is that it relied on questionnaire responses that largely used closed questions. It could also be argued that only people who had an interest in their care were sufficiently motivated to return the questionnaire. Furthermore, it is possible that even though participants were assured that their responses were anonymous, the fact that the study was conducted within the NHS could have impacted the results.

Ali, Fleisher, and Erickson (2016) conducted a recent study in Canada investigating psychiatrists' attitudes towards trans people. The authors used the Genderism and Transphobia Scale to measure negative attitudes. Based on their findings, the authors suggest that psychiatrists and psychiatry residents may be more accepting of transgender individuals than the general population. It is suggested that increased personal contact with trans people may be associated with more positive attitudes (Ali, Fleisher, & Erickson, 2016). The results indicate a positive shift in physician attitudes towards this population. However further research is needed in order to ascertain whether a similar shift is occurring in the UK.

Ellis et al. (2015) examined trans people's experiences of mental health services as well as GICs using data from the Trans Mental Health Study (McNeil et al., 2012). The results from the online survey indicated mixed experiences within the NHS. Although the majority of respondents reported being satisfied with their experiences of mental health services, one-third of participants expressed being dissatisfied with the treatment they had received. The most commonly reported concern by participants regarding access to mental health services was a fear that being trans would be viewed as the cause or symptom of their mental health problem (Ellis et al., 2015, p. 8). Another significant complaint related to practitioners' lack of experience and knowledge around trans issues. These findings indicate that, in general, participants perceive mental health practitioners as having insufficient awareness (Ellis et al., 2015). The authors observe that this is particularly worrying as they act as "gatekeepers" to treatment.

Of the respondents that reported using GICs, 46% described experiencing difficulties obtaining the treatment and assistance they required (Ellis et al., 2015). Excessive waiting times was a common source of dissatisfaction for participants, with 32% reporting that they had to wait between 1 and 3 years, and 10% more than 3 years. Of the participants, 30.9% reported having lied or withheld information during appointments with health professionals, due to fears that it may affect their ability to access treatment. Most commonly, people identified withholding information related to mental health, employment, and sexuality. Respondents also mentioned that they felt unable to express any uncertainty relating to their transition due to concerns that treatment would be delayed or denied. Fifty-three per cent of participants recalled feeling worried about their mental health while attending a gender clinic, but reported that they did not feel able to talk about this with their clinician.

A small proportion of participants reported feeling pressured by clinicians to do things that they did not feel ready to do, such as make an official name change. Respondents seemed to feel that they were expected to conform to the practitioner's "narrow definitions and restricted understandings of gender" (Ellis et al., 2015, p. 14). Some trans people reported feeling that clinicians asked questions and performed examinations in a manner that felt intrusive, and showed little concern for the preservation of their dignity. In order to avoid this in the future, the authors suggest that practitioners explain clearly and sensitively why they are asking any questions that might seem invasive or inappropriate (Ellis et al., 2015).

The House of Commons Women and Equalities Committee recently released a report looking into equality issues affecting trans people (Miller, 2015). Their findings indicated that transgender people face significant difficulties when accessing NHS services, largely as a result of insufficient knowledge and understanding, but in some cases due to explicit prejudice or discrimination. GPs were identified as lacking understanding of trans identities, diagnosis of gender dysphoria, referral pathways, and hormone treatment. This was seen as particularly problematic considering the key role that GPs play as "gatekeepers" to other services and as the providers of continuing hormone treatment. The report highlighted that although GPs often have good intentions, they lack sufficient knowledge of trans issues. In response to this, the Royal College of

General Practitioners has recently launched an online training course on gender variance.

NHS GICs were also seen as having serious shortcomings, particularly in relation to waiting times and poor-quality administration. In addition, since these services controlled access to treatment, patients often felt unable to challenge clinicians, even when they felt they were asked irrelevant and highly personal questions. Another concern was related to the requirement that trans people have to undertake the “Real-Life Experience” before they are permitted to undergo gender confirmation surgery. This treatment protocol was seen as reinforcing old-fashioned and stereotyped attitudes to male and female gender roles.

McBride (2011) conducted a study exploring healthcare issues for trans people living in Northern Ireland. Qualitative data was gathered through interviews and focus groups, which were conducted with both healthcare providers and members of the trans community. The majority of interviewees felt that health professionals lacked sufficient awareness of gender identity issues. Lack of awareness was seen as especially pervasive among GPs. A number of respondents described negative and prejudicial encounters with healthcare services. These experiences were found to exacerbate participants’ emotional vulnerability, and hinder access to therapeutic support. Participants reported feeling hurt and humiliated as a result of inappropriate behaviour from healthcare staff.

Respondents also described a number of positive experiences with health staff, and they emphasized the benefits of having a clinician who was non-judgmental and took the time to listen. Aside from delays, most participants described being satisfied with the service provided by the GIC. Therapeutic support provided at the GIC was said to have had a positive impact on mental health, well-being and self-image. Training was viewed as essential by both transgender people and healthcare staff in order to increase awareness of gender identity issues and dispel unhelpful myths about trans people. McBride (2011) argued that basic awareness training should be made mandatory for healthcare professionals such as doctors, nurses, and therapists. Since each country within the UK has slightly different health systems, it is possible that trans people's experiences in Northern Ireland might vary from those reported in other parts of the UK.

1.14 Training

Many authors have noted that psychologists, therapists, and other health professionals rarely receive formal training in transgender issues (Bess & Stabb, 2009; Carroll et al., 2002; Ettner, 1999; Gainor, 2000; Hope, Mocarski, Bautista, & Holt, 2016; Lev, 2004; Raj, 2002). As a result, clinicians are often poorly informed about the unique difficulties faced by trans people, and are therefore ill-equipped to meet the needs of these clients (Carroll et al., 2002; Lev, 2004; Raj, 2002). It is important that therapists develop a good understanding of transgender people's experiences so that we can be fully prepared for the complexity of issues that these individuals may bring (Carroll et al., 2002). Chavez-Korell and Lorah (2007) suggest that training is important as it is likely that most therapists will see at least one transgender client during their career, and even more likely that they will see a family member of a trans person.

It is similarly well documented that most doctors and other health professionals have received insufficient training on how to provide adequate support to trans people (Coolhart, et al., 2008; Ellis et al., 2015; Gainor, 2000; Hendricks & Testa, 2012; Lev, 2004; McBride, 2011; Somerville, 2015; Whittle et al., 2007). Coolhart et al. (2008) suggest that the lack of training in this area is especially concerning, since trans people who wish to transition are dependent on the health system in order to obtain referrals for medical treatment. Bess and Stabb (2009) argue that this lack of understanding and awareness amongst healthcare professionals has led to trans people finding it difficult to trust clinicians.

1.15 Rationale

Carroll et al. (2002) posits that using qualitative research methods allows "transgender people to speak for and about themselves" (p. 134). Similarly, Bess and Stabb (2009) observe that while there are a few writers who have made recommendations for working therapeutically with trans clients, "the views of transsexual clients themselves are largely unpublished" (p. 267). For this reason, I chose to use IPA, as it focuses on the subjective experience of the participants and the process of individual meaning-making. Furthermore, since IPA uses direct quotes from the participants themselves, my hope was that this would help give these individuals a voice. Counselling psychology is grounded in humanistic values and prioritizes the client's personal perspective over assessment and diagnosis (Bury & Strauss, 2006). Counselling psychologists are committed to understanding the human subjective experience through the pursuit of innovative phenomenological methods (Bury & Strauss, 2006).

By adopting a phenomenological approach, the current study intends to explore in depth the individual, multifaceted experiences of a small group of transgender people. This project aims to further inform counselling psychologists and other healthcare providers of the specific needs of this client group, with implications for improving future treatment and support in this area. The present study, therefore, aims to contribute to the small body of research that has examined trans people's experiences of healthcare, psychological, and therapeutic services in the UK.

1.16 Clinical Relevance

Lev (2004) argues that whilst transgender people are often in particular need of therapeutic services, they have consistently been underrepresented in academic texts and professional journals. The lack of research aimed at educating psychologists about the difficulties faced by transgender individuals has been previously highlighted (Chernicoff, 2002). Although increasing attention is being paid to the experiences of LGBT clients, there continues to be a lack of research that focuses solely on trans people (Ellis et al., 2015). Collectivizing the experiences of LGBT people results in the unique needs of trans people going largely unnoticed (Ellis et al., 2015; Hope et al., 2016). Although they face similar difficulties in relation to minority stress, there is a range of issues distinct to the transgender community that are likely to be ignored if research continues to generalize all LGBT experiences.

Laird (1999) asserts that, as therapists, we have a responsibility to take the stories of our transgender clients into the professional literature and on to the streets. Coolhart et al. (2008) argue that more research is needed to assist therapists working with this client group. Although there has been an increase in transgender awareness in recent years, there continues to be a substantial gap in the literature (Benson, 2013). Hope et al. (2016) emphasize the need for "high-quality research that focuses on topics of particular relevance to transgender persons" (p. 362). Similarly, Winter et al. (2016) argue that "much research remains to be done in the field of gender incongruence". Elder (2016) suggests that researchers and providers are only just starting to understand the specific needs of the trans community, and therefore more research is needed to access the effectiveness and efficiency of the services currently on offer and to explore potential obstacles to treatment. The high rates of suicidal behaviour reported amongst the transgender population reinforces the need for psychologists and therapists to continue to learn more about the challenges this group faces so that they are equipped to provide appropriate and effective support.

The existing body of literature clearly demonstrates that trans people around the world often experience difficulties when accessing primary, secondary, and specialist healthcare (Bauer et al., 2009; Boyce et al., 2012; Coyle, 2011; Grant et al., 2011; Murillo et al., 2007; Linander et al., 2017; Pitts et al., 2009; Sanchez et al., 2009; Taylor, 2013; Winter et al., 2016; Wagner et al., 2016). Grossman and D'Augelli (2006) argue that the shortage of adequate services available to assist transgender people reflects their marginality and insignificance in society.

Despite the introduction of new guidelines and regulations, recent research indicates that trans people continue to report negative experiences of healthcare services in the UK (Ellis et al., 2015; McBride, 2011; Miller, 2015; Whittle et al., 2007). This is problematic, as trans people are reliant on the medical profession in order to receive gender affirming treatment (Ellis et al., 2015). Recent research conducted in the UK indicates that some transgender people find engaging in therapy anxiety provoking (Applegarth & Nuttall, 2016), and may feel misunderstood by their therapist (Hunt, 2014). Bearing in mind that trans individuals recount mixed experiences of healthcare and psychotherapy, it is imperative that we endeavour to better understand how they perceive these services and investigate in detail both what facilitates and hinders service-user satisfaction.

As trans people become increasingly visible, and more individuals begin seeking treatment for gender-related issues, it is important that allied professionals continue to attempt to improve the support that is currently on offer. Hope et al. (2016) point out that social attitudes and understanding around the experience of being transgender change so rapidly that literature can become quickly outdated. As mentioned above, only two published qualitative studies exist that have looked at transgender people's experiences of therapy in the UK. Aside from the McBride (2011) Irish study, all of the UK research to date examining healthcare experiences has involved data gathered via large-scale online surveys and questionnaires. Consequently, there is a need for a project using a qualitative design and conducted in the UK to examine in detail the variety of experiences that are described by trans people across services.

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2. Methodology

2.1 Overview

This chapter will address the methodology employed to answer my research question: How do trans people experience healthcare and psychological services during transition? I will endeavour to explain why I chose a qualitative methodology and, more specifically, why I decided to employ interpretive phenomenological analysis (IPA). I will explain how these decisions were informed by the aims of my research as well as my own epistemological position. I will also address the historical and philosophical underpinnings of IPA. I will then explore the methods and strategies used to carry out this research by describing in detail how I went about collecting the data and conducting the analysis. Finally, I will address issues relating to validity, ethics, and reflexivity. Although there is a subsection at the end of this chapter dedicated to reflexivity, I will also make reflective comments throughout, as continual reflexivity is an essential element of the research process.

2.2 Qualitative versus Quantitative

Psychological research can be broadly divided into two categories, according to its adoption of one of two methods: qualitative and quantitative. There has tended to be an emphasis on quantitative methods owing to the importance placed on psychological research being seen as scientific (Braun & Clarke, 2013). This preoccupation with scientific methodology and empirical rigour has led many psychologists to reject qualitative methods. However, this predilection is no longer so prevalent, and increasingly quantitative and qualitative methods are being viewed as equally legitimate modes of inquiry (Smith & Heshusius, 1986).

The two modes of inquiry are differentiated by the fact that quantitative research deals with numerical data and statistical analysis, while qualitative research is more exploratory, dealing with non-numerical, linguistic data, such as interview transcripts. Since quantitative research often involves experimental manipulation, it is usually necessary to conduct experiments under laboratory conditions, which are often quite artificial, whereas qualitative research is able to employ more naturalistic settings. While quantitative research is typically concerned with measuring behaviour, qualitative research concentrates more on meaning and experience.

Another significant difference between these two research method categories is their opposing philosophical underpinnings, specifically in relation to their positions on epistemology and ontology. Epistemology is concerned with how we come to acquire knowledge and understanding, and ontology pertains to the study of being, existence, and reality. In terms of epistemology, quantitative research is based on positivism, which stresses the importance of empirical and scientific methods and the objective status of knowledge (Morgan & Smirchich, 1980). Qualitative research, on the other hand, is based on interpretivism, which rejects positivism, and stresses the importance of understanding the thoughts and subjective experiences of the participants (Morgan & Smirchich, 1980). According to Bright and Harrison (2013), "Whereas positivism is concerned with the construction of 'a single reality' interpretivism enables the discovery of different, multiple realities" (p. 61). In terms of ontology, quantitative research is associated with objectivism, which views reality as objective and independent of human perception, while qualitative research is frequently associated with constructivism, which considers reality to be socially constructed and therefore continually changing (Sale, Lohfeld, & Brazil, 2002).

2.3 Why Use a Qualitative Methodology?

While some aspects of human behaviour can be measured and quantified, I believe that an individual's meaning-making and subjective experiences are better understood through qualitative methodology. Ashworth (2003) contends that qualitative research facilitates the understanding of human experience. Since this study will focus on the subjective experience of the participants, a qualitative methodology will be employed. It has been suggested that qualitative methodology is particularly useful when the participant group is under-represented and difficult to access (Hegarty, Lenihan, Barker, & Moon, 2004). Although the transgender community has become more visible in recent years, it remains relatively unacknowledged in today's society. It therefore seemed appropriate to use a qualitative design for this research study, as it provides the opportunity to gain valuable in-depth information about a population that tends to be marginalized.

2.4 Epistemology

Willig (2012) argues that before embarking on a research project, it is important to think carefully about the type of knowledge that you are trying to create and the type of assumptions that you make about the world. Similarly, Ponterotto (2005) asserts that the researcher should have a good understanding of the "philosophy of science parameters that anchor their work" (p. 127). A crucial question when considering how we acquire knowledge about the world is the extent to which we believe that there is a single reality that can be known and understood.

It is possible to draw a broad distinction between realist conceptions of knowledge that relate to a single and shared reality, and relativist positions that are founded on the view that there are multiple realities, which are constructed either by the individual or by the underlying structures of society, language, and culture. The relativist conception of multiple realities, particularly associated with social constructionism, appears attractive because it emphasizes the diversity of experiences, and provides a basis for challenging the claims of those with power and authority. However, despite acknowledging that an individual's experiences will be conditioned by their unique situation, social position, and relationships, I assert the existence of a single reality, even though different people may interpret it differently. For this reason, this study is founded on the assumption that the experiences described by the participants are grounded in real events.

Willig (2012) draws the distinction between naive and critical realism. As I do not consider there to be a simple or direct correspondence between our experiences and reality, I therefore identify my epistemological position as that of critical realist. Critical realists posit that in order to obtain knowledge about the world, it is necessary to move beyond the “data” (participants’ experiences) by drawing on theories and evidence from outside the study in question (Willig, 2012). For a critical realist, “although data can tell us about what is going on in the real (i.e., material, social, psychological) world, it does not do so in a self-evident unmediated fashion” (Willig, 2012, p. 9).

I am interested in the experiential world of my participants and aim to represent their perception of the world, while also attempting to uncover the underlying structures and social processes that inform these experiences. While I acknowledge that my own world view will inevitably affect my interpretations of the participants’ experiences, I attempt to make myself aware of the ways in which this is happening by adopting a reflexive stance throughout the analytical process.

2.5 Why Use Interpretative Phenomenological Analysis (IPA)?

This research aims to explore the phenomenological experience of a group of trans people who are in the process of transitioning. I was committed to engaging with the idiographic by attempting to uncover the quality and texture of a particular and unique lived experience. Willig (2012) identifies two types of phenomenological research: descriptive and interpretative. Descriptive research attempts to stay as close to the participants’ accounts as possible and aims to take the data “at face value” (Willig, 2012). This is done in order to accurately capture the participants’ experience as they themselves understand it. However, interpretive research aims to add another layer of meaning to the participants’ accounts by looking for underlying themes that the participants may not be aware of. It is this deeper level of meaning that I am interested in.

This study, therefore, employed IPA in order to capture the subjective experience of its participants. IPA is especially valuable when the research topic in question involves complexity, process, or novelty (Smith & Osborn, 2003). Finley (2006) refers to the importance of the embodied experience in IPA. She asserts that the researcher should attend to both participants’ language and their body during the interview. A central concern for transgender individuals is the misalignment of their embodied experience to their gender identity; it therefore seemed especially relevant to employ IPA, as it acknowledges the importance of bodily behaviour and expression. Finally, and perhaps most importantly, IPA was selected as it fitted in with my own epistemological stance.

An alternative qualitative-research option that I considered using was Foucauldian discourse analysis (FDA). This approach was inspired by the work of philosopher and social theorist Michel Foucault. FDA looks at how language and discourse influence wider social processes such as power dynamics and legitimation within society (Willig, 2001). This approach held a certain appeal because of "the patient" status of trans participants, since "within a biomedical discourse, those who experience ill-health occupy the subject position of 'the patient', which locates them as the passive recipient of expert care within a trajectory of cure" (Willig, 2001, p. 107).

However, since the main objective of this research was to gain a rich understanding of how trans people perceive the support they receive from healthcare and psychological services, I felt that it would be better to stick to the participants' experiences as closely as possible, rather than focusing on the discourses they use to construct their experiences. I therefore felt that in order to answer my research question, IPA would be preferable to FDA. Nevertheless, if I were to continue conducting research in this area, I would be interested in using FDA to explore current social and political discourses around transition, particularly as transgender issues have recently become such a widely discussed and controversial political topic.

2.6 History and Theoretical Underpinnings of IPA

IPA was developed as a way of allowing the researcher to unpack the meanings contained in participants' accounts of a particular experience, event, or state (Smith & Osborn, 2003). IPA acknowledges that it is never possible to access the subjective experience of participants directly, since the researchers own view of the world will always affect the analysis in some way (Willig, 2013). Therefore, according to IPA, two levels of interpretation are involved: First, the participant attempts to make sense of their world; and, second, the researcher attempts to make sense of the participant's attempt to make sense of their world (Smith & Osborn, 2003).

IPA utilizes an idiographic mode of inquiry rather than a nomothetic approach. This means that it is concerned with making specific statements about the experiences of individuals, rather than generalizing about populations (Smith & Osborn, 2003). IPA is dedicated to the particular and creating in-depth and detailed analysis. It is also concerned with understanding how particular phenomena can be understood from the perspective of a specific person in a specific context (Smith, Flowers, & Larkin, 2009).

Interpretative phenomenology was inspired by a branch of philosophy known as phenomenology, which is concerned with describing how we as human beings understand and make sense of the world around us (Willig, 2001). Phenomenological psychological research aims to elucidate as closely as possible a real-life situation in which individuals have first-hand experiences that can be described in detail (Giorgi & Giorgi, 2003).

The philosopher Edmund Husserl founded phenomenology in the early 1900s. He regarded phenomenology as the correct method for all philosophical inquiry. A primary principle was that we should begin our investigation of anything by carefully describing the ways it presents itself to us (Husserl, 1989). Therefore, the starting point of any inquiry must be the detailed and rigorous study of the forms of our thoughts, feelings, and experience as they occur to us, without imposing our assumptions or preconceptions about the world upon them. He referred to this process of suspending judgement about the external world as *epoché*, translated into English as 'bracketing' (Husserl, 1950). In this way, he believed that we could capture the essential features of a particular experience as it might present itself not just to the individual, but to others as well.

In suspending our normal background assumptions and focusing on things as they present themselves, we abandon the "natural attitude" and adopt the "phenomenological attitude" (Husserl, 1950). He believed that this shift involved us moving our focus from the objects in the world to our perceptions of these objects. In order to do this, we must attend to how we experience the world, rather than getting caught up in the everyday activities that dominate our lives. Husserl asserts that by becoming aware of our perceptions, we are engaging in a continual process of reflection. He also believed that it was possible to discover what is at the core of a particular mode of experience. He referred to this idea of getting to the essence of an experience as "eidetic reduction" (Husserl, 1989).

Although Husserl was a philosopher and not a psychologist, his work created the foundations of IPA. He introduced the idea of rigorous and detailed examination of the content of conscious experience (Smith et al., 2009). He also emphasized the necessity of attending to our perceptions through the process of continual reflection, which is something that remains central to IPA as well as to qualitative methodology as a whole. However, while most of his work focused on understanding his own experiences as investigator, IPA usually focuses on illuminating the experiences of others. It is important to note the difference between phenomenological inquiry into one's own experience and phenomenological inquiry into someone else's experience (Willig, 2001). "In phenomenological psychological research, the research participant's account becomes the phenomenon with which the researcher engages" (Willig, 2001, p. 53).

Heidegger was a student of Husserl. However, he believed that Husserl's work did not sufficiently address the question of our concrete being or existence. He argued that our very mode of existence is different from that of other things that we encounter in the world. He referred to this distinctive mode of existence as *Dasein* – in English, "being there" (Heidegger, 1962). Furthermore, our being is always "being-in-the-world". Instead of being isolated minds who can bracket the very existence of the world, he insisted that we are intrinsically involved with the world from the start. In addition, our "being-in-the-world" is not just a matter of passive containment, but, rather, active engagement (Heidegger, 1962). As a result, we primarily relate to things in the world as things that we can make use of or do things with. For example, a table is not just a geometric arrangement of wood; it is an item that can be sat at, eaten off, or worked at.

Moreover, our “being-in-the world” is always in relation to our being with others like us, as well as our knowledge of language, culture, and objects. For Heidegger, whenever we are confronted with a situation, we already have a certain take on it. Therefore, it is impossible to bracket completely our preconceptions and assumptions of the world, as these are fundamental to how we make sense of our experiences and surroundings. Heidegger teaches us that as human beings, we are inseparable from the world of objects, relationships, and language.

Heidegger is a particularly influential figure in the development of IPA because of the way that he links Husserl’s phenomenology with the hermeneutic tradition. Hermeneutics is, in the first instance, the methodology and theory of the interpretation of texts. However, in the 19th century, certain philosophers argued that the distinctive features of textual interpretation are also present in the understanding of all human thought, speech, and action: “Understanding and interpretation is the method used throughout the human sciences. It unites all their function and contains all their truths” (Dilthey, 1985, p. 152). A central theme of this philosophical approach is, therefore, that understanding the thought and activity of ourselves and of others is always a matter of interpretation of meaning. Furthermore, this understanding is quite different from the kind of understanding that we employ in the physical sciences. Therefore, the human sciences should not try to mimic the physical sciences, as they employ very different methods and structures of inquiry and explanation (Dilthey, 1985).

A central theme of the hermeneutic tradition is that of the hermeneutic circle. This is the idea that interpretation is built up by moving back and forth between the part and the whole (McLeod, 2001). Therefore, in order to understand a sentence, we must look to the individual words. But at the same time, in order to understand the words, we must look to the sentence in which they occur. The same principle applies to other parts and wholes: an extract and the complete text; a chapter and the book; an interview and the research project. This circular, back-and-forth way of making sense of material is particularly useful when thinking about IPA. A key feature of IPA is that the analytic procedure is multidirectional and involves reading and rereading the text, examining it in different ways and from different angles, while always bearing in mind our own relationship to the text and what impact this might be having on our analysis (Smith et al., 2009).

2.7 Sampling Considerations

This study employed purposive sampling, which involved the researcher carefully selecting participants based on a set of predetermined criteria. This was done in order to achieve a homogenous sample. I was initially unsure whether or not to include both trans man and trans women, as opposed to focusing on one group. After discussing this with my supervisor, we decided that we did not need to distinguish on the basis of gender in order for this group to be considered a homogenous sample. This was backed up by the fact that similar studies looking into the experience of trans people have used both trans women and trans men (e.g. Applegarth & Nuttall, 2016; Hunt, 2014). Participants were selected based on the following criteria:

- they identified as trans;
- they had begun transitioning (i.e., living in their authentic gender and had started hormone treatment);
- they were over the age of 18
- they were living in the UK

2.8 Recruitment

Participants were recruited through various London-based charities, societies, and support groups. I contacted over 40 LGBT and transgender organizations, including Gendered Intelligence, Sibyls, Mosaic LGBT Youth Centre, Stonewall, Trans Network London, Mermaids UK, Spectrum London, Opening Doors London, the Naz Project, Trans London, the Clare Project, FTM London, and LGBT Jigsaw. I sent out an introductory email (see Appendix 1) along with my recruitment flyer (see Appendix 2). Word-of-mouth networking and a “snowballing effect” were also employed (Punch, 2000). Once a potential participant had made contact with me via email, I would send them a copy of the participant information sheet (see Appendix 3), and, if they were happy to continue, we would arrange a time and place to meet. The aim was to recruit eight participants, which was within the range (of between four and ten) suggested by Smith et al. (2009) for professional doctorates.

When I first began this project, I was unaware of the negative connotations associated with the term "transsexual". As I was looking to recruit people who had received medical treatment as part of their transition, I believed that "transsexual" was the appropriate word to use. Therefore, my initial recruitment flyer called for "self-identified transsexuals". In my introductory email, as well as giving a brief overview of my study and asking for help with recruitment, I explained that I would be grateful for any advice that the recipient could offer. When I sent out my first call for participants, I received a response from one of the charities agreeing to help with recruitment, but also suggesting that I changed the word "transsexual" to "trans", as this might help broaden my scope. I was advised by the charity that many trans people, especially those from the younger generation, do not identify as transsexual, because it is seen as pathological. I therefore decided to change the terminology in line with this suggestion.

I initially struggled a fair amount with recruitment. The majority of the charities I contacted failed to get back to me. However, I was able to recruit through Mosaic, Sibyls, Spectrum, Gendered Intelligence, and Opening Doors. Mosaic LGBT youth centre were especially accommodating and willing to help with recruitment. However, as most of the young people they supported were under the age of 18, this limited the number of potential participants that met my inclusion criteria. During the recruitment phase, I was contacted by a total of 13 individuals over a period of 10 months. However, not all of the people who contacted me ended up participating in the study. Two individuals, after initially making contact, simply stopped responding to my emails, and a further two pulled out of the study after agreeing to meet, but before the interview had taken place. Of these, one individual reported being unwell and not feeling up to meeting, and another explained that, on reflection, they felt that the interview topic would be too sensitive.

2.9 Participants

There were nine participants in total: five trans women, and four trans men. They were aged between 18 and 62. Some participants had transitioned privately, some via the NHS, and some a mixture of both. Similarly, some participants had received therapy at a gender clinic, some privately, and some through a charitable organization. All participants identified as trans and had begun hormone treatment. Demographic details relevant to the study can be found in Table 1 below. All participants were given pseudonyms in order to preserve their anonymity. Since the trans community is still relatively small, I have kept demographic information to a minimum to further ensure that participants remain unidentifiable. Demographic questions were optional and primarily related to what types of medical interventions participants had received and when. The demographic information was obtained in order to confirm that the participants fitted the inclusion criteria and to check the homogeneity of the sample. Information regarding when they had transitioned and what types of treatment and support they had received was gathered. They were asked to provide their age, but information relating to cultural background, social class, and educational status was not obtained.

Table 1

Pseudonym	**Gender**	**Age**	**Started transition**	**Started hormones**
Anna	Trans woman	56	2 months ago	19 months ago
Barbara	Trans woman	59	3 years ago	3 years ago
Caroline	Trans woman	34	2 years ago	2 years ago
Daniel	Trans man	18	7 years ago	1 year ago
Ethan	Trans man	24	3 years ago	1 year ago

Francesca	Trans woman	31	7 years ago	10 years ago
George	Trans man	29	4 years ago	4 years ago
Heather	Trans woman	62	13 years ago	10 years ago
Ian	Trans man	38	13 years ago	10 years ago

2.10 Data Collection

Data was gathered through semi-structured interviews with the aim of capturing the phenomenology of the participants' individual experiences. Nine one-to-one interviews were conducted in person by the researcher, which lasted between 45 and 105 minutes. The interviews were all digitally recorded and later transcribed. The audio recordings were encrypted, and the transcripts were saved as password-protected documents. All interviews took place at City University in a private meeting room on a day and at a time convenient to the participant. Participants were offered reimbursements for travel costs, although some refused on the basis that they already had London travel cards that would cover the cost of their journey.

Before each interview, I introduced myself and gave the participant a hard copy of the participant information sheet (see Appendix 3) for them to read again. At the beginning of the participant information sheet, I clearly stated the purpose of this project. I wanted to ensure that participants had another opportunity to read this, along with the other information about the project, so that it was clear that my main interest in conducting this research was improving the care and support offered to trans people. Historically, trans people have been pathologized and misunderstood within the research literature (Coolhart, Provancher, Hager, & Wang, 2008; Gainor, 2000; Lev 2004). I therefore felt that it was especially important that participants understood that my intention was not to pathologize or criticize the trans community in any way.

After clarifying the goals of the project, we both signed two copies of the consent form (see Appendix 4): one for my own records, and the other for the participant to keep. I then asked them to provide some background information relating to their transition and the types of treatment and support they had received (see Appendix 5). I explained that these questions were optional and were simply to help set my research in a specific context. Although I asked participants their name and date of birth, I made it clear that these questions would not be used to identify them in any way. I endeavoured to put my participants at ease by explaining that there were no right or wrong answers, and that I was simply interested in hearing about them and their experiences (Smith et al., 2009).

I then started the audio recorder and began conducting the interviews according to my pre-prepared schedule (see Appendix 6). The semi-structured interview schedule was developed based on the protocol outlined by Smith et al. (2009). Semi-structured interviews are useful as they allow the researcher to modify their questions as they go along and explore interesting topics as they arise (Smith & Osborn, 2003). The interview schedule provided me with a loose guide to follow, although, in reality, I rarely needed to consult it during the interviews. However, the schedule was particularly useful as it forced me to think about how I wanted to word my questions and what order to put them in. It also helped me feel less nervous about the interviews, as I knew I had something to fall back on if I encountered any difficulties. In order to generate suitable data, interview questions were open-ended and non-directive (Willig, 2013). I also made sure that the questions were clear, avoided jargon, and were neutral rather than leading (Smith & Osborn, 2003). My interview schedule consisted of eight open questions with two to three prompts per question. I also had some general prompts aimed at encouraging less forthcoming or reserved participants to expand on their responses.

Smith et al. (2009) highlight the importance of establishing a good rapport with your participants. I therefore tried to use the skills I had acquired as a trainee counselling psychologist, such as listening attentively, staying curious, demonstrating empathy, and remaining non-judgemental. In doing this, I hoped to put my participants at ease, while gathering as much rich and relevant data as possible.

Smith et al. (2009) warn that disclosure from the interviewer needs to be handled with caution and should take place at the end of the interview once the participants have had the opportunity to express themselves in their own terms. I had, therefore, initially planned that if participants asked me questions about my own background or interests either before or during the interview, I would tell them that I was happy to answer their questions, but that I wanted to wait until the end of the interview to do so. However, after some feedback from a tutor regarding this, I changed my mind, and decided that I would answer questions openly and honestly as and when they were asked. On reflection, I came to understand that waiting until the end of the interview to answer questions could leave my participants feeling that I had something to hide and result in them making unsafe assumptions about me. I also left extra time at the end of each interview to ask participants if there was anything else they wanted to ask me. At some point, either before or after the interview, all participants asked why I had chosen to undertake this research topic. I explained that I worked therapeutically with transgender clients, and that my decision to undertake the project was partly due to my desire to conduct research that would hopefully contribute towards improved services, but also due to my desire to better inform my own practice.

After each interview, I gave participants a debrief sheet (see Appendix 7). After the first three interviews, I took time to ask the participants about how they had found the questions and my interview style in general. I explained that I was still in the early stages of the research process, and that I was keen for feedback to help me refine my questions and improve upon my interview style. I also took time after each interview to make my own notes on how I felt the interview had gone, and to think about ways that I could improve my style.

2.11 Analytical Procedure

In order to understand the respondents' psychological world, the researcher must engage in an interpretative relationship with the texts (Smith & Osborn, 2003).

The transcripts were analysed one by one, and cases were only integrated once detailed engagement with each individual case had been completed (Willig, 2013). As this was my first time conducting an IPA analysis, I followed the step-by-step process outlined in Smith et al. (2009). The authors suggest that the analytic process is multidirectional and requires reflective engagement with each individual's account. The prospect of conducting the analysis was, at first, a daunting one. Smith et al. (2009) assert that it is a complex process, which can be "personal, intuitive, difficult, creative, intense and conceptually demanding" as well as "uniquely interesting, insightful and rewarding" (p. 80). I therefore threw myself into the task with the knowledge that, while it may at times be demanding and challenging, it would also hopefully be creative, interesting, and gratifying.

First, I attempted to immerse myself in the data by thoroughly reading and rereading the transcript. On the first reading, I listened to the audio recording at the same time in order to facilitate a particularly in-depth engagement with the material. I also noted down my initial ideas and observations about the data. The second stage involved making detailed and inclusive notes and comments in the right-hand margin of the transcript. I made notes on what I thought was particularly interesting or important, while asking myself questions and commenting on similarities, differences, repetitions, and contradictions.

In line with Smith et al. (2009), these exploratory comments fell into three categories: descriptive, linguistic, and conceptual. The descriptive comments were largely concerned with summarizing the key content of each small section of text, often using words from the original transcript. The linguistic comments involved observations on the way participants said things and their use of language. This included notes on hesitations and repetitions, as well as their tone of voice. The conceptual comments represented my endeavour to engage further with the text and my preliminary attempts to make sense of the participant's lived experience. These notes were often posed as questions in an attempt to understand what a word or sentence meant to me, or what it might mean for the participant (Smith et al., 2009).

The next stage of the analysis concerned identifying emergent themes in the left-hand margin of the transcript. This involved shifting the analytic focus from the original text to the exploratory comments (see appendix 8 for example). These themes were usually expressed as a phrase or a word, and were a reflection of the participant's original words as well as my own interpretation (Smith et al., 2009). The fourth stage involved clustering the emergent themes by looking for connections between them. I first typed out the themes in chronological order into an Excel spreadsheet. I spent time looking for connections, contrasts, and repetitions. I also took time to think about how the emergent themes related to my research question. I then tried arranging them into clusters of related themes. The aim of this was to draw the themes together in a way that would highlight the most interesting and important aspects of the transcript (Smith et al., 2009). While doing this, I was able to combine and collapse similar themes in order to reduce the number. I tried different ways of grouping the themes, and once I felt happy with the clusters, I put them into a table with master themes at the top and the sub-themes listed below each one (see appendix 9 for example).

After I had completed these four steps for the first participant, I moved on to the next participant's transcript. Although it was inevitable that I would be influenced by what I had already found (Smith et al., 2009), I endeavoured to examine each case on its own merits in order to ensure that I was open to the emergence of new themes.

Once each transcript had been analysed, I began looking for patterns of themes across cases. I inputted all the clusters of themes that I had compiled for each transcript into one large Excel spreadsheet. I highlighted the themes from each participant using a different colour so that I could keep track of which transcript each theme had originated from. I collapsed and renamed the master themes so that I ended up with approximately 8 master themes with 30-40 emergent themes under each one. I had the master themes running along the top of the Excel spreadsheet and under each, the corresponding emergent themes listed in a column. At this point all the emergent themes from each participant were grouped together under the master themes. I have added an extract from the Excel spreadsheet to illustrate this step of the analysis. The extract in question shows the emergent themes from each transcript that related to the master theme, ‘experiences in therapy’ (see appendix 10). I then began moving the emergent themes around within the columns so that they were grouped together in terms of similarity rather than by participant. I clustered similar and matching themes together so I could clearly see how many times a certain theme came up and how many transcripts it was present in. I have added an extract from the Excel spreadsheet to illustrate this step of the analysis. This extract shows the emergent themes related to the master theme, ‘power’ (see appendix 11). Following this, I spent time collapsing, relabeling and reconfiguring the themes (Smith et al., 2009). It is important to note that, when selecting the final themes, a variety of factors were taken into consideration in addition to mere prevalence within the data (Smith & Osborn, 2003). These final results were then compiled into a master table of themes for the whole group.

2.12 Validity and Reliability

Although “validity” and “reliability” are terms that are more commonly associated with quantitative research, they also play an important role in qualitative research. However, the dimensions by which they are assessed within qualitative research are fundamentally different from quantitative research (Silverman, 2000). Yardley (2000) suggested that in order to ensure validity and reliability, a qualitative research project should adhere to a set of guidelines or criteria. He proposes assessing the quality of qualitative research according to the following four principles:

- sensitivity to context;
- commitment and rigour;
- coherence and transparency;
- impact and importance.

Yardley (2000) argues that sensitivity to context can be demonstrated in a variety of ways. I attempted to show sensitivity to context throughout the recruitment, data collection, and data analysis stages of the research process. Accessing participants was not easy in this case, and it required both persistence and patience. I spent time establishing relationships with key individuals at a number of charities in order to gain access to the sample I needed. During the interviews, I tried my best to remain sensitive to each participant by putting them at ease, demonstrating empathy, and carefully negotiating any interactional difficulties (Smith et al., 2009). During analysis, I spent time and energy immersing myself in the material and making sure that any claims or interpretations were backed up with direct quotes from the data. Finally, I ensured sensitivity to context by using my awareness of the existing literature to provide a clear rationale for the study and to back up the research findings.

I attempted to follow the principles of rigour and commitment, again, throughout the recruitment, data collection, and data analysis stages of the process. I demonstrated rigour by choosing an appropriate and homogenous sample for my research question, conducting respectful and thorough interviews, and engaging in a detailed and extensive analysis (Smith et al., 2009).

I aimed to meet the criteria for coherence and transparency by setting out a distinct and thorough account of each stage of the research process. I described in clear and precise terms how participants were selected, how I prepared and conducted the interviews, and how I conducted the analysis step by step (Smith et al., 2009). I ensured coherence by producing a write-up that was logical and easily to follow. I tried to make sure that each section linked with the other sections and flowed as a whole. I also endeavoured to be consistent with the underlying principles and philosophy of IPA, and to make this apparent in the write-up (Smith et al., 2009).

Finally, I attended to the principles of impact and importance by producing a rich and meaningful description of my participants' experiences of healthcare and psychological services. I aimed to conduct a study that the reader will find useful and interesting (Smith et al., 2009). My ambition was to increase awareness of trans people and their experiences for counselling psychologists, as well as for healthcare professionals in general, in the hope that this would result in services being better equipped to meet the needs of this client group, which would in turn lead to an increased standard of care.

2.13 Ethical Considerations

Ensuring ethical practice is a vital and ongoing part of the research process. Before recruitment could begin, ethical approval for this study was obtained from the City University Research Ethics Committee. Before I was given ethical clearance, I was asked to make a few amendments to my ethics application form as well as to the participant information sheet, consent form, and debrief sheet. The final ethics application was then submitted (see Appendix 12), and ethical approval was confirmed (see Appendix 13). The research was conducted in line with guidelines provided by the British Psychological Society (BPS) as well as the Health and Care Professions Council (HCPC).

Signed consent was obtained from all participants prior to data collection (see Appendix 4). Participants were reminded that their involvement was voluntary and that they had the right to withdraw from the study at any time. Participants were informed that information provided was solely for research purposes and that the data would be kept confidential. In order to ensure anonymity, all names and identifying characteristics were changed, and data was stored anonymously. Before taking part, participants were fully briefed as to the aims and purposes of the study.

It was intended that respondents should benefit from participating in this study, first, by being given the opportunity to have their voice heard, and, second, by contributing to research that aims to inform future treatment in this area. However, due to the potentially sensitive subject matter of the interviews, great attention was paid to the well-being of the participants. I was particularly vigilant for any signs of distress, and endeavoured to maintain a respectful, non-judgemental, and empathetic manner throughout the process. Participants also were provided with a debrief sheet (see Appendix 7), which included a list of charities that could provide psychological support if necessary.

Participants were informed that the data belongs to the researcher and City University London. It was also explained that the data would be published as part of researcher's thesis in the City University London library and potentially in a relevant journal.

2.14 Reflexivity

Reflexivity is essential part of qualitative research. Finlay (1998) argues that it "offers a tool where the problem of subjectivity in research can be turned into an opportunity" (p. 453). Bright and Harrison (2013) argue that the practitioner-researcher should "foster the same forms of reflective engagement with research as is generated through therapy itself" (p. 17). IPA results are dependent on the researcher's interpretation of the participant's responses. It is therefore critical that the researcher adopt a reflexive attitude throughout the research process. Personal reflexivity requires the researcher to reflect upon how his/her own values, beliefs, experiences, and interests may shape the research (Willig, 2013). Finlay (1998) identifies four subjective elements of personal reflexivity: the researcher's assumptions; expectations; behavioural/emotional reactions; and unconscious responses. Langdridge (2007) provides a list of potential questions for researchers to consider in order to aid reflexive practice.

I was aware that my pre-existing assumptions and experiences would inevitably affect my understanding of the participants' thoughts and feelings, as would my age, gender, and socio-cultural background. I acknowledged that my background and world view would undeniably impact the questions I asked, as well as my interpretations of the data. Therefore, throughout the research process, I endeavoured to reflect on, question, and evaluate the impact that I might have on choice of topic, methodology, research strategy, data collection, and data analysis.

My interest in this area was sparked as a result of my long-term work with a trans client during my first year of training. When we first started working together, I knew very little about trans issues, and neither did my clinical supervisor. I began reading and researching as much as I could, but at the same time I was open about my lack of knowledge. At times, I felt extremely underqualified. However, working from a person-centred perspective allowed me to focus on demonstrating empathy and acceptance without worrying too much about needing to be an expert.

When I first started seeing this client in March 2014, he had discussed his gender with a few close friends and family members, but was still living as female. By the time we ended therapy in July 2015, he had made a formal name change, begun hormone treatment, and come out as trans to the rest of his friends, family, and work colleagues. It was supporting my client through these profound life changes that lead me to consider conducting research in this area. My client had expressed dissatisfaction with the healthcare support he had received, and I was eager to learn more about the experiences of other individuals in a similar position. I was struck by the lack of qualitative research that focused on the experiences of trans people. I also felt frustrated by the lack of understanding around trans issues, my own and others, and this was an additional motivator for conducting this research. I was particularly surprised by the lack of research and literature focusing on protocol for working therapeutically with trans individuals.

I subsequently started a 15-month placement at a gender clinic, and have since worked therapeutically with a number of trans clients. I really enjoyed this work and, although I began to feel that my understanding of this client group improved enormously, I was still often left feeling naive and unprepared. I currently work 4 days a week at a psychosexual service and continue to see trans people for therapy there.

Continual reflection was especially important in this research, as the issues being explored were ones that I did not have first-hand knowledge of. Throughout this process, I have always been acutely aware that I am an outsider to the experience of my research participants. I have always taken my gender for granted, and until recently I had never properly questioned the notion of gender. I have never experienced gender dysphoria, and never experienced life as a trans person. I have, therefore, never experienced the discomfort and stigma described by many trans individuals. I was conscious that this would probably be evident to the participants and would need to be taken into account. Would my being an outsider affect how participants responded to me? Would this make them more likely to distrust me? Could my attempts to understand their world be seen as intrusive or, worse, pathologizing? I thought carefully about these issues and tried to ensure that it was clear from the participant information sheet that I was not trying to sensationalize or pathologize their experience, and that my aim was simply to better understand their perceptions of healthcare and psychotherapy with the hope of informing future practice.

During my time at the gender clinic, I have been made aware of the lack of understanding and the stigma that trans people face every day in our society, not just from their peers, but from some health professionals as well. I was therefore particularly keen to focus on their experiences of healthcare and psychological services during gender transition. This was partly due to my desire to conduct research that I hoped would contribute towards improved treatment in this area, but also due to my desire to better inform my own practice as a trainee counselling psychologist working with this client group.

Working at a gender clinic while simultaneously conducting this research had both benefits and drawbacks. It was useful, as it meant that I was familiar with a lot of the language and protocols described by the participants. On the other hand, I was aware that I would need to bracket the assumptions and expectations that I had developed while working with this client group. When interviewing participants, it was important to adopt an open and naive stance, which might have been easier had I not felt so immersed in the topic.

During my first research interview, the participant talked about her frustration at not being challenged enough by the clinician about her decision to transition. I was extremely surprised by this response, as my personal experience of working with this client group, as well as my reading around the subject, had led me to expect the exact opposite. This made me realize that I was making assumptions, which in turn highlighted the importance of remembering that my participants will have both individual and shared experiences. During the interview, as I became aware of my own surprise, I was careful to remain curious and keep an open mind.

Having never conducted qualitative analysis, I was quite apprehensive that I would find it time-consuming and difficult. Growing up quite heavily dyslexic, I knew that the reading and rereading and note taking would take me longer than it might take others. I therefore put aside several weeks at a time to focus solely on the analysis to ensure that I would be able to fully immerse myself in the data.

While conducting the analysis, I was acutely aware of the responsibility I had to my participants, and my desire to accurately represent their experiences. Acknowledging the role that the researcher plays both during data collection and data analysis, I sometimes worried that I would have too much of an impact on the findings. At times, the prospect of identifying the final themes and choosing which quotes to use felt daunting and even anxiety provoking. I frequently questioned my motives for prioritizing certain quotes over others. Was I looking for particular patterns and ignoring others? Was I somehow invested in presenting a specific narrative or painting a certain picture? How would my participants feel about the interpretations or inferences I was making? Was I more attentive to the negative experiences and less to the positive ones?

I finally managed to overcome my unease while compiling the final themes, again, by making sure that I dedicated enough time to this phase of analysis. As someone who was new to qualitative analysis, I was patient with myself. I inputted all the themes into an Excel spreadsheet, colour-coding them so that I knew which transcript they had initially derived from. I spent hours carefully collapsing and combining themes until the final themes emerged. It was usually only after completing each stage of the analysis that I would recognize things I could have done to make the process easier and quicker. I suspect that if I were to do an IPA analysis again, I would move through the stages much more efficiently. However, as a novice, I felt that in order to do my participants justice, I should give myself permission to spend as much time as possible on this part of the process.

I also struggled when taking steps to move beyond descriptive comments by making interpretations in an attempt to infer deeper meaning. I was aware that trans people often feel misunderstood, and I was cautious of making inferences in case they did not faithfully reflect my participants' subjective experiences and might result in them feeling – if they were to ever read my study – further misunderstood and alienated. I had to remind myself that making interpretations is a key element of IPA, and acknowledging the impact that the researcher has on the process is inherent in qualitative methodology. I tried to ensure that my interpretations were considered, tentative, and respectful.

Although I found the conducting the analysis challenging at times, I was surprised with how much I enjoyed the process. I found the stage of analysis where I was compiling and combining all the themes from different transcripts particularly enjoyable. I found looking for connections and divergences exciting and stimulating, and being able to experiment with the clusters afforded me an opportunity to be creative that I have rarely experienced while conducting quantitative analysis.

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3. Analysis

3.1 Overview

In line with Smith, Flowers, and Larkin (2009), this chapter explores in depth the themes that emerged from my analysis of the data. The themes discussed in this section offer an insight into the subjective experiences of the participants. While master themes were common to all participants, sub-themes were not necessarily present in all participants' transcripts (see Appendix 14), but were selected according to salience and relevance to the research question.

I have detailed each master theme in turn by exploring their subthemes using verbatim quotes from the participant transcripts.[1] There was some material that could have fallen under more than one theme, indicating a degree of overlap. In order to remain faithful to their phenomenological experiences, this section does not include references from existing literature and will instead be focused around the direct quotations (Smith et al., 2009). Longer quotes are presented in italics, and shorter quotes run into the text are illustrated using quotation marks. All quotes are followed by the participant's pseudonym along with a page and line number from the original transcript. As previously mentioned, participants have been given pseudonyms to maintain their anonymity. A list of these pseudonyms and some demographic information is outlined in Table 1 in the methodology chapter.

My comments following the quotations represent my tentative interpretations of the participants' own interpretations and sense-making of their lived experience. In line with Smith et al. (2009), I make both conceptual and linguistic comments. The linguistic comments involve observations relating to each participant's use of language, including hesitations, repetitions, and tone of voice.

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[1] Author interpolations/clarifications are encased in square brackets **[text]**. Pauses/hesitation/petering out in speech are represented by three dots **…** And deliberate omissions are represented by three dots inside square brackets **[...]**.

Three master themes (presented in bold) and ten sub-themes emerged from the analysis of the data, and are outlined in Table 2, below:

Table 2

Challenges of Living	**Negotiating Care**	**Survival**
In Limbo	Visibility	Finding the Strength Within
Stigma and Rejection	Battle for Treatment	Seeking Connection
Turmoil	Power	Choosing the Right Therapist
	Clinical Transphobia	

3.2 Challenges of Living

This master theme creates the backdrop for understanding the participants' experiences by highlighting the difficulties faced by many trans people in their day-to-day lives. All participants explained that once they had started transitioning, they were happy and relieved to be living authentically. However, sooner or later they began to encounter a range of problems related to frustrations with the process, how they were perceived by society, and the impact that maltreatment from others had on their psychological well-being. This is summarized in Caroline's comment below:

> *I think I kind of see it as sort of problems of living and problems of being. I've solved the problems of being bit because I'm happy as I am ... I'm happy with myself in a way I've never been. I have a sense of self that I've never had [...] The problems with living, yeah, I mean, that just gets worse to a large extent. (Caroline, 11, 471–481)*

Caroline distinguishes between the "problems of being" (i.e., how she feels within herself) and the "problems of living" (i.e., how she is treated by others, and her environmental circumstances). She explains that although she was finally living authentically and therefore felt happy within herself, transitioning seemed to be accompanied with a whole host of new problems.

3.2.1 In Limbo

Participants often discussed feeling vulnerable and frustrated during the early stages of transition. They described feeling eager for physical changes to occur, and often seemed exasperated by the seemingly slow progress during this time. Their frustration was often linked to discomfort around their body and concern about how they appeared to others. From their accounts, there is a sense that participants felt in limbo, waiting for something to happen, and unable to do anything to accelerate the process.

Francesca describes feeling highly self-conscious and uneasy in her body during these initial months:

> *So for that first six months you're basically standing out in the world going "Hey everyone, look at me," even when you try not to because you're ... you have to work, but yet you're still obviously male, but yet you're trying to present yourself as a female so like you can't go to the gym, you can't go ... do anything. (Francesca, 14, 535–540)*

Francesca talks about feeling particularly visible during the first few months of her transition. Her comment seems to suggest that she felt that she was somehow inviting unwanted attention, even when she deliberately tried not to. I wonder whether her use of the word "world" here signifies the magnitude of her discomfort. She talks about the difficulty of trying to present as female while still looking quite masculine, and indicates how limiting she felt this was. I wonder whether her use of "you" rather than "I" could indicate that she is trying to distance herself from the memory of this difficult time. She goes on to expand on this point:

> *I don't know how other people feel, but I felt especially vulnerable because you're not one thing, but you're not the other. (Francesca, 14, 574–577)*

Here, Francesca describes how difficult it felt to present outside the gender binary.

Her description seems to capture her sense of being in limbo. She alludes to a lack of belonging possibly leaving her feeling lost and isolated. She seems to wonder whether others feel the same, perhaps suggesting a search for shared experience. George also talks about struggling at the beginning of his transition:

> *I just felt like in a really vulnerable pos– ... when you come out and then you're living, you know, in your gender for however many months like, um, for some people if you ... if you're on a slow ... if you're at a slow gender clinic, it can be like years. (George, 20, 707–711)*

George appears to have felt particularly exposed during this period when he was living in his actual gender, but before he had been seen at a gender clinic. He alludes to the strain of having to wait for treatment. He suggests that he and other trans people are in a helpless position during this period of waiting. Barbara also seems to have felt in limbo during the early stages of her transition:

> *No one wants to do that ... that in-between bit where you ... you're literally ju-just changing your name and changing your clothes. Um, everyone wants to kind of have some physical changes. As it makes your life easier. There's ... there's no real benefit to having people point at you or laugh at you or stare. (Barbara, 29, 1055–1058)*

Barbara refers to feeling particularly susceptible to ridicule and mockery during this time. This stage appears to present plenty of challenges and drawbacks with no real benefits. There is a sense that things have to get worse before they get better, and she seems to find this unfair and unnecessary. A similar sentiment is reflected in Anna's comment:

> *It's a very intense process, and I just want to get through it, but mentally adjusting takes time, physically it takes time, um, but it's not a particularly pleasant place to be in this halfway stage. (Anna, 9, 435–438)*

Like Barbara and Francesca, Anna highlights her discomfort and explains how desperately she wanted to move past this phase of the transition process. From her use of the phrase “halfway stage”, I got a sense that she feels not just in limbo, but almost stuck in purgatory.

Ethan talks about his frustration while waiting for the hormones to take effect.

> *I think certainly in the early days kind of before hormones and stuff, um, or even just like when you’ve started hormones but they’ve not started to take effect, it is quite easy to feel like you’re not really getting anywhere and you’re just kind of treading water. (Ethan, 33, 1386–1388)*

I get the impression that Ethan feels stuck. He uses the metaphor of “treading water”, which suggests that he felt he was expending a lot of energy just keeping his head above water, but barely making any progress. Time appears important, as he appears desperate to move forward, but unable to do anything to speed up the process. Daniel too seems to feel in limbo while waiting for treatment, and describes a sense of restriction in what he is able to do because of his discomfort with his body.

> *For me, chest surgery is the biggest thing [...] I’ve not been able to do physical activity in school because my body dysphoria is just crazy; it’s just like I’m on a sports course. Like for me to pass this course, I’ve got to do the physical side. And I just physically can’t do it. (Daniel, 15, 524–537)*

Daniel appears stuck and frustrated. The thought of doing sport seems impossible to him as a result of the distress he feels towards his chest. He explains that this is particularly problematic as he needs to be able to play sport in order to pass his PE course at school. Although there is no actual physical constraint preventing him from playing sport, his psychological inhibition seems to leave him feeling that it is genuinely beyond his physical capability.

Ian talks about his experience of attending a support group and his own response to other trans people during this early phase of transition.

> *But to me they looked like weird half creatures and sort of like everything that I didn’t want to be. I didn’t’ want to be a freak. (Ian, 19, 719–722)*

Despite identifying as trans himself, Ian's initial response to these trans men appears to have been to *other* them. His comment implies a fear of looking different and standing out. I wonder whether what he really wants is to blend in. His use of the word "creature" suggests that those who do not fit the gender binary are seen as somehow subhuman. Perhaps his comment "I didn't want to be a freak" suggests that, deep down, this is in fact how he felt about himself.

3.2.2 Stigma and Rejection

A common experience described by participants related to how they felt they were treated by others. They recounted incidents of harassment in public, discrimination at work, and rejection from friends, family, and others in their communities. They described these experiences of maltreatment, and discussed the devastating impact that this had on them. Caroline captures this in her comment below:

> *Being trans isn't why you end up wanting to kill yourself; that's ... that's more round about what happens as a result depending on how you're treated. (Caroline, 30, 1272–1277)*

I wonder whether Caroline feels that this is a common misconception, which is why she feels the need to emphasize this point. I also wondered whether Caroline herself had been suicidal at times as a result of how badly she had been treated by others. I got the sense that she wanted to highlight that being transgender in itself is not synonymous with mental ill-health or suicidal tendencies.

Heather talks about her experience of being rejected by her church:

> *I personally was kicked out of my church where I had been the treasurer for twenty-eight years and ... um, you know, I was denounced [as] an agent of Satan. I said there's still people from that church who will cross the street to avoid me. (Heather, 25, 1068–1075)*

From her description, I sensed the profound impact that this experience had had on her. She describes being ostracized after being part of the community for 28 years, highlighting the enormity of the rejection. She talks about not only being forced to leave the church, but also being actively avoided and labelled as “evil”, implying the extent of the stigma experienced by trans people. Being “denounced [as] an agent of Satan” seems so strong and hateful, I imagined how hurtful it must have been to hear this.

George reflects on his experience of transitioning at work and feeling discriminated against:

> *I had a feeling at work that ... because I never got to go to any kind of events, I had a feeling that I was like kept in the office because I looked a bit strange. (George, 21, 752–755)*

George explains that although it was never explicitly stated, he sensed that his colleagues were embarrassed of him. George appears to describe a subtle process of exclusion and rejection preceding his dismissal. Caroline talks about a similar experience before she was dismissed from her job:

> *It’s ... everything ... It’s the little things then, you start realizing, you get the message you’re not really wanted here, you know, the GPs suddenly decided they ... they can’t work with me anymore, I’ve been there nine years, what suddenly happened and I ... I just couldn’t do anything right anymore. (Caroline, 16, 688–693)*

Again, what Caroline seems to be describing here is a felt sense of rejection. Like George, she has no concrete evidence that she was dismissed as a result of her transition, but she seems to have got the impression that her colleagues were no longer comfortable working with her. She elaborates below:

> *You get a kind of feeling that some of it was simply the fact that they just didn’t think that, um, it was good having me there because it was too much of an embarrassment for them. (Caroline, 18, 777–780)*

The way that her colleagues behaved towards her seems to have given Caroline the impression that they were disconcerted by her transition. Prejudice and stigma are often indirect and implicit, and this can arguably make it harder to deal with. Both George and Caroline describe a "feeling" that they cannot prove, and it seems that without concrete evidence, they are unable to confront the people who are treating them badly, meaning that their distress goes unacknowledged.

Caroline describes reading the report that she was sent after she was dismissed, and explains why she decided not to fight the allegations.

> *A couple of the comments that I did read in that ... in ... in the file was from people that I'd known for quite some time and I'd been working with, and I really couldn't believe they could say that, and that's one of the reasons why I couldn't go through it. I just found ... I just found it too distre– ... I just couldn't, you know. (Caroline, 21, 900–906)*

In her comment, her incredulity and disappointment are apparent. She explains that once she had read "the lies" (17, 733) that her colleagues had said about her, she felt it would be too upsetting to drag it out. Caroline starts saying the word "distressing", and then stops herself. I wonder whether the fact that it had been such a hurtful experience for her meant that it was almost too painful to say the word.

Francesca talks about being rejected by the LGBT community:

> *OK, we used to have one gay club, but when I went to that gay club, especially early on in transition, people were like, "Well you shouldn't be in here; you're not part of like the gay community, and this is like a gay club." And you're like, "Well I am; I'm part of the T in the community" ... "Yeah, but that isn't proper; you shouldn't really be in here because you're actually straight because you fancy men, but you're a woman, so you actually aren't really anything to do with us." And it's like "oh" [...] You didn't really feel part of the LGBT community. (Francesca, 19, 752–767)*

Francesca describes attending a local gay club and being made to feel like an outsider. It seems that she is made to feel that trans people are not legitimately part of the LGBT community. Throughout the interview, Francesca talks about her experiences of rejection and isolation. However, this rejection seems especially acute, as she is dismissed by the very community that she had hoped to take refuge with.

Daniel explains that after first being rejected by his parents and put into care, he was fostered by an aunt at the age of 4. However, he recalls that when he came out to her as trans, she was unable to accept or support him:

> *I broke ... I broke down ... This is when I was able to cry. I broke down and explained everything, and then I never had the support from family, that I felt like was a major thing for me, because where I'd been living with my aunt for like fourteen years, I feel like if you can take me from the care system, this is one thing I should be able to talk about, um, and that kind of like went downhill, so I felt like because I never had her support, I feel like I shouldn't ask someone else to help. (Daniel, 9, 309–314)*

Daniel describes this extremely poignant moment where he allowed himself to be emotionally vulnerable, only to be subsequently rejected by his aunt. Daniel repeats the phrase "broke down", which perhaps emphasizes the significance of this for him. He appears so hurt by her lack of support that he decides to give up asking others for help.

As well as recounting actual incidents of maltreatment, participants also discussed the impact that fear of rejection, harassment, and discrimination had on them. From their accounts, it sometimes seemed that dealing with the fear that something bad might happen was almost as bad as dealing with the reality.

> *I was really struggling with anxiety and panic attacks and just like walking down the road, or some days I couldn't leave to go to work, I had to call in sick, and like things like that and, um, like I had some bad experiences in public. (Barbara, 17, 607–610)*

Barbara's fear of harassment seems so debilitating that just going about her day-to-day life is challenging. On some occasions, the memory of these incidents appears to be so anxiety provoking that she cannot bring herself to leave the house.

Heather remembers the moment after her first gender-related healthcare appointment, and describes her acute fear of rejection and loss.

> *I sat in the car for twenty minutes, because as soon as I got in the car, I burst into tears. I thought it's the end of everything. I'm going to lose my marriage; I'm going to lose my job; I'm going to lose my children; I'm going to lose everything. (Heather, 12, 518–522)*

Heather's panic and dread seem apparent here. She seemed to believe that transitioning would inevitably result in her being rejected by everyone in her life: her wife, her colleagues, and her children. She later recalls the trepidation she felt about transitioning due to her concern about how she would be perceived and treated by others:

> *If I transition, I'm going to be like a hunted animal. Everybody's going to be looking at me. (Heather, 14, 623–625)*

She describes her concern of becoming a spectacle. Her image of the "hunted animal" is extremely evocative, and highlights how vulnerable and exposed she might have imagined being. The use of the word "animal" suggests a possible concern that if she transitioned, she would be dehumanized by others.

Francesca talks about her fear of going out by referring to the account of another trans women who, like herself, had joined the army before she transitioned:

> *She said that when she first started transitioning, she found it harder to go outside 'cause she was more frightened of other people than she would be, um, like jumping out of planes in Afghanistan or fighting the Taliban in close combat. She said it was actually more frightening every day leaving the house than it was to do that, um. And from like my personal opinion, even though I never did any of those amazing kind of scary feats […] I'd arrive for like work nights out, and I'd sit the car for twenty minutes trying to get the confidence to*

> *get out of the car, because I didn't want to get out of the car; I was terrified. The car was safe. It had walls round it, even though they're glass and people could see through, it was like a box around you, and you were safe. Um, you then get out your car and go into your pub, and someone goes "Oi. That's a man." You want your shield back around you. (Francesca, 28, 1196–1117)*

She explains that the fear she experienced before leaving the house when she had first transitioned was worse than the fear she felt "jumping out of planes" or fighting "close combat". Having herself joined the army, it is evident that this is a sentiment that resonates strongly with her. The juxtaposition of fighting in the army and walking down the street is extremely powerful. It is commonly understood that fighting in the army takes a great deal of mental and physical strength, and it is widely accepted as both courageous and impressive. By making this comparison, Francesca highlights just how terrifying and devastating the abuse and harassment she experienced must have been. I wondered whether her decision to relate her experience to another trans women was a way of trying to normalize what she had gone through.

3.2.3 Turmoil

All participants described experiencing emotional and psychological turmoil both before and during transition. Ian describes the difficulty growing up feeling isolated and misunderstood. He explains how he used to write stories about characters whose experiences mirrored his own.

> *Um, but that story is about how one of the brothers is effectively made invisible by the other five and by their parents. He's like an outcast in the family. Um, um, I kind of thought actually that is quite a ... quite a good metaphor for how it feels growing up transgendered. That although people are talking to you, they think they're talking to you, you don't feel that they're actually seeing you at all; you feel like they're talking to this image, and you're behind this pane of glass, and you have no means of communicating with them. (Ian, 14, 495–505)*

He uses the metaphor of being behind a "pane of glass", which illustrates how distant and detached he felt from those around him. It appears that not being able to explain how he was feeling about his gender acted as a barrier, leaving him feeling like an outcast, isolated and alone. I wondered whether the fact that he could not be authentic with others and show them his true self left him feeling unable to make genuine connections, even when people had the best intentions. He later elaborates on his sense of loneliness growing up:

> *So I went through my entire childhood thinking I'm the only person in the world who feels like this. I cannot talk to anybody about this 'cause they'll just think I'm crazy. (Ian, 16, 582–585)*

There is such a sense of sadness here as Ian describes spending his "entire" childhood thinking that he was the only person alive who felt like this. His sense that no one else in the world would be able to relate to his experience conjures up a vivid and devastating image of isolation. Correspondingly, Barbara talks about "struggling for a long time on my own" (6, 201), and Anna echoes a comparable sentiment in her frank statement below:

> *I didn't know what I was. I just, um, I just felt very, very alone, and I felt so ashamed, I couldn't tell anybody. (Anna, 2, 81–83)*

She describes her confusion about her gender identity and her inability to explain to anyone how she was feeling. By using the word "what" rather than "who", she seems to be objectifying herself. Her comment "I didn't know what I was" seems to suggest that there is something so essential about gender in the formation of identity that being unsure about it perhaps left her feeling detached from humankind and herself as a person.

Daniel talks about his struggle and having to deal with depression without the support of others:

> *Um, especially if like you're where I was at the stage where it was like depression because of your body anxiety, and at that point you had no one to talk to. The waiting time like, um, six to twelve months, it was just ... it was crazy for someone to go through body anxiety as well as depression, but on top*

> *of that have no one to talk to. (Daniel, 3, 94–100)*

He describes feeling overwhelmed and isolated. His comment "it was crazy" perhaps illustrates how absurd and unfair it seemed to him that he had to deal with all these issues without having anyone to confide in.

Participants talked about the debilitating effect that social anxiety had on their ability to go about their lives and function day to day. Barbara describes having "panic attacks all the time" (17, 607), and George talks about how his fear of being misgendered resulted in him feeling "really self-conscious in public" (George, 11, 380–382).

Francesca refers to the absolute dread she felt when preparing to leave the house early on in her transition:

> *Especially early on when it's terrifying to leave the house, and you're frightened, you're scared, you're making mistakes, and you go to leave the house and you're terrified. (Francesca, 13, 490–492)*

Francesca's anxiety is evident through her repeated use of synonyms for fear. She also talks about "making mistakes", and I wondered whether this was indicative of how significantly her distress was affecting her behaviour. I also wondered whether this indicates that she was perhaps being quite harsh on herself in feeling there was a right and wrong way to do things.

Caroline describes the catastrophic effect that transitioning had on her life in the following quote:

> *You know, my life ... my entire life is collapsing around me with remarkable ease and rapidity. I mean, short of my flat being hit by a giant meteorite and waking up one day and finding the world's [...] succumbed to a zombie apocalypse, what else could go wrong? (Caroline, 7, 2801–2806)*

From her comment, it seems like Caroline's whole life was in turmoil. Throughout the interview, she used humour, putting an amusing spin on some of the terrible experiences she'd had during her transition. This usually served as a way of lightening the mood, and I wondered whether she did this to distance herself from the painful memories. Perhaps for Caroline it was easier to laugh than to cry. The above comment is a perfect example of this. Her references to "giant meteorites" and "a zombie apocalypse" reminded me of sci-fi movies far removed from the devastating reality that she was describing. However, there is a real sense of despair and distress behind her initial comment, "my entire life is collapsing around me".

Anna talks about continuing to experience psychological turmoil in the form of constant rumination and worry about her family, her future, and her identity:

> *[T]he main thing has been rumination about this ... rumination about this process. What it means to be transgender; how I'm going to end up; what I'm doing to the family. Shame is still an issue, but less so, but there is the whole guilt and, you know, I still ... What am I? I'm not ... I'm never going to be a woman, um, I'm not exactly a normal man. (Anna, 9, 435–538)*

In addition to worrying about the impact that transitioning would have on her family, Anna seemed to be stuck in a constant cycle of existential questioning. From the interview, I got the sense that she knew who she was and had a clear sense that her gender identity was female. However, she seemed to struggle to make sense of herself as a trans person, particularly in relation to how she fitted into the binary system. I wondered whether Anna had internalized societal transphobia, leaving her continually questioning her identity, and preventing her from being able to see herself truly as a woman.

Barbara reflects on the negative impact that the process of transitioning had on various aspects of her life:

> *My issues were, um, going out in public, anxiety, obviously family issues and stuff, which were happening at the same time, but, um, it's hard to get through the process [...] [B]y the time you even get to the Clinic, you know, it's stressful and you're not in a good place. (Barbara, 28, 1005–1013)*

Barbara begins to list some of the challenges associated with transition. She seems to suggest that the accumulative impact of all these factors took its toll on her so that even before she had had her first appointment with the gender clinic, she was already overwhelmed and dejected.

3.3 Negotiating Care

This master theme relates to participants' experiences of healthcare. It highlights areas for improvement across disciplines and services. Negative experiences were associated with feeling invisible, powerless, and stigmatized. Positive experiences were often associated with feeling understood, empowered, and validated.

3.3.1 Visibility

Participants discussed their desire to be understood by health providers and the value of talking to someone who was attuned to their needs. A major source of frustration related to the lack of knowledge and awareness amongst health professionals, and particularly GPs. Participants described feeling invisible within the healthcare system. They reported frequently encountering clinicians who were uninformed and uneducated about trans issues, and therefore unable to provide the necessary support.

Francesca describes being made to feel that being transgender was not a serious concern:

> *If doctors treated it as a real issue rather than some bizarre, invisible issue that they pretend isn't there, or they actually could sit there and listen to you, that would be amazing. (Francesca, 26, 1025–1028)*

She expresses her exasperation with doctors who do not seem to view trans patients as a priority and are not willing to properly engage with them. She also suggests that the medical profession sees transition as abnormal in some way. Her use of the word "invisible" seems to indicate that she feels that some doctors do not even think that being transgender exists.

Similarly, George talks about feeling that his GP would have taken more care when monitoring his hormone treatment if it had been related to an illness rather than transition:

> *At times it's felt a bit like a kind of ... black hole, but I feel like if you had another kind of illness – not that this is an illness – but if you were taking other sort of medication, they ... your GP would probably be more concerned about how you manage it. (George, 25, 895–899)*

George feels that gender transition is in some way less legitimate than other medical complaints. His metaphor of a "black hole" illustrates the extent to which he feels that trans issues represent the unknown within healthcare: instead of knowledge and understanding, there is a dark vacuum. He later expands on this:

> *So I think like there's something quite fundamental in just learning the basic just, yeah, sort of terminology, or getting a basic grasp, so if someone says, I don't know, they're a trans woman, you don't have to say, "Does that mean you want to do this?" or, you know, "Does that mean you're going from this way that way or this?" ... you know, because you sometimes get stupid questions. I ... I found that in the beginning when I told my GP I was trans and they're like, "Does that mean you used to be, or you want to be?" (George, 35, 1250–1258)*

George clearly feels disappointed that his GP could barely grasp the basics of what it means to be a trans man or a trans woman. His exasperation is evident when he talks about being asked "stupid questions" by his GP. This is similar to the experience described by Caroline:

> *It seemed mad that I'd have to explain it to the GP, and then I'd have to go back and re-explain, and then even at the end of explaining it, she's still not sure which way I'm going. [Laughing]. (Caroline, 29, 1254–1257)*

Caroline expresses her frustration with her GP's lack of knowledge. She seems exasperated and incredulous that after explaining her situation numerous times, her

GP still seemed confused. This extract highlights the way in which Caroline feels so misunderstood, the pain of this perhaps so unbearable, that she uses humour and makes light of it to manage her difficult feelings.

Ethan notes the importance of educating healthcare professionals:

> *If you're not giving people the best training, obviously the stuff that they come out with is ... is, you know, it's garbage in, garbage out. (Ethan, 15, 652–654)*

Ethan seems to believe that clinicians are either not getting any training or not getting appropriate training on how best to treat trans people. It seems that he does not necessarily blame the individuals themselves but rather the institution that trains them. His comment "it's garbage in, garbage out" highlights the level of ignorance he seems to feel is present. Later on in the interview, he expands on this point:

> *If you're not willing to listen to your patients, and also you're not getting that background kind of support and education as a practitioner, I imagine it's quite difficult to really keep yourself informed, um, so I think more awareness, um, if nothing else as to, um, just to how an interaction should go really I think is the main thing. (Ethan, 34, 1466–1471)*

His comment suggests that he feels that clinicians do not care enough to be educated by their patients, and since they do not receive sufficient training, they remain ignorant to such an extent that they are unable to even conduct an appointment appropriately.

All participants seemed to agree that doctors need to be better trained so that they are able to appropriately support trans people. Barbara states that "GPs just need to be educated" (22, 807), and Heather argues that "doctors need far more training" (35, 1441–1441).

George expresses a similar attitude:

> *It's like there's not one standard body of information that all doctors are*

> *following; they're just like piecing it together. (George, 26, 921–924)*

Although there are NHS guidelines for working with trans people, participants' accounts suggest that GPs do not seem to be aware of the correct protocol. From George's comment, he seems to have the impression that most doctors take an unsystematic, piecemeal approach.

Although many participants reported disappointing and frustrating encounters with healthcare professionals, they also recounted positive experiences during which they described feeling listened to and supported. Participants talked about occasions when they felt the clinician had understood them and been able to meet their emotional needs. George recalls a recent appointment with his GP:

> *I had a GPs appointment last week, and my GP was really good about it; he used like the right terminology. Sort of respectful, he was like positive, kind of understood what I was doing, and had a bit of knowledge about what was happening, which was good. (George, 33, 1178–1184)*

Caroline similarly highlights an encouraging experience with her GP:

> *There is ... there is ... um, she was very good, and she was very, um, understanding and all the rest of it, and she was re- really wonderful. (Caroline, 1, 23–27)*

Caroline emphasizes how important simply feeling understood was to her. Ethan also talks about the importance of having a supportive GP, particularly during the early stages of transition:

> *Um, I was quite fortunate in that the GP that I spoke to had already had another transgender patient like male to female, so she was at least roughly familiar with the kind of referral process, and, you know, the language to tick all the boxes and stuff. Um, you know, she was very kind of, um, understanding. [...] I think it ... it does kind of go to show that it ... it is very much a kind of a lottery as to how understanding your GP is. You know, I know other people*

> *who haven't had as good experiences, um, and yeah, I ... I think sort of at that early stage, it was quite important to have, you know, that at least understanding, otherwise, you know, you do get your confidence knocked and I think it makes obviously the ... the subsequent stages a bit harder. (Ethan, 4, 132–164)*

Ethan clearly appreciated having a GP who was understanding and had at least a basic knowledge of the transition process. He refers to the detrimental effect that having a bad experience with a GP can have, and how long-lasting this impact can be. He suggests that having to deal with an unsympathetic GP makes the whole process that much harder. He compares finding an understanding GP to the "lottery", implying that he sees it as based on luck and completely out of the patient's control. I also wondered whether by using the word "lottery", he is suggesting that the chances of finding a supportive GP are extremely low.

Barbara explains that her GP arranged for her to go for regular check-ups while she was waiting for her referral to be accepted by the gender clinic:

> *I think I went ... I went to the GP, I think on a fortnightly basis. She asked me to come back, well, I think it was once a week to start with just to check in. Like five minutes, how are you doing, that kind of thing, um, which was, I think, really helpful, um, she didn't have to do that. I felt bad because it wasn't ... to me it wasn't like, you know, something doctorish. It was ... it was more sort of support. (Barbara, 3, 89–100)*

Barbara felt that her GP understood how stressful waiting can be. She describes feeling bad that her GP was providing her with emotional support, as she sees this as going above and beyond the duties usually performed by a doctor. I wondered whether having so many negative experiences had left her feeling undeserving of proper support.

Ian explains that he senses that positive changes have occurred since he transitioned:

> *I think from speaking to people, I think a lot of the changes have happened, that*

> *... that gender psychologists today will tend to be more respectful, will actually listen to what the patients are saying. Um, if that's not the case, I think that certainly needs to be. (Ian, 26, 965–969)*

This comment suggests that Ian had not felt heard or respected by his psychologist. However, he explains that from listening to other trans peoples' experiences, he suspects that things have changed. His final remark emphasizes how essential he thinks it is that healthcare professionals demonstrate these basic courtesies.

3.3.2 Battle for Treatment

Participants discussed some of the obstacles they had faced when dealing with the healthcare system. They talked about their struggle to access treatment, and described having to constantly "fight" to get what they needed. Participants also described the detrimental effect that having to deal with the health system had on their psychological well-being. They explained that the uncertainty of not knowing if or when they would receive treatment meant that they were often left feeling demoralized and anxious. The language that was used by participants was often very combative and seemed to imply that they saw the system as hostile and sometimes obstructive.

Ethan talked about "trying to fight an uphill battle against the NHS" (9, 296–297), and, similarly, Heather described "having to fight tooth and nail" (30, 1262). Francesca explained that she felt that she was "always fighting" against clinicians (27, 1060–1062), and Ian talked about feeling as though his appointments "became a real battleground" (2, 57). These descriptions highlight the extent of the struggle involved in accessing the appropriate treatment, and the determination required to progress through the system. There is a sense that participants felt that the healthcare system and sometimes the clinicians themselves were working against them, rather than with them.

Ian recalls a negative experience with a psychologist:

> *And that became the pattern of how he was, um, in our meetings; confrontational, always picking fault, always sort of trying to catch me out.*

> *Um, so, yeah, it was not a positive experience. (Ian, 1, 32–35)*

Ian describes feeling attacked and criticized during the session. He comments that the psychologist was “trying to catch [him] out”, which suggests that he felt that the clinician was working against him.

Francesca’s description of her interactions with GPs encapsulates her frustration:

> *Four weeks later, you’re still going back to them, and they still haven’t bothered looking it up. That’s when you’d actually like some help rather than feel you’re always fighting. (Francesca, 27, 1059–1062)*

Francesca had explained that she was frequently confronted with doctors who knew nothing about trans issues and seemed completely unwilling to educate themselves. She described being told numerous times, “I don’t know; I’ll look it up” (27, 1054), and then going back time and again only to realize that this had not been done, and they still knew nothing. Francesca’s exasperation is evident here, and her comment “they still hadn’t bothered” implies her perception of a real lack of concern on the part of the GPs. She expresses disappointment that instead of receiving some much-needed support, she is constantly faced with indifference.

Barbara also reports feeling that GPs were reluctant to help her:

> *And it’s just been like that, and it ... it’s been ... I think the ... the GPs have been an eye opener for me. Just generally how little they know, um, and how unwilling they are to do anything to do with this to ... to a degree. (Barbara, 11, 397–399)*

Barbara seems to experience GPs as not only uninformed, but also uncooperative. She depicts their conscious resistance towards supporting trans people and an unwillingness to facilitate transition. Her surprise made me wonder whether her experiences had challenged the basic assumption that many of us have that doctors are supposed to help people, not hinder them.

Ethan talked about his difficulty trying to get treatment from his GP:

> *He's not really reading the correspondence, um, so I've had to fight him a couple of times and sort of insist that "no, I am due for injections this week". (Ethan, 27, 1145–1148)*

Again, it seems that Ethan was made to feel that no effort was being made to help him, and therefore his only option was to demand that he receive his hormone injections.

Caroline talks about the difficulty she had trying to get an initial appointment with a psychiatrist:

> *They forgot ... the psychiatrist forgot to send me an appointment, and I had to chase it up, so there was this gap between when my GP referred me, the psychiatrist forgot all about making the appointment, and I ended up having to chase them up to sort of say, "When is my appointment?" (Caroline, 3, 115–117)*

Participants often described being forgotten or getting lost within the system. Therefore, in order to ensure that they got appointments, they had to spend time chasing them up. Caroline's experience was echoed by George, who explained that "you've got to chase them up constantly" (24, 850). This seems to have left participants feeling unimportant.

Caroline also explains that she has now been waiting almost a year for her surgical referral:

> *So that's ongoing. It's getting to the point where I imagine if anything's going to happen with that, it will probably be posthumously. I've had visions that they're sort of ... they're shoving me in the crematorium, and some NHS official is going to come and run in and say, "Stop! We've have an appointment for you." (Caroline, 13, 540–545)*

Caroline uses humour to emphasize her hopelessness at waiting almost a year for her surgical referral.

Participants reported that a major hurdle of the transition process was getting an appointment at a gender clinic. Francesca mentions that it took her “about ten years” (2, 70) to get an appointment with a gender clinic because of the reluctance from GPs to write her a referral. She states, “I went time after time after time; they didn’t want to do anything” (3, 85–86).

George also comments on the difficulty of getting a referral. He explains that it was “such a long drawn-out process” (7, 257) that he decided to go privately:

> *I just had this sense that the NHS process was going to be really slow, and I just couldn’t ... I felt like ‘cause I’d waited so many years, you know, from nearly twenty just to start and I ... I couldn’t really wait any more. (George, 10, 351–354)*

Based on his previous experiences with the NHS, it is clear that George felt that going privately would be the best option. He seems to feel that as he had already spent so much time waiting to be able to acknowledge his gender identity, having to wait any longer to live authentically would be unbearable. For him, having to wait years for treatment would have been intolerable. His sentiment was echoed by Caroline when she comments, “I don’t think, um, dragging the process out for such a length of time really is that beneficial” (30, 1278–1280). Caroline feels that having to wait for such long time to progress through the system is both unhelpful and detrimental.

Heather explains that even once she had been referred to the gender clinic, she still had difficulty getting appointments: “The number of times that you didn’t get an appointment, you just waited and waited and waited” (28, 1195–1196). Her repetition of the word “waited” emphasizes how excessive it must have seemed to her. She explains that she tried to get in contact with the clinic numerous times, but never seemed to be able to talk to anyone:

> *You rang the phone, and it just rings out. They say "leave a message", and you do, and nobody ever gets back to you, you know; it's administrative chaos, which is a big problem. (Heather, 29, 1217–1219)*

Heather seems frustrated being at the mercy of a clinic with no other option than to continue ringing and waiting. She describes it as "administrative chaos", implying she felt that the whole system was completely unorganized and ineffective. Daniel states, "I was ringing the clinic ten to fifteen times, and I just got no answer" (14, 495–496). He explains that no matter how many times he reached out and tried to contact the gender clinic, he was continually met with silence, which seems to have left him feeling anxious and uncertain. Daniel argues how useful it would be for people to have some assurance from the clinic. He explains that it would be helpful "to reassure them that they are on the waiting list, rather than you just holding your breath" (4, 129–131). This metaphor of "holding your breath" conjures up an image of suspense, unable to breathe – waiting for something you desperately want, with no idea of when or even if it will happen.

George reflects on the contradiction that exists within gender clinics, and the difference between what they aim to do and the reality of what they actually do:

> *I feel like they kind of want it to be a therapeutic service, but because the ... because it's so slow administratively, because there is ... the process is so long and they demand quite a lot, I think it ends up having a kind of detrimental effect on people's mental health. (George, 22, 798–802)*

He suggests that even though gender clinics aim to be supportive and therapeutic, in actual fact because they are so slow and ineffectual, they end up causing psychological distress rather than alleviating it. He later warns others who are planning to transition to "be prepared for like long delays" (37, 1301). Perhaps by emphasizing the importance of being prepared, George, like Daniel, feels that his own experience might have been easier if he had known what to expect, even if it was negative (i.e., long waiting times). This highlights the significant role that uncertainty seems to play in increasing anxiety.

3.3.3 Power

Participants explained how negative encounters with clinicians, uncertainty around appointments, and having to jump through hoops left them feeling powerless, anxious, and distressed. Whereas feeling that their opinion was valued and being given the opportunity to set the pace of appointments resulted in them feeling empowered.

Francesca talks about her struggle to be taken seriously by her GP. She recalls being told, "We don't agree with it, and we don't understand it, so we don't think it's a good use of NHS money" (3, 91–92). She describes the lengths she had to go to in order to be treated in the following quote:

> *It took me to write and actually plead with them after going time after time, and when you're actually feeling nervous, you're scared, you're terrified, and you're going to these people who are ... you see as all-knowing, and they say things like that. It shouldn't be allowed, but it's all ... they're still doing it now. (Francesca, 3, 106–111)*

Francesca describes feeling vulnerable and helpless during this time. She comments on the position of power that doctors hold in society. She alludes to their privileged position, not only as gatekeepers of treatment, but also in their status as people who are "all-knowing". Her outrage at the way they seem to abuse this power is apparent in her comment that "it shouldn't be allowed".

Anna describes feeling completely distraught following an appointment with a private psychiatrist:

> *He said to me [...] I need to get over this, and I'm not one of these transsexuals, and ... and ... and I need to almost pull myself together, and I can remember feeling ... walking out of there, and feeling absolutely suicidal; it was the most awful experience, for which he charged me £300. And I thought, "I'm not paying it." And I did pay it, because I'm meek and mild, and he ... I suppose he's a colleague, but he ... he was awful, and he was a senior psychiatrist, and I was thinking, "He ... he doesn't have any empathy*

> *for people. How can he do this job?" Anyway ... I ... anyway, so that was a very bad experience. (Anna, 7, 313–333)*

Anna seems to feel that his treatment of her was shocking, especially considering mental health professionals are supposed to show "empathy" and help patients, not leave them feeling desperate, distressed, and "absolutely suicidal". Anna admonishes herself for paying the psychiatrist's fee, even though she felt that he had treated her badly. She describes herself as "meek and mild", suggesting that she felt angry with herself for not having the strength to stand up to him. Even though Anna is herself a medical professional and is in a position to know that his treatment of her was inappropriate and unacceptable, the fact that she felt unable to stand up to him suggests that, as she was presenting as a patient, the power dynamic still existed.

Barbara recounts a similarly distressing experience with a private psychiatrist:

> *Um ... I don't know. I think I felt dismissed, and I'd gone there with all my letters, all the previous assessment things that I'd had before. Um, I spoke about my history, my like depression, self-harm and all ... all sorts of stuff, and he kind of just said maybe ... maybe I was borderline [borderline personality disorder] or autistic, and I was just like ... I was just ... It was like a slap in the face. (Barbara, 9, 321–326)*

Barbara explains that after openly and honestly discussing her mental health history and presenting her letters from other healthcare professionals, the clinician insensitively and inappropriately misdiagnosed her. This seems to have left her feeling invalidated and misunderstood. She describes this experience as a "slap in the face", which highlights how upsetting and insulting she found it.

Later on in the interview, Barbara reflects on the assessment process:

> *Looking back ret- retrospectively, you ... you see them for one forty-five minute, sixty-minute session, and from that they make a deduction about your whole life, where you've ... where you've come from, and where you ... where you're allowed to go, and that's ... it's, yeah. I ... I find that kind of ... I can't really*

> *comprehend how that ... that works, um, because there's all sorts of things that you might not have got to say or ... or whatever, and there's a lot of pressure on the patient going into that situation, because often they want the end game [...] you feel like they have a lot of power, um, but they don't know you, and they can make recommendations on very short sessions, and I find that kind of unusual. (Barbara, 24–25, 875–897)*

Barbara describes feeling that there was a power imbalance between her and the clinician assessing her. She seems to feel that the process is crude and reductive and puts a lot of pressure on the patient to say the right thing. She finds it unfair and confusing that, after one short meeting, the clinician is able to make a decision that will impact her life in such a profound way.

Similarly, Caroline describes feeling at the mercy of the assessing clinician:

> *They were forever kind of, um, making me jump through a whole new set of hoops. So you ... you go to an appointment, and they say, "Well, you've got to do this." "OK," so you do that; you turn up at the next appointment, "Well you've now got to do this." And it's like an endless stream of things that you have to do [...] I didn't know from one appointment to the next whether they were going to treat me; all I knew was they kept telling me ... telling me to do all these things. (Caroline, 4, 141–178)*

Caroline resents being told what to do, and I wonder whether this was partly because the requirements seemed arbitrary to her. Her sense of powerlessness is highlighted by her uncertainty, not knowing from one appointment to the next if she was going to be treated or not. Like Caroline, George uses this metaphor of jumping through hoops when talking about the assessment process:

> *It's so clearly like hoop-jumping or like they really ... some doctors really just clearly set out, you know, five steps that you should have reached, and this means that you're transitioning, or this means that things are going well, and it's so weirdly rigid and like they ... there's no like, I can't ... can't say it. I think it would just be good if ... if people could question ... I think if people had*

> *a more active role in that process. (George, 15, 139–546)*

George feels that doctors come up with strict and inflexible rules that patients have to follow in order to receive treatment. He seems to regard the requests imposed on him as generic requirements of the service, rather than focused on his individual needs. He appears to especially resent the lack of autonomy, and his perception is that patients are unable to question the current protocol.

> *I found that [...] kind of mental health assessment quite stressful, because I found the ... I think the psychiatrist quite pushy, and like [they] really argued about definitions of gender quite a lot. (George, 2, 45–57)*

George experiences the psychiatrist as being unnecessarily aggressive and argumentative. He seems to feel that the clinician was more interested in debating and deconstructing gender as a concept rather than trying to understand George's point of view and what gender meant to him. He also seems uncomfortable with the amount of private information that he was expected to disclose during the assessment sessions:

> *I suppose it is to do with mental health and like how much you have to disclose, and then how much becomes like public knowledge, but you basically have no choice; that's what you have to say in order ... That's the amount of detail you have to go into. (George, 13, 449–453)*

George refers to information being shared with GPs and other healthcare professionals as becoming "public knowledge". His exaggeration reflects how much of an invasion of privacy this sharing of information feels to him. His comment "you have no choice" highlights his perception that he has no autonomy in this process.

Ian recalls an initial appointment with a gender psychologist regarding transitioning:

> *I wear ... wear, um, rings, and he'd say, "Why are you wearing rings?" So like [I'd say], "I like them." So [he'd reply], "Well boys don't wear rings. You're going to have to take those off," and things like that. [...] He had this very old-*

> *fashioned view of, um, sort of gender-stereotype view of emotional expression. It was like boys don't cry; boys get angry. (Ian, 2, 45–71)*

This extract highlights Ian's experience of a psychologist who appears to have very rigid and out-of-date views about gender expression, which he was ready to impose on to his patients. Ian describes the psychologist as very confrontational and authoritarian, telling him what he should be wearing and how he should act with no regard for what he might want. Ian elaborates on the impact of these meetings in the quote below:

> *Um, I mean, I actually started, um, self-harming again, which was something I hadn't done for years, um, but I just felt so much stress, and I felt like he was watching me all the time, um, and I knew it was irrational. He's not watching me all the time; he's not tracking me. But I just felt like everything I did, he was somehow watching me to see if it was ticking the right gender boxes. (Ian, 3, 95–101)*

I felt quite shocked listening to the devastating impact that these interactions appeared to have on him. Ian explains that he began self-harming as a result of the stress he experienced from these encounters. He seems to have felt so attacked by the clinician that he internalized this and began attacking himself. It appears that he felt under such scrutiny from the psychologist that he began to feel paranoid and persecuted outside of the sessions, as well as during them. He describes feeling so undermined that he began second-guessing himself and questioning everything he did. Ian summarizes his discomfort with the power imbalance in his frank statement below:

> *He just had all the power, and just ... it was just a really horrible feeling. (Ian, 4, 143–144)*

He seems to have hated the feeling that the clinician had all this power over him. He expands on this later on in the interview, when he describes how the disparity in power impacted what he said during sessions:

> *I didn't feel I could be open with him. I mean, I certainly didn't tell him that I'd started self-harming; that would have been absolute, "You're out the door." (Ian, 12, 411–414)*

Ian explains that he felt unable to be honest about his self-harming due to the fear that he would be discharged and denied further treatment. This demonstrates how significantly the power of being gatekeeper impacts on the therapeutic relationship and can lead patients to feel that they need to withhold information in order to be treated.

George reports feeling pressure to conform to a particular narrative:

> *I think [it] goes back to that original point of like missing certain pieces of information out, um, because you want to kind of ... you need to have this like coherent narrative. (George, 15, 548–551)*

Again, George describes feeling the pressure to omit information and hold things back during assessment sessions in order to fit in with what he thinks the clinician wants to hear. Ethan describes a similar experience:

> *Yeah, I mean, there ... there were certainly times that with the ... the kind of the flow chart, um, approach to the interview, I felt like there was an answer they were looking for. (Ethan, 39, 1640–1642)*

Ethan reports feeling that the interview took a "flow chart" approach, suggesting that it felt linear and rigid. This is supported by his sense that the clinicians were looking for specific answers to their questions. Ethan seemed to feel that it was more important to give the correct answer than to be honest.

Heather, on the other hand, talks enthusiastically about her experience with a clinician at a gender clinic:

> *We had some very adult conversations, and they let me go at my own pace, and we had intelligent, mature discussions. (Heather, 38, 1541–1542)*

Heather seems to value being given the opportunity to have in-depth and intellectual discussions. She highlights the benefit of being allowed to determine the pace of the session, which seemed to help her feel in control. This suggests that although there is an inherent power imbalance between patient and clinician, the patient can be helped to feel more in control if the clinician is willing to allow them to set the pace of the session. She refers to being treated like an adult, which perhaps suggests that she has previously felt that she was treated like a child.

Similarly, Ethan talks about the value of being able to have a considered and frank conversation with his gender clinician:

> *I mean, in terms of the interactions I had, they were all sort of very open-minded, you know. We talked about sort of non-binary identities and stuff as well, so I didn't feel like I was sort of shoved through the sausage machine of either them talking me into it, or indeed talking me out of it. Um, you know, I ... I think it ... it ... they were able to discuss my feelings in quite abstract terms, which I think is quite helpful when there's not really an analogy to get across. You know, why you think that something is the right treatment for you in ... in the case of something, which is kind of, um, emotionally driven and sort of innate, um, but I think that, you know, being able to have discussions with someone who was obviously up on the language was ... was quite a helpful way of doing it. (Ethan, 6, 249–261)*

It is apparent that Ethan appreciated being able to explore the concept of gender in detail with someone who was familiar with the topic and able to use the appropriate terminology. He seemed relieved that he had not felt cajoled one way or the other, which suggests that this had been a concern for him. The "sausage machine" metaphor conjures up a powerful image of being forced through the system without any consideration of individual needs or differences, while being treated like a piece of meat rather than a human being. The fact that this seemed to be a concern for Ethan suggests that he had initially had quite low expectations, and was pleasantly surprised with how he was treated.

3.3.4 Clinical Transphobia

Participants described facing discrimination, prejudice, and blatant transphobia within healthcare at certain points during their transition. These experiences of clinical transphobia often seemed to leave participants feeling discredited and invalidated.

Anna recounts an appointment with a private psychiatrist:

> *He described trans people who transitioned as tarzans. He said, "Oh, you're not one of these tarzans who go and have all this surgery." Like ... I didn't know what he meant by it. Um, and he ... he just thought I needed to man up. He didn't quite use that word, but that's what he meant. (Anna, 39, 1704–1709)*

Anna explains that the psychiatrist not only disregarded her needs by telling her what to do, but he also dismissed her gender identity by using a derogatory and offensive term to describe trans people. His use of the word "tarzans" suggests that he sees trans people as unnatural and subhuman. She also talks about the importance of doctors treating trans people the way they would any other patient:

> *I think they have to put their own prejudices aside, the same as they do for all their other patients, and it's shocking the number of doctors who don't do that, and the horror stories you hear of people either refusing to prescribe for people or to refer them on, and actually, I think if this is acceptable treatment, I think that kind of treatment should be reportable to the GMC. I don't think that is acceptable. (Anna, 42, 1848–1855)*

Anna expresses her outrage regarding the "horror stories" she has heard about doctors withholding treatment due to personal biases and prejudicial attitudes. As a health professional herself, Anna condemns the poor treatment that trans people are subjected to, and is resolute that doctors should abandon their prejudices or be held responsible.

Francesca recounts the first time she went to see her GP regarding her gender:

> *OK, first with the GP, I probably talked to him when I was twelve, and I was told, "You don't want to go down the road" by the coun– ... like a country doctor. "It's a bad road; it's perverted. Um, what you need to do is you need to find a girlfriend, um, you need to form a relationship with a girl as quickly as possible, and it will cure you." (Francesca, 1, 23–29)*

This extract appears to highlight the prejudice and ignorance that exists amongst some healthcare professionals, which is perhaps particularly prevalent in rural areas. It is evident that the doctor has absolutely no understanding of what it means to be trans, and is confusing gender and sexuality by suggesting that she "find a girlfriend". Francesca explains that, some years later, she went back to the same GP practice, but to see a different doctor:

> *Um, I went again when I was about sixteen, seventeen, um, and I was told, "What you needed to do was find a girlfriend. If you can't find one, you can hire a girl for the night, and that can cure you, and that will cure you. You just don't know what you want. You don't know; you're too young. You don't understand, um, those people are perverted. They're horrible people." Um, and that was with another doctor at the same place, so I stopped ... I didn't go back to the doctor; then joined the Army. (Francesca, 2, 44–52)*

It appears that not only is she denied the possibility of seeking support of treatment for this problem, but she is, again, shamed and made to feel like a deviant. It appears that these encounters had such a detrimental impact on her that she decided to give up trying to seek help for her gender dysphoria. She then reflects on her experience of going to A&E after falling off her bike. Even though she had socially transitioned, changed her name, and started taking hormones, they refused to put her on a female ward (because she did not have a gender recognition certificate):

> *They went, "Oh well; you'll have to be in the Men's." And I was like, "Well, I'm meant to be put with women." And they were like, "No, well, you'll have to be on the men's ward." So I said, "Fine." I said, "I'll go." "Oh well, we have ... you haven't been seen by a doctor. You have to be seen by a doctor because we think like you've got a broken bone." And I*

> *said, "Well, I'm not prepared to be treated like that so bye" and just left because I'm ... they said it would be five to six hours, but I wasn't prepared to be put on a men's ward ... for that long, and have the doctors laughing and joking with the nurses, and you can actually hear them. Um, I wasn't prepared for that. (Francesca, 5, 182–195)*

The thought of being put on a men's ward appears to be so upsetting to Francesca that she decides to leave the hospital despite not having been seen by the doctor. When she heard the staff members laughing at her, she decides that she is not willing to allow herself to be mistreated and mocked.

Ian recalls having to attend an appointment, after he had transitioned and was living as male, to have some cysts removed from his breasts:

> *First of all, the nurse who had the list, she started to sort of like take issue with me; she wouldn't believe that I was in the right place. [...] But then the doctor arrived. The doctor was very young; she looked ... only looked about early twenties, and she could only just have graduated. She walked in the door and burst out laughing. [...] And she couldn't stop herself. She was like, "I'm sorry. I'm sorry," and then burst out laughing again, so, um, so that ... that was the worst lack of professionalism I came across. (Ian, 8–9, 295–320)*

Ian describes first being dismissed, and then openly laughed at. He acknowledges that the doctor was young and therefore possibly simply inexperienced rather than purposefully malicious. It almost appears that Ian is half excusing her behaviour. He talks about the incident as demonstrating a "lack of professionalism", which seems like an understatement. I wonder whether this was his way of trying to diminish the true impact of what was arguably not just unprofessional, but cruel and offensive too. He struggles to articulate his final comment, which perhaps signifies the depth of his distress at being made to feel an object of ridicule, whether it was purposeful or not.

Caroline mentions being avoided by her GP:

> *I think my new practice, um, my sort of named GP that I'm supposed to be*

> *allocated to has not seen me. Um, he avoids me like the plague. (Caroline, 1, 23–27)*

She seems to feel that he would much rather not have to deal with her, or even come into contact with her. Her comment that he avoids her "like the plague" implies that he made her feel as if she had some sort of contagious disease and should be shunned and avoided at all costs.

George talks about visiting his GP for his hormone treatment and feeling that he took pleasure in causing him discomfort during the injections:

> *He was like slightly sadistic. I don't know; he was a bit weird about it. He ... he did it, and he was almost like, "Oh, I dislike this as much as you do." (George, 32, 1125–1128).*

Like Caroline, he senses that his GP is uncomfortable around him and would rather not have to see him or treat him. Furthermore, he seems to make no attempt to conceal his feelings, and instead appears more than happy to make George aware of his discomfort.

Ethan reports picking up on prejudice from doctors and feeling judged for who is he:

> *I mean, there was a sort of implied element of judgement there I think, um, in terms of, um, that they ... they thought it would be a waste of money. (Ethan, 14, 618–620)*

He describes being made to feel that trans people are undeserving, and treating them is a waste of public money and resources. Similarly, Heather explains that there are "still issues with some GPs who project their own moral views […] on to patients" (35, 1462–1463). Her comment suggests that she suspects that some doctors disagree with the idea of gender transition, and so try to impose their biases on the trans patients they see.

3.4 Survival

This final master theme relates to how participants made sense of their ability to survive various obstacles and hurdles during transition. They reflected on coping strategies and their experience of building resilience. They talked about things they would have done differently, and considered what advice they would give to other trans people just beginning the transition process. This theme is particularly relevant to counselling psychology as it has implications for how best to support and work therapeutically with trans clients.

3.4.1 Finding the Strength Within

While talking about ways of coping, all participants emphasized the importance of developing resilience and building assertiveness. Most participants seemed to feel that assertiveness and resilience went hand in hand. Ethan talks about the importance of trans people making sure that their needs are being met when accessing healthcare:

> *It's important to be quite insistent that ... basically, where your needs aren't being met, it's important to make clear that, you know, there's something that you need. Otherwise you're going to fall through the cracks. (Ethan, 30, 1266–1269)*

Ethan emphasizes the necessity of having a good understanding of what you want to get from appointments to ensure that you get what you need. He implies that if trans people are unable take control of their care, no one else will. Ethan seems to suggest that relying on others is not safe. His metaphor of "fall[ing] through the cracks" serves as a warning: unless you are willing to fight for yourself, you are in danger of becoming lost in the system. He elaborates on this point:

> *If you're not willing to, um, to have sort of confrontations sometimes – not like, you know, aggressively or making a scene – but if you're not willing to push back or, you know, assert, as you say, the ... your right, then ... I think it is easier to be fobbed off sometimes. (Ethan, 30–31, 1294–1300)*

Ethan talks about the importance of being confrontational, but then warns against becoming too hostile. His comment "if you're not willing to push back" sounds almost combative, as it conjures up an image of battle and forcing the enemy to withdraw. He seems to feel that it is easy to be dismissed or ignored by the medical power. I wonder if perhaps at times he felt that they were looking for any excuse to get rid of him. He mentions "your right", emphasizing that trans people have the same right to be treated and to access healthcare as anyone else.

Similarly, George talks about the importance of being assertive:

> *And I ... I think I could have been much more pushy [...] I think you have to be more ... much more assertive, especially because services are slow at the moment. And also I think you have to like look after yourself a bit. (George, 36, 1289–1295)*

Like Ethan, he describes the necessity of being "pushy", which implies being not only assertive, but forceful. He repeats the words "much" and "more" several times, which emphasizes how crucial he feels this is, particularly when subjected to slow services and long waiting times, as is often the case when dealing with the NHS. His final comment about having to "look after yourself" suggests that he believes it is a risk to rely on others.

Francesca highlights the importance of being prepared to fight:

> *Um, that's rather depressing to say. Um, but yeah, I think I'd still be waiting. If I hadn't been prepared to fight, I don't think I'd have got half this far. (Francesca, 27, 1068–1071)*

Again, there is the suggestion of combat with her comment "prepared to fight". She clearly lacks confidence in the system, which is evident through her suspicion that she would "still be waiting" had she not been willing to stand up for herself. Her assertion that it is "rather depressing to say" suggests that she is aware that her viewpoint is quite pessimistic. Her final comment points to her awareness of her own strength and determination in being able to come as far as she has. She later expands on this point:

> *Um, stick up for yourself; be as strong as you can; don't let people wear you down; don't give in, and fight and fight and fight. And then wake up in the morning and [...] do it all again. (Francesca, 34, 1342–1345)*

There is a dogged determination in the above quote, which can be seen through the repetition of the word "fight". Francesca gives the impression that she has been fighting a perpetual battle against the world. It is clear that she has needed to find the strength within herself in order to prevent herself being worn down by others. Although she is talking about her ability to stay resilient in the face of adversity, there is also a sense of weariness. Francesca continues emphasizing the importance of resilience when she compares transition to running a marathon:

> *You have to believe in yourself, and you have to fight for yourself, and it's a long run. It's like running a marathon; most of it's in your head. OK, you have to be physically fit, but after like you've run ten ... ten miles, there isn't much difference to running twenty miles, and once you've started down the road, the NHS can help you by putting you on pills. The NHS can help you by giving you a final operation at the twenty-sixth mile, but you have to actually get there. You have to fight yourself to get there. That is the only way of doing it. (Francesca, 35, 1373–1383)*

Francesca highlights the importance of self-confidence, determination, and perseverance during transition. The metaphor of running a marathon suggests that transition was a long and difficult journey for her. She explains that although transition is about changing one's body, it is more of mental battle. She mentions that while the NHS can help by proving medical interventions, she feels that getting through the process is down to the individual and their ability to be psychologically robust.

In the following quote, Caroline describes the process of learning how to become resilient:

> *It becomes kind of self-affirming. You do it once, and you keep on doing it, and it gets easier and easier and easier, and you suddenly find that it's no longer a*

> *problem to do it, and, and that's ... that's really what made the biggest difference [...] I suppose you ... you suddenly learn how to be resilient because you ... you ... if you want to do it, you've got to. There isn't ... there isn't a kind of alternative. (Caroline, 23, 975–982)*

Caroline explains that she learnt how to be resilient by facing challenges head on and doing what she found difficult time and again. Her repetition of the word "easier" implies an almost joyous sense of triumph and a celebration of success through her own efforts. She describes this process as "self-affirming", and it is clear that she feels that this transformation was what got her through. In many ways, her message is positive, since it implies that anyone can learn to become resilient. However, in her final comment, "there isn't a kind of alternative", I sensed a touch of sad resignation. Like most of the other participants, Caroline indicates that in order to survive, she had no choice but to become resilient, since she was not going to get the support she needed from anywhere else.

Ian also talks about the importance of being resilient when he comments, "I probably would say be prepared to be tough" (Ian, 27, 1018), and, similarly, George mentions the necessity of finding "that strength within yourself" (George, 37, 1315).

Daniel discusses the importance of being true to yourself and resisting the pressure to please others:

> *Be yourself and, yeah, you may get stick for it, but you're not out there to please other people in your life; you're out there to please yourself. (Daniel, 19, 681–683)*

He explains that although you might get "stick for it", he believes that it is important to put yourself first. His comment implies a determined belief in inner self-worth and a capacity to succeed in spite of judgement from others.

Reflecting on what she would have done differently, Barbara indicates that she wished she had been more assertive. She expands on this below:

> *I would say you can't be too passive. I think that's what my main problem with how I approached it [was]. […] There's a lot of people who are ballsy, and a lot of people who are incredibly timid. And it's … I think it's probably more difficult if you're timid. (Barbara, 29, 1040–1069)*

Barbara warns against being too "passive" or "timid", recognizing that this was a stumbling block for her, and implying that she wished she had approached transition more prepared to be proactive and assertive. She suggests that in order to progress more easily, it is necessary to be "ballsy" (i.e., bold, courageous, and determined).

Heather talks about her initial apprehension about going out and being read as trans, and the potential negative judgement from others:

> *You know, eventually I just thought well blow it, I'll just go with it, you know; do it anyway. If somebody reads me, they read me. (Heather, 14, 630–632)*

She explains that after a brief internal struggle, she decided that she would do it anyway regardless of any potential negative judgement from others. Her comment "blow it I'll just go with it" hints at her strength of character and inner confidence, suggesting that whatever happened, she would be able to handle it.

3.4.2 Seeking Connection

Another factor that was identified by all participants as an essential component of surviving the process was feeling connected to others and receiving support. Anna highlights the value of seeking social support below:

> *Find some support and maybe go along to one or two of the sparse support groups, you know, and find like-minded people and probably to confide in one or two good friends. […] Um, so, yeah, I think, yes you should seek proper support. Never, never, never do it alone, and always make sure that, you know, in those dark, dark days that you've got people who you can talk to rather than do something to yourself. (Anna, 25, 1142–1153)*

When she talks about finding "like-minded people", Anna seems to be emphasizing the importance of integrating with those who have had similar experiences and are likely to share similar values. She urges people to try attending support groups as well as utilizing close relationships, which offer the intimacy of friendship and provide a shoulder to cry on. Her repetition of the word “never” serves to illustrate how emphatically she believes that trying to “do it alone” is a mistake. Her final comment comes as more of a warning than a suggestion. Her repetition of the word “dark” alludes to moments of bleakness, despair, and struggle during her own journey, when having someone to talk to was perhaps the only thing that prevented her from harming herself.

Daniel also refers to the positive impact that social support and specifically an LTGB youth group had on him:

> *I feel like if I didn’t have this youth group, I feel like I would either be on the street, be in a riot, or in prison, if I didn’t have the support from here. (Daniel, 17, 597–600)*

Daniel seems to feel that he would have been unable to cope without the support of the other people from this youth group. His assertion that he would have either resorted to violence, criminality, or disintegrated to the point of homelessness points to how desperate he must have felt at times, and emphasizes the significant role that the support group played in helping him survive.

Heather reflects on the moment that she told her partner that she was trans, and the profound effect that her continuing support has had on her:

> *She said, “Look, whatever happens, we’re staying together. We got married for better, for worse, and, you know, you are the person I love, and we’ll ... we’ll just have to sort out what’s best, but I’m staying with you,” you know, which was lovely, because that was an enormous, enormous thing that, you know, I don’t think I’d have had the courage to do it if I’d not had her with me. (Heather, 12, 529–531)*

Her repetition of “enormous” suggests what a major impact it had on her knowing that she had the love and devotion of her wife to rely on. She voices her doubt that she would have had the courage to progress with her transition without her, which indicates how central unconditional love and support from others is.

Ethan discusses the potential benefit that having a mentor brings:

> *I think ... I think it's really hard, um, without the support of a kind of a mentor or someone pushing you like in ... in a positive way, outside your comfort zone, with the reassurance that you've got someone on hand if it all, you know, goes pear-shaped. (Ethan, 31, 1323–1326)*

He explains that without the encouragement and guidance from someone you look up to and trust, transitioning can be extremely difficult. He alludes to the need to push himself and move beyond his comfort zone, and evidently feels that having someone to guide him would have helped him through those tough times.

Francesca reflects on how much she would have appreciated having someone to talk to when she was struggling and in need of a sympathetic ear:

> *There needs to almost be someone on call who you know who you can phone them up at not stupid o'clock at night, but five o'clock at night, and go, "Help, can I have a five-minute chat, ten-minute chat." They might be able to do it, and they might not. They might say, "Can you call back in an hour?" but that's what you need. (Francesca, 37, 1443–1448)*

Francesca describes wanting someone who she knew would be there for her in an emergency. A person who would respond to her call for help, and if they were unavailable at that moment, would be able hold her in mind until they had 5 or 10 minutes to spare. I got the impression that just knowing someone who cares was there would have almost been more valuable than the conversation itself.

Ian echoes this and emphasizes that there should be someone to talk to and confide in who is outside the healthcare system:

> *Have somebody that you can talk to, you know […] You might be talking to your gender psychologist alone in the room […] but, um, have somebody you're going to meet up with straight after, um, in case things do go not very well. (Ian, 27–28, 1019–1023)*

Here, Ian refers to the importance of having an alternative source of support alongside a psychologist or therapist. This seems especially pertinent, as he initially described finding his appointments with healthcare professionals unhelpful and anxiety provoking. Therefore, he valued being able to have someone who he knew cared about him and would support him when he had a disappointing or distressing appointment. This indicates that due to his own experiences, he is inclined to believe that trans people will often feel let down by the clinicians they see and, as a result, he feels it is advisable to have someone outside the system to fill that gap.

3.4.3 Choosing the Right Therapist

When talking about their experiences in therapy, most participants seemed to feel that it was important to find the right therapist who was able to understand their specific needs.

Anna explains that she had been seeing a psychologist for regular therapy, but decided to stop seeing him as she felt he did not properly acknowledge the impact that transitioning can have on the whole family, and did not take her family concerns seriously. She explains that he responded negatively when she tried to explain this to him, and as a result their therapeutic relationship ended on a "sour note". She describes how she felt leaving after their final session together:

> *I remember coming out from that consultation and feeling lonely in a way I hadn't felt even since before I was married. It was a cold – well it wasn't cold ... it was an autumn evening, and it was dark, and it was damp. I just thought the world felt so large and empty. (Anna, 15, 691–695)*

From her account, it seems that this encounter made Anna feel worse rather than better. Her description of the world as "large and empty" indicates how abandoned and isolated she felt, and her depiction of the evening as cold, dark, and damp serves as a metaphor for her despair. Anna corrects herself after mentioning that it was cold as she realizes that it was an “autumn evening”, but it is possible that the coldness she was recalling was the coldness she was experiencing within.

She then describes going back to a previous therapist who had gone on maternity leave. She explains in the comment below how much she valued finding a therapist that was able help her explore her family concerns:

> *I’ve gone back to seeing the other psychotherapist, and I think she’s actually ... she’s very good, and I think now that she’s had a child, I think ... well, she told me I think she understands what I’m saying about families and children and attachments to your children, and how important that is. (Anna, 15, 696–701)*

She highlights how important it was to her that her therapist could not only empathize but could understand first-hand how it feels to be a parent. It also seems that she appreciated how emotionally attuned she was, and that she demonstrated her understanding by explicitly voicing it. George also talks about the value of having a therapist that helped him explore the impact that transitioning could have on his family:

> *We talked a lot about families because I had that fear of like coming out to my family, and he sort of figured out that it was something to do with I thought it would really harm them in some way. (George, 30, 1074–1078)*

George seems to feel that by being able to acknowledge his fears around hurting his family in therapy, he was able to work through these feelings so that he could progress with his transition. His comment “he figured out” suggests that George felt heard and understood by the therapist.

Anna describes how her therapist also helped her address her feelings of guilt:

> *She said that she was going to concentrate on my guilt feelings, and, I mean, she wasn’t saying to me, well, I shouldn’t feel guilty; she was just saying we’ll explore where they’ve come from and how to deal with them in a functional*

> *way, which she did do, and I found that useful. Um, and, you know, and therefore she was supportive and nurturing of my situation. (Anna, 21, 965–971)*

It appears that Anna appreciated that her therapist was able to help process her emotions in an open and non-judgemental way. She explains that her therapist took the lead by suggesting that they focus on her feelings of guilt. She seems to feel that her specific needs were identified, and her therapy was tailored accordingly. She describes her therapist as "nurturing", which implies that she was able to provide a safe and containing environment within which Anna felt able to tackle her difficult feelings. Similarly, George talks about his therapist being able to identify his fears around not being masculine enough:

> *He saw that the issues were to do with like fear, and he also saw that I was sort of struggling to accept my own masculinity like I kept comparing [myself] to some sort of ideal that didn't exist, so he was good at like working ... I felt like he really helped me work through those problems in a relatively short amount of time, and then at the end of that I could sort of start to transition, or like change my name and start all this. (George, 9, 326–332)*

George explains that his therapist was able to recognize this fundamental issue, and that by drawing his attention to this and helping him talk it through, George came to realize that his concerns were unfounded. It is evident that he saw the work he did with this therapist as crucial in allowing him to progress to the next stage of his transition, and that without this support it might have taken a lot longer.

Barbara mentions particularly appreciating being able to confide in someone unbiased:

> *I think counselling is ... is very, um, is very useful, I think if ... if anything, it means that they can just be freer in what they say, because when you go through something like this, it can be so complicated about who you can talk to, what they think about the situation, um, you know, so it's ... it's good to have someone that you can just ... There ... there's no strings attached to the*

> *conversation. (Barbara, 28, 1020–1026)*

Barbara emphasizes the benefits of having someone to talk to without reservation and without having to worry about the consequences. There is the implication that she has felt that talking to others about her gender has been risky, and therefore seeing a therapist who made her feel safe allowed her an outlet that she otherwise would not have had.

Similarly, Caroline discusses the importance of having a therapist who was understanding and non-judgemental:

> *It was useful to able to talk to someone who was.. was understanding, and who I felt I could say anything to without the fear of them then turning round and suddenly ... suddenly saying, "You're not committed" kind of thing, which is what I was getting. (Caroline, 23, 1020–1024)*

She expresses a sense of being liberated knowing that she could talk openly and honestly without fear of being questioned or challenged:

> *I suppose it was kind of sort of a final kind of confirmation, sort of ten weeks of going through that and talking to her and everything, and like realizing, "Yes; I should be doing this; it was the right thing to do," and it kind of help ... got me to kind of sort of formulate what ... how it was going to actually work in reality. (Caroline, 24, 1032–1037)*

Caroline talks about therapy serving as a final confirmation that she was doing the right thing. She explains that therapy helped her feel certain about her decision, while allowing her to explore some of the practical issues around transitioning.

Ethan reflects on what he found helpful from his sessions with a gender psychologist:

> *I don't think there was anything particularly poignant that anybody said. I think it was more having the opportunity to articulate my thoughts [...] really distilling down the essence of, you know, what I wanted from transition, or how*

> *far along the gender spectrum I felt I was […] you know, to really have to pin things down into adjectives, and get that across to someone. I found that it ... it was quite helpful in terms of framing my boundaries of what I was happy with […] Being able to have someone who's obviously, you know, both aware and kind of educated about stuff like this to, um, really chew the fat with was the most beneficial bit. (Ethan, 24, 1006–1029)*

Ethan describes using the sessions as a way of clarifying his thoughts and feelings. He seems to have particularly valued being able to talk to someone who had a good understanding of trans issues. He talks about being able to "chew the fat", which suggests that he felt there was a level of intimacy, familiarity, and mutual respect.

Daniel also describes a helpful relationship with a psychologist from an adolescent gender clinic:

> *It was helpful. The guy supported me, um, until I got my first appointment, and it [the letter] was like there in hand, um, and he's been ... he's been ... They've been all supportive. (Daniel, 3, 72–74)*

Daniel had talked about the anxiety he felt throughout the referral process due to the uncertainty about getting an initial appointment. It is evident that he felt that this was picked up on by his psychologist, who sensed that Daniel would benefit from regular check-ups until he had received his initial appointment letter. Later on in the interview, he reflects on the how therapy helped him cope with emotional distress without having to resort to self-harm:

> *I feel like if I get it off my chest, I'm not holding it, and I won't have to keep building it up and then resorting to like self-harm, like I used to. So it was one good thing that whenever you're comfortable about talking, you can talk about how you feel, and just use the space, which I did. (Daniel, 6, 182–186)*

He explains how talking in therapy meant that he was able to stop bottling up his feelings and becoming overwhelmed. He talks about needing to get this "off [his] chest", which takes on a double meaning as, several times during the interview, Daniel talked about his body dysphoria towards his chest.

Anna talks about her disappointment with the lack of compassion that she encountered:

> *I think that a lot of doctors and maybe some therapists and some psychologists, you get the feeling that they're talking to somebody who's almost an automaton to them. Do you know what I mean? It's just ... I want there to be some kind of acknowledgement that there's a person across the table; there's a human being. (Anna, 38, 1661–1667)*

Anna herself has worked within healthcare for many years and so was able to draw from her experience both as a patient and a clinician. She emphasizes how important it is to recognize and respond to the humanity of others. She mentions feeling that many healthcare professionals lose sight of the human situation and instead behave like robots without compassion or empathy. Being able to connect to the other on this fundamental level seems, for Anna, to be key.

Barbara talked about feeling that her therapist was not present during their sessions:

> *With him, it was more just his lack of ... I felt he wasn't in the room with me, um, and if ... When that's, I suppose, when you're paying money, it ... it can be ... You feel a bit cheated. (Barbara, 14, 502–508)*

Barbara describes feeling disappointed that her therapist seemed distant and unable to engage with her concerns or give her his full attention. Furthermore, the fact that she was paying for his time appeared to rub salt into the wound. This seems to have left her feeling conned in some way.

Daniel recalls feeling confused and frustrated after being told by a therapist to see how he felt getting undressed in front of a mirror:

> *Um, no, OK – because if you've got body dysphoria, you're not going to look at your body either way. Um, it's like with me, I can't even get changed with the*

> *light on, let alone stand in front of the mirror. [...] It was like, yeah, never say, "Stand in front of a mirror" [...] And that was like their approach, and I was just like, "Are you serious?" (Daniel, 13, 456–474)*

It is evident that Daniel felt that his therapist had completely misunderstood the depth of his distress and the discomfort he felt towards his body. His comment indicates that not only did he feel that the suggestion was unhelpful, but also potentially damaging. His final remark, "Are you serious?" captures his complete incredulity, and highlights how misguided he felt this approach was.

George reflects on a particularly negative experience he had with a university counsellor:

> *She couldn't really handle it, and she started dramatizing it and saying, you know, "Your life is going to be really terrible, and why ... why are you doing this?" And I was like, "OK. This is ... this is really not helpful." (George, 9, 316–319)*

George explains that his therapist seemed completely opposed to the idea of him transitioning and was keen to convince him to follow a different path. He clearly felt that adopting this judgemental attitude was unhelpful and inappropriate. Later on, George highlights the importance of choosing a therapist carefully:

> *Um, I suppose based on my experience of counsellors or therapists, I think you should be careful. [...] 'Cause it can be very expensive, and it can be possibly more harmful than helpful if you're in a vulnerable position. (George, 40, 1405–1425)*

George suggests that having the wrong therapist can not only be unhelpful, but potential damaging. He alludes to the power imbalance that exists in therapy and emphasizes the financial burden.

Ian voices his disappointment about not being able to explore his gender properly with his therapist:

> *I would almost have liked it to be a bit more about gender things, but she didn't feel qualified to really talk about that kind of thing, and I just felt like I was telling her things, and she clearly had no idea. (Ian, 10, 366–369)*

Ian talks about his frustration that his therapist's lack of understanding severely limited what he could to talk about with her. He seems to have felt that whenever the topic of gender came up, therapy became a one-way process, as his therapist was unable to offer any input. He clearly feels that it is important that therapists working with trans clients have a least a basic awareness of trans issues. He later elaborates on his experiences with this therapist:

> *She just kept blocking me every time I started on the subject or told me she didn't know it ... know anything about it. (Ian, 11, 396–398)*

Ian felt that his therapist was so out of her depth, she was unwilling to even discuss the topic of his gender with him at all, and would activity discourage him when he tried to bring it up. As a result of her lack knowledge, she was unable to properly support him when he wanted to explore his gender. This seems to have been a common experience for him, as he explains:

> *I think counsellors need to be more educated. I've never found anyone who had any sort of experience, um, or who felt that they were qualified to talk to trans people. (Ian, 27, 991–994)*

Similarly, George explains that he felt his therapist was ill-equipped to deal with trans issues:

> *I felt like the therapist didn't have sort of a basic understanding of trans issues, like it would have been kind of a learning point for her. [...] I just felt like she ... the therapist got the wrong end of the stick, and I was like, I don't really ... I didn't feel like it would be a therapeutic experience. I felt like I would have to explain a lot, and she maybe didn't understand so ... I think I found that quite a few times with therapists. (George, 29, 1031–1047)*

It appears that George felt that having to constantly explain things to his therapist might have been helpful for her, but would not have been beneficial for him. The fact that she seemed so ill-informed and would often misunderstand what he was saying perhaps left him feeling uncontained and unsafe.

3.5 Summary

This chapter has explored in depth the themes that emerged from the interpretative phenomenological analysis of the nine interview transcripts. The initial master theme, “Challenges of Living”, describes the difficulties that participants experience in their day-to-day lives, particularly in relation to how they feel they are treated and perceived by others in society. This theme provides context and highlights why some of the frustrations that participants experience while accessing healthcare seem especially discouraging given the concurrent struggles they often face.

The second master theme, “Negotiating Care”, captures the multitude of experiences both positive and negative that participants encountered while accessing healthcare and therapeutic support. It explores the issues that caused the most frustration and disappointment, such as long waiting times, lack of understanding, and prejudicial attitudes. It also highlights factors that help participants feel supported and encouraged, such as feeling that the clinician is knowledgeable, open-minded, and emotionally attuned.

The final master theme, “Survival”, outlines the factors that participants identified as being important in order to cope with general life struggles, as well as the challenges associated with accessing healthcare. Cultivating a solid support network and finding a therapist who is informed, non-judgemental, and supportive were seen as especially important. Participants recognized resilience and assertiveness as useful coping strategies.

4. Discussion

4.1 Overview

This final chapter will draw together the previous three sections and consider the implications and conclusions of this study. First, I will review the overall research aims and question. Then, I will discuss the findings in relation to existing theory and literature, taking each master theme in turn. Following this, I will explore implications for clinical practice and considerations for working therapeutically with trans people. Strengths, limitations, and suggestions for future research will then be presented. Last, I will reflect on my personal learning and final conclusions.

4.2 Summary of Aims

This research project set out to investigate trans people's experiences and perceptions of healthcare and psychological services during transition. I aimed to gain insight into their lived experiences, which I hoped would, in turn, enrich understanding of their specific needs. In order to give the transgender community a voice, a qualitative methodology was employed, and the findings were presented using direct quotations from the participants. I hope that the findings of this research will inform future practice and enable counselling psychologists and other health professionals to better support trans people.

4.3 Discussion of Findings in Relation to Existing Literature

I will now discuss the findings of the current study in relation to existing theory and literature, taking each master theme in turn.

4.3.1 Challenges of Living

All participants discussed the challenges associated with living as a trans person. Although the focus of this research was to explore experiences within healthcare and psychological services, this theme is important as it provides context and will hopefully help the reader better understand the world view of the participants. Du

Plock (2010) argues that in order to adequately support our clients, all aspects of their lives should be carefully explored and considered.

Participants talked about feeling especially vulnerable and frustrated during the early stages of transition. There was a sense from their accounts that they felt they were “in limbo” while waiting for treatment. They reported feeling self-conscious about their physical appearance, and, as a result, restricted in what they could do. One of the main reasons participants seemed to experience such discomfort was due to feeling that their appearance did not fit neatly into the traditional gender categories. This highlights how entrenched the gender binary seems to be in our society, with its presumption that people should look either male or female, and how falling outside these categories inevitably attracts unwanted attention. Social identity theory suggests that people derive a sense of who they are based on the social groups they belong to (Tajfel and Turner, 1979). Maass, Cadinu, Guarnieri, and Grasselli (2003) argue that gender is one of the most noticeable and ubiquitous social categories. Therefore, it is perhaps unsurprising that many participants found this period of time difficult, since social categories can serve to “other”, erase, and make invisible those who seem to fall outside of them.

Prior to receiving hormones or undergoing surgery, trans people are usually encouraged to socially transition for a period of time (i.e., live full time in their authentic gender). This is sometimes referred to as the Real-Life Experience (RLE), and tends to involve coming out to family and friends, making a name change, and altering outward presentation to match inward gender identity. This is supposed to give trans people the opportunity for a “trial run” (Brown & Rounsley, 1996). However, some have argued that this process can be unnecessary and cruel (Levine, 2009). While the House of Commons Women and Equalities Committee highlighted the concerns related to RLE, they also expressed doubts about the “informed-consent model” (Miller, 2015).

The informed consent model focuses more on personal autonomy and patient consent, and less on adherence to pre-set criteria. It is based around the notion that patients should be able to choose what gender treatments they receive without needing to be assessed and endorsed by a medical or psychiatric professional. According to the informed consent model, the clinician's role is primarily to provide information so that the patient can make decisions regarding treatment themselves. Levine (2009) argues that there should be less of a focus on the period of time required to complete the RLE, and more on defining its purposes and clarifying the parameters and endpoints.

From my time working in a gender clinic, I am aware of the benefits of making a social transition prior to receiving medical treatment. However, it is important to consider the discomfort described by some participants, and to think carefully about what can be done to help alleviate some of this distress. Several participants talked about their disappointment that therapeutic support had not been made available during the early phase of their transition. Those working with transgender people, particularly at a primary care level, should be aware that referrals to therapeutic services could be especially helpful at this time.

It is well documented in the literature that trans people frequently experience harassment, discrimination, and rejection (Bockting, Knudson, & Goldber, 2006; Elder, 2016; Gainor, 2000; Grant et al., 2011; Lombardi, Wilchins, Priesing, & Malouf, 2002; Whittle, Turner, & Al-Alami, 2007). This certainly seemed to be a common experience recounted by the participants of this study. The findings are also in line with Goffman's (1963) account of the impact of stigma. Goffman argues that the stigmatized individual is exposed to various kinds of discrimination, and is generally treated by others as "not quite human" (p. 15). This results in the development of a discredited identity. Participants from the current study described being harassed, discriminated against, shunned, and rejected, which all seemed to leave them feeling discredited and "less than".

One participant recounted being ostracized from her church, and another reported going to a gay club and being told that she did not belong there. Previous research suggests that trans people face discrimination from their spiritual groups (Elder, 2016) and even from within the gay and lesbian community (Gainor, 2000). Two participants talked about being forced to leave their jobs after they had transitioned. Similarly, participants from previous studies described experiencing job loss as a result of their gender identity (Elder, 2016; Grant et al., 2011; Whittle et al., 2007). One of the participants from the current study who lost her job had been working as a health professional, supporting the assertion that both patients and staff are susceptible to discrimination within healthcare settings (Somerville, 2015).

As well as recounting incidents of actual harassment, discrimination, and rejection, participants also described experiencing significant distress as a result of fear of maltreatment by others. This finding is in line with Hendricks and Testa's (2012) assertion that one aspect of minority stress is related to the anticipation of external stressful events such as violence or harassment. It is important for providers to be aware that trans people are often subjected to harassment and discrimination, and to be mindful of the potential impact this could have on their psychological well-being. Wester, McDonough, White, Vogel, and Taylor (2010) suggest that empathy is especially crucial when working with trans clients, as they may perceive their therapist as being part of the general culture that rejects gender diversity. It is essential that health professionals conduct appointments sensitively, using appropriate language and adopting a non-judgemental attitude (Ellis, Bailey, & McNeil, 2015).

The findings of this study suggest that trans clients may present for therapy or at health appointments in a highly distressed state. Participants reported having to deal with psychological distress at various points during the transition process. As noted in the literature, participants described exhibiting symptoms of anxiety and depression usually as a result of feeling isolated or misunderstood (Budge, Adelson, & Howard, 2013; McNeil, Bailey, Ellis, Morton & Regan, 2012). Participants also talked about times in their lives when they had experienced thoughts relating to suicide or self-harm. The increased risk of suicidal behaviour amongst transgender populations has been previously noted (Hunt, 2014; Maguen & Shipherd 2010; McNeil et al., 2012; Nodin, Peel, Tyler, & Rivers, 2015; Virupaksha, Muralidhar, & Ramakrishna, 2016).

4.3.2 Negotiating Care

According to findings, provider ignorance continues to be a significant barrier to accessing appropriate healthcare. This suggests that in spite of increased awareness around trans issues, there is still much work to be done in terms of education and training. Participants reported feeling frustrated that they had to spend time teaching clinicians about trans issues. Aside from specialized gender clinics, most participants described feeling that health providers lacked sufficient knowledge and awareness. Previous research conducted in the UK has similarly highlighted that health professionals often lack sufficient understanding of gender identity issues (Ellis et al., 2015; Hunt, 2014; McBride, 2011; Miller, 2015; Somerville, 2015; Whittle et al., 2007). Somerville (2015) reported that 72% of patient-facing staff stated that they had not received any training regarding the health needs of trans people, and one in four reported that they did not feel able to respond to the specific needs of this patient group.

Participants from the current study seemed to feel that lack of awareness was especially prevalent amongst GPs. This is problematic, as GPs are usually the first port of call for transgender individuals seeking support, and are also responsible for making referrals to gender clinics. Previous research has also noted that participants found GPs particularly ill-informed regarding trans issues (McBride, 2011; Miller, 2015; Whittle et al., 2007). As mentioned above, trans people are likely to feel isolated and misunderstood within society. It is possible that these feelings are then reinforced when GPs and other health professionals display an obvious lack of knowledge.

The House of Commons Women and Equalities Committee reported that the Royal College of General Practitioners recently launched an online training course on gender variance (Miller, 2015). However, since data collection for the current study took place between October 2015 and October 2016, it seems unlikely that this new initiative would have had an impact on participants' experiences yet. As trans people become increasingly visible, and with the introduction of new initiatives, it would be interesting to see how this impacts their experiences in healthcare, particularly at a primary care level. Further research is needed if we are to continue monitoring progress in this area.

When participants talked about positive experiences with health professionals, they described feeling listened to, understood, and respected. They tended to feel that being open-minded and taking the time to properly listen to patients could usually make up for an overall lack of awareness. Participants spoke enthusiastically about health professionals who were empathic, genuine, and affirming. Similarly, McBride (2011) noted that participants valued therapists who were non-judgemental and good at listening. This suggests that trying to build a strong working relationship by satisfying the core conditions (Rogers, 1961) is useful for all mental health practitioners, and not just psychologists and psychotherapists. Participants also discussed the value of talking to clinicians who used the correct terminology and were knowledgeable about trans issues. For participants, it was seen as important for all health professionals to receive basic training to ensure that they are at least familiar with appropriate terminology.

Participants discussed a number of other obstacles that made accessing treatment difficult. They reported feeling that clinicians were not only ill-informed, but also unwilling to learn or educate themselves. This was perceived as indifference towards the trans community, and in particular those who presented for treatment. As noted in previous research, a major obstacle cited by participants is that of lengthy waiting times (Ellis et al., 2015; McBride, 2011; Miller, 2015; Whittle et al., 2007). Participants mentioned having to wait months and sometimes years for their referrals to gender clinics, and again for their initial appointments. They also complained of delays caused by administrative errors. The House of Commons Women and Equality Committee also noted that poor-quality administration was an issue within NHS GICs (Miller, 2015).

Long waiting times seemed to have a detrimental effect on the mental health of participants. This appears to be largely due to the fact that they felt uncertain about whether they would ever receive an appointment or be approved for treatment. This feeling of not knowing was associated with high anxiety. A study on trans-specific healthcare conducted in Sweden similarly noted that waiting was associated with embodied experiences of distress, anxiety, and powerlessness (Linander, Alm, Hammarström, & Harryson, 2017). The authors also observed that long waiting times left participants feeling deprioritized within the healthcare system.

The subjective experience of being “in limbo” while waiting for treatment is possibly why long waiting times appear to be especially distressing for transgender people compared with other service users. As previously mentioned, participants described the early stages of transition when they were waiting to gain access to treatment as particularly difficult. They recalled feeling self-conscious about their physical appearance, and limited in what they felt able to do. There was a sense from their narratives that time seemed to pass frustratingly slowly. Overall, participants seemed to give the impression that once they had made the decision to transition, having to wait for treatment seemed unfair and unnecessary.

Participants described feeling disempowered by healthcare providers particularly during psychiatric assessments. Current protocol means that trans people are reliant on medical and psychological professionals to achieve their goals (Coolhart, Provancher, Hager, & Wang, 2008). In order to gain access to gender affirming medical interventions in the UK, trans people are required to be assessed for eligibility by a health professional. Participants resented feeling controlled and dictated to, and described feeling at the mercy of assessing clinicians. Carroll & Gilroy (2002) argue that many transgender people view psychological and medical professionals with suspicion because they see them as regulators and gatekeepers of treatment.

Even after initial assessments, participants seemed to experience uncertainty around whether they would continue to be seen at the gender clinic or receive medical treatment, thus reinforcing their sense of powerlessness. Participants described feeling confused and frustrated that healthcare professionals were able to make life-changing decisions regarding treatment on the basis of a few short interactions. They talked about having to “jump through hoops” and feeling pressure to present a certain narrative in order to fulfil the criteria imposed by clinicians. Trans participants from previous studies similarly described feeling that they had to “jump through hoops” in order to be eligible for treatment (Coolhart et al., 2008; Ettner 1999).

The strong sense of powerlessness described by participants is similarly reflected in the literature. In the United States, therapists also play a gatekeeping role, as they are permitted to write letters of recommendation, which can understandably impact the therapeutic relationship. Although this is not common practice in the UK, Applegarth and Nuttall (2016) observed that when clients receive therapeutic support at gender clinics, they often feel that they must convince their therapists that they are genuinely transgender and psychologically stable enough to receive medical treatment. The authors argue that within specialist gender identity services, clients are hampered by fears that they may lose treatment if they do not appear to conform to the binary gender narrative. As a result, those who attend therapy through charities are more likely to feel able to authentically explore their gender roles and identity.

Several participants explained that they had withheld information during appointments because they worried about treatment being denied or delayed. They described being apprehensive about disclosing any uncertainty around their gender identity or gender expression. Participants also seemed concerned about whether experiencing mental health problems would be a barrier to treatment, and tended to feel that it was safer to not report such difficulties. According to Ettner (1999), trans clients are often mistrustful of clinicians, as they worry that their treatment will be withheld. Ellis et al. (2015) found that 30.9% of survey participants reported that they had either lied or withheld information during appointments. Fifty-three per cent of participants recalled feeling worried about their mental health while attending a gender clinic, but reported feeling unable to talk about this with the clinician (Ellis et al., 2015). Carroll, Gilroy, and Ryan (2002) suggested that trans clients may be reluctant to disclose mental health difficulties. Rachlin (2002) argues that it is expected that trans people may have reservations about talking openly and honestly to a clinician who has the power to grant or deny them access to treatment.

Participants described feeling empowered by clinicians who valued their input and took their opinions seriously. They emphasized the importance of feeling that they were involved in treatment decisions. They appeared to appreciate when clinicians took a more flexible and collaborative approach. Additionally, being given the opportunity to set the pace of sessions seemed to be experienced as empowering. Adopting a trans affirmative approach involves normalizing all forms of gender expression (Chavez-Korell & Lorah, 2007). Participants in the current study seemed to value being given the opportunity to explore non-binary identities. This emphasizes the importance of gender clinicians acknowledging and affirming both conventional as well as diverse gender identities and presentations.

Participants from the current study additionally described being dismissed, ridiculed, and chastised during appointments. They talked about negative encounters with healthcare professionals who made inappropriate suggestions and used offensive and transphobic language. These findings support previous research that indicates that transgender people often encounter transphobia, discrimination and inequality when accessing healthcare (McBride, 2011; Miller, 2015; Somerville, 2015; Whittle et al., 2007). In a recent survey, one in five patient-facing staff reported hearing other colleagues either use discriminatory language or make negative remarks about trans people (Somerville, 2015).

Participants explained the destructive impact of being confronted with a clinician who they experienced as dismissive, hostile, or offensive. Several participants described feeling suicidal after negative encounters with health professionals, and one participant explained that he found his appointments so stressful that he started self-harming again. Since trans people often face minority stress, it is not surprising that they found negative experiences with health professionals especially distressing. It would therefore seem especially important that clinicians working with this population are sensitive to this and make a particular effort to be supportive and understanding.

Aside from specialist gender identity services, discrimination and transphobia was reported across a range of healthcare settings, but particularly within primary care. One participant recalled her GP saying that transgender people are “perverted” and need to be “cured”, and another remembered a private psychiatrist referring to people who transition as “tarzans”. One participant described being openly laughed at by a doctor when attending a breast clinic, and another recalled hearing A&E doctors and nurses laughing and joking at her expense.

Participants expressed that transphobic comments are highly distressing, as they serve to invalidate their identity and are often experienced as a rejection or dismissal of their essential self (i.e., who they are as a person). Such comments were cited as being especially upsetting and confusing when the verbal attack came from the person they were looking to for support and assistance. McBride (2011) observed that a number of his participants recounted negative experiences of discrimination within healthcare in Ireland. Participants reported feeling hurt and humiliated as a result of inappropriate behaviour from healthcare staff. These experiences were found to exacerbate participants’ emotional vulnerability, and as a result discourage access to therapeutic services (McBride, 2011). Clinicians should be mindful of this and remain open to discussing past negative experiences that trans patients might have had with other health professionals, and make it absolutely clear that this type of behaviour is not condoned.

4.3.3 Survival

This theme offers important implications for the field of counselling psychology. Hearing how participants overcame difficulties and fostered resilience is especially useful for counselling psychologists as it can help us understand how to better support trans individuals within therapy. This is particularly important for this population as there is a shortage of research exploring therapeutic interventions for transgender individuals (Austin & Craig, 2015). All participants talked about the importance of developing coping strategies to manage the difficulties associated with transition and to negotiate obstacles to treatment. Resilience is defined as an individual’s ability to cope with adversity through the use of a set of resources and learned behaviours (Harvey, 2007). Building resilience has been identified as an important factor in counteracting minority stress (Hendricks & Testa, 2012; Singh, Hays, & Watson, 2011).

Singh et al. (2011) conducted a phenomenological study exploring the resilience experiences of 21 transgender individuals. The authors identified five resilience strategies that were common to all participants: evolving a self-generated definition of self, embracing self-worth, developing awareness of oppression, making connections with a supportive community, and cultivating hope for the future. They identified an additional two resiliency themes that were common to most participants, but not all: social activism, and being a positive role model for others. The authors discussed implications for therapy and highlighted the importance of being aware of these resilience strategies. Singh et al. (2011) argued that their findings support the recent move towards trans affirmative treatment models. They suggested that therapists working with trans people should incorporate a trans affirmative approach with interventions that facilitate empowerment and resilience.

Participants from the current study emphasized the value of connectedness and developing good social supportive networks. They talked about the importance of fostering close relationships with others who were able to provide acceptance and encouragement. This finding is in line with previous research that has stressed the significance of social support (Lev, 2004; Singh et al., 2011). Satisfaction with life after transition is more likely to occur when people have social support such as good family relationships (Carroll, 2015). Participants discussed the benefits of having someone to talk to, whether this was someone else in the trans community with shared experiences, or just a sympathetic friend or family member. The positive impact of social support was discussed in relation to managing general stresses associated with transition as well as frustrations with the healthcare system. A number of participants explained that they would have been unable to cope during transition without the support of other people. This finding indicates that, whatever therapeutic approach is used, signposting support groups and encouraging trans clients to seek social support is important.

Participants also talked about internal resilience strategies. They described learning how to build self-worth and foster hope. One of the most commonly identified strategies for coping with life stresses and dealing with the healthcare system was assertiveness. Participants discussed the value of being able to communicate clearly what they needed during appointments with clinicians. They talked about needing to be proactive and insistent in order to ensure that their needs were not dismissed or ignored.

Participants described both positive and negative experiences in therapy. They discussed the importance of having a therapist who was present, engaged, and non-judgemental. In line with previous findings, participants reported that feeling connected to their therapist helped them feel safe and supported, while feeling disconnected resulted in them feeling hurt and angry (Applegarth & Nuttall, 2016). Helpful and healing experiences were facilitated by therapists who were perceived as respectful, caring, good at listening, knowledgeable, and affirming (Bess & Stabb, 2009; Elder, 2016; Israel, Gorcheva, Burnes, & Walther, 2008). These findings support the notion that a strong therapeutic relationship is more important than technique or modality (Hunt, 2014). Participants also frequently described feeling misunderstood during therapy. This suggests that some therapists still do not know how to work appropriately with trans clients. When therapists do not have sufficient knowledge, it is especially important that they adopt a sensitive and empathic attitude. Receiving unconditional positive regard and feeling accepted is arguably especially important for trans clients, as they will likely have been exposed to rejection and discrimination in their everyday lives.

As outlined in the literature review, there has been a recent move towards trans affirmative therapy (Chavez-Korell & Lorah, 2007; Lev, 2004; Raj, 2002), and participant accounts certainly provided support for this type of approach. In line with previous research, participants emphasized the importance of being able to acknowledge their gender identity and to have it affirmed even when it was not the focus of therapy (Benson, 2013). Being able to explore gender identity and gender expression was identified as particularly helpful. A number of participants described feeling that their gender identity was not acknowledged or affirmed during therapy. Several participants talked about the damage that can be done when therapy was conducted by someone who was not comfortable with gender variance. This suggests that in some cases it is useful for clients to seek out specialist gender therapists.

Several participants highlighted the value of being able to explore the impact that transition had had on their family. Similarly, previous literature has emphasized the importance of normalizing family disruption and helping clients work through these concerns in therapy (Lev, 2004). One participant from the current study reported that she had stopped attending sessions with a previous therapist because he seemed unwilling to explore this with her. Another participant talked about a positive experience with a therapist who helped him explore and work through his fear that transition would harm his family.

4.4 Implications for Clinical Practice

4.4.1 Recommendations for Counselling Psychologists and Therapists

A number of participants from the study described experiencing suicidal thoughts and reported engaging in self-harm. Previous research suggests that trans people are at increased risk of suicide attempts and suicidal ideation (Hunt, 2014; Maguen & Shipherd, 2010; McNeil et al., 2012; Nodin et al., 2015; Virupaksha et al., 2016). It is important for therapists and other health professionals who come into contact with trans people to be mindful of this so that they can be extra vigilant when assessing risk and, if necessary, put sufficient preventative measures in place.

Although all participants reported experiencing symptoms of anxiety and depression, their distress was usually associated with maltreatment by others. Psychologists and therapists should be aware that although some trans people may experience mental health difficulties during their lifetime, psychological distress is often a result of minority stress rather than pathology (Hendricks & Testa, 2012; Kelleher, 2009). Communicating this to clients can help normalize their experiences and reduce shame and self-blame. Singh et al. (2011) suggest that encouraging clients to critically examine society norms helps build resilience and reduce the impact of negative societal messages.

Participants highlighted the difficulties associated with having to make a social transition before receiving medical treatment. Previous research has discussed the drawbacks related to the RLE, suggesting that it can be needless and unhelpful (Levine, 2009). It is important that those working therapeutically with trans people are mindful that this phase of the transition process is likely to be especially challenging.

Participants talked about feeling disempowered by health professionals who they perceived as gatekeepers of treatment. Although therapists in the UK do not make recommendations for treatment, it is worth noting that clients may still perceive them as having some sort of gatekeeping role. As previously mentioned, a recent study reported that clients receiving therapy within gender clinics can be hampered by feeling that they need to convince their therapists that they are stable enough to receive medical treatment (Applegarth & Nuttall, 2016). Therapists working in gender clinics should be attentive to how this setting can impact the therapeutic relationship and, if necessary, remind clients that the purpose of therapy is not to determine suitability for treatment. All therapists working with trans clients should try to be sensitive to the frustrations associated with undergoing assessments and be willing to acknowledge that this process can sometimes seem unfair and dehumanizing (Coolhart et al., 2008).

The findings of this study support previous research that highlights the importance of building a strong therapeutic relationship, which enables the client to feel affirmed and supported (Chavez-Korell & Lorah, 2007; Lev, 2004; Raj, 2002). Participants emphasized the value of having a therapist who was respectful, caring, good at listening, and empathic. According to Wester et al. (2010), conveying empathy is especially important when working with trans clients, as they may perceive their therapist to be part of the general culture that rejects them and their gender diversity.

Psychologists and therapists working with trans clients should adopt an affirmative approach that validates gender diversity (Chavez-Korell & Lorah, 2007; Elder, 2016; Hunt, 2014; Lev, 2004; Raj, 2002). In order to do this, it is essential that the therapist clarifies how the client defines their gender identity and what their preferred name and pronouns are (Chavez-Korell & Lorah, 2007; Hendricks & Testa, 2012; Raj, 2002). According Carroll et al. (2002), therapists working with trans clients should adopt an “informed not knowing” stance. Participants talked about disappointing encounters with therapists who lacked knowledge and awareness around trans issues. Therapists unfamiliar with transgender issues should spend time reflecting on their own values and preconceptions around gender and sexual diversity in order to ensure that they separate their own views from those of their clients. If therapists feel either too unfamiliar or too uncomfortable with gender diversity, they should be willing to acknowledge their own limitations and signpost appropriately.

Lev (2004) suggests that when working therapeutically with trans clients, it is useful to be aware of specific topics that might be brought up. Participants in the current study identified several themes that they had addressed in therapy. They talked about the benefits of being able to explore the impact that transitioning had had on their families. They discussed the value of working through feelings of guilt. Additionally, being able to explore issues around masculinity and femininity was also recognized as a useful intervention.

4.4.2 Implications for CBT

During the interviews, participants highlighted the difficulties associated with transition. They talked about their battle for treatment and having to fight to be recognized within the healthcare system. They also mentioned having to deal with negative reactions from others. They described being rejected by family and friends, harassed by strangers, and discriminated against both professionally and personally. In the final master theme, “Survival”, participants emphasized the importance of cultivating personal strength. Bearing in mind the level of adversity and stress that many trans people have to deal with, affirmative therapists working with this client group should be prepared to help build resilience as well as facilitate positive gender belonging. Budge, Adelson, and Howard (2013) argue that therapists working with transgender individuals should focus on interventions that increase social support and facilitate positive coping styles.

Padesky and Mooney (2012) developed a four-step strengths-based model designed to help clients build and strengthen personal resilience. Adjustments were made to the classic CBT approach, and specific clinical modifications were suggested. Recommended interventions included therapists helping clients identify existing strengths, turning personal strengths into general strategies, and shifting the focus of behavioural experiments from problem resolution to staying resilient. Therapists are also encouraged to employ constructive therapy methods such as giving positive feedback and conveying enthusiasm.

Participants identified assertiveness as an important coping strategy. They described becoming assertive through necessity as they realized that there was no other way to ensure that their needs were met. Although participants seemed to improve their assertiveness over time through trial and error, assertiveness can also be worked on during therapy. Building assertiveness through skills training is used to facilitate behavioural change in CBT (Beck, 2011). Assertiveness training teaches clients how to recognize what they want, and how to communicate this clearly and confidently to others. It is also helps improve confidence and build self-esteem (Powell, 2009).

Participants talked about the importance of feeling connected to others and building a strong social support network. CBT adopts a structured and goal-oriented approach (Beck, 2011). It involves designing behavioural assignments for clients to complete as homework between sessions (Westbrook, Kennerley, & Kirk, 2011). CBT is therefore ideally suited to clients who need help fostering social relationships, as it helps them think practically about creating opportunities and practising the necessary skills.

Much of the existing literature on working therapeutically with trans people has discussed the benefits of adopting a humanistic or person-centred approach (Brown & Rounsley, 1996; Ettner, 1999; Lev, 2004; Livingstone, 2008). Other therapeutic approaches that have been discussed include existential (Richards, 2011; Richards, 2016) and, more recently, CBT (Austin & Craig, 2015). Austin and Craig (2015) introduced a transgender-affirmative adaption of cognitive behaviour therapy (TA-CBT). From the onset of therapy, say the authors, the clinician should establish themselves as trans-affirming by making it clear that they acknowledge and validate all types of gender identity and expression. The authors also argue that supporting clients in developing resilience strategies is as important as identifying specific risk factors. They present a brief summary of the eight-session TA-CBT model. For best results, they suggest adopting a flexible approach to ensure that the individual needs of each client are met. The manualized programme includes a number of adapted CBT interventions, such as psychoeducation and cognitive restructuring. Additionally, specific resilience-building interventions are proposed, such as creating a hope box, growing social networks, maintaining important relationships, learning to be assertive, and practising how to respond to discrimination.

Although CBT has not yet been tested empirically with trans clients, Austin and Craig (2015) argue that it represents a promising approach for relieving stress amongst minority clients. Bearing in mind the value that participants placed on building assertiveness and resilience, adopting a CBT approach that includes skills-training interventions could be useful. Considering the strain on funding and resources currently within the NHS, the fact that CBT is structured and time limited serves as another potential benefit.

4.4.3 Recommendations for Gender Clinics

From my time working in a gender clinic, I came to understand that excessive waiting times are largely a result of lack of funding and resources within the NHS. Therefore, although reducing waiting times would seem like an ideal solution, this may not always be a realistic aim. Participants seemed to feel that long waiting times were particularly anxiety provoking due to the uncertainty around if or when they would be seen. Keeping patients informed of what stage of the referral process they are at and approximately how much longer they can expect to wait would potentially go a long way to reducing this sense of uncertainty. I am aware that some gender clinics have begun introducing such a system, which involves patients being sent letters once their referrals have been accepted in order to reassure them that they are on the waiting list and will be seen in due course. If this is not already protocol at other gender clinics across the country, then it might be a scheme worth considering.

Trans clients often feel frustrated about having to undergo multiple assessments, and are resentful of the power imbalance between them and the assessor (Lev, 2004; Rachlin, 2002). Lev (2004) argues that it is important to be aware of the implications of adopting a gatekeeping role and the impact it will have on the working relationship between client and clinician. It would be helpful if assessing clinicians could acknowledge the power imbalance and, wherever possible, attempt to empower trans clients. This could be done by facilitating a collaborative approach, allowing clients to set the pace of the session, and encouraging them to voice any concerns they may have.

According to the current findings, some trans participants felt it was safer to withhold information due to fears that voicing uncertainty or disclosing mental health difficulties may hinder access to medical interventions. Having worked in a gender clinic, I am aware that reporting a mental illness does not inevitably prohibit patients from accessing treatment. The World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) clearly states that “the presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria” (Coleman et al., 2012, p. 25). However, the findings of this study suggest that some service users continue to worry that reporting a mental health problem will act as a barrier to treatment. Clinicians should be mindful of this and make time at the beginning of initial appointments to dispel common myths and emphasize the importance of being as open and honest as possible. This is particularly important in relation to mental health to ensure that clients feel safe disclosing any psychological distress they may be experiencing.

4.4.4 Recommendations for GPs

In line with previous research, the findings suggest that many GPs lack sufficient knowledge and understanding, which results in participants feeling invalidated and unsupported. Primary care services are usually the initial port of call for trans people. This means that a GP is sometimes the first person that a patient talks to about their gender identity. Participants talked about the lasting impact that negative first encounters could have. GPs should be mindful of the importance of adopting a respectful and empathic attitude. As mentioned previously, participants talked about experiencing psychological distress. This seemed to be especially bad during the early phase of transition while they were waiting for referrals and/or access to treatment. It is important for GPs to have a good understanding of the referral process so that patients are not forced to wait even longer than necessary to get their initial appointment. Participants talked about positive experiences with GPs who were able to provide interim support in the form of regular check-ups during this time. However, due to the current pressure on NHS resources, this may not always be feasible. Alternatively, it would be useful if GPs could research potential sources of support so that they can signpost accordingly. When appropriate, this should include referrals for talking therapy.

4.4.5 Education and Training for Healthcare Professionals

The findings of this study support the notion that therapists and other health professionals should receive specialist training to ensure that they can competently and sensitively work with trans people (Bess & Stabb, 2009; Carroll et al., 2002; Chavez-Korell & Lorah, 2007; Coolhart, et al., 2008; Ellis et al., 2015; Ettner, 1999; Gainor, 2000; Hendricks & Testa, 2012; Lev, 2004; McBride, 2011; Raj, 2002; Somerville, 2015; Whittle et al., 2007). Training should include information regarding the use of pronouns, as well as on the general needs and rights of trans people (McBride, 2011).

Participants described feeling frustrated about the lack of knowledge and awareness particularly among GPs. This is worrying, as GPs act as gatekeepers to gender clinics and other NHS services. McBride (2011) argued that specialist training should be made mandatory for doctors, nurses, and therapists. As discussed above, in 2015, the Royal College of General Practitioners launched an online training course on gender variance (Miller, 2015). In line with McBride’s (2011) suggestion, it would perhaps be advisable to make this training, or something similar, mandatory for GPs. Additionally, leaflets containing brief guidelines for working with trans service users should be made readily available (Whittle et al., 2007).

It would also be useful if gender diversity could be covered in some capacity within therapeutic training courses, as this would help ensure at least a basic awareness of gender identity issues. In line with previous research, it is suggested that clinicians working with this population should take steps to familiarize themselves with the available literature, and actively seek out information regarding the process of transitioning (Chavez-Korell & Lorah, 2007; Coolhart, et al., 2008).

The findings indicate that despite the growing visibility of trans people within society, transphobia continues to be a pervasive problem. Teaching children and adolescents about gender diversity, identity, and transition could help encourage a widespread positive change in attitude early on. Additionally, this could help normalize trans identities and reduce societal stigma. Furthermore, it might help reassure young people struggling with gender identity and encourage them to seek support.

4.5 Accessing Quality and Validity

The aim of this research was to advance understanding of how trans people experience healthcare and psychological services. In providing further knowledge on what participants found helpful and unhelpful, it is hoped that counselling psychologists and other healthcare professionals will be able to use this information to improve the support they offer to this client group. This study used a qualitative method in order to allow participants to express their views and have their voices heard.

As mentioned in the methodology chapter, it is important to consider the quality of qualitative research. Yardley (2000) identified the following four characteristics for assessing quality: sensitivity to context; commitment and rigour; transparency and coherence; impact and importance. I will briefly discuss my adherence to each of these dimensions in turn.

I ensured sensitivity to context by conducting a thorough and broad review of the literature. This ensured that I was familiar with recent and relevant research, conscious of the historical and political context, and aware of the correct language and terminology. This in turn helped me provide a clear rationale for the current study. My time working in a gender clinic provided me with an introduction to the clinical context. This was useful, as it gave me insight into the day-to-day workings of a busy gender clinic and helped me understand what is required both of patients and clinicians. I was able to develop my understanding of the transition process and the current NHS protocols.

Additionally, I spoke to people from the trans community so that I could be exposed to an alternative perspective outside of a medical context. As discussed in the methodology chapter, sensitivity to the experience of my participants was assured by careful commitment to professional and ethical guidelines. During the interviews, I made sure to remain sensitive to each participant. I tried to make them comfortable by being genuine, transparent, attentive, and empathic.

Commitment and rigour was carefully considered throughout the research process. First, I immersed myself in the topic by thoroughly engaging in the current literature. I conducted respectful and thorough interviews, and engaged in a detailed and methodical analysis. The themes were firmly grounded in the participant transcripts, and backed up with direct quotes. I discussed the interview schedule, the analysis procedure, and the emergent themes with my supervisor. He questioned me on all aspects of this process, and his feedback encouraged me to re-examine and critically reflect on my findings and conclusions. During our meetings, my supervisor would sometimes encourage me to demonstrate how I had decided on the themes and the rationale behind the subsequent labelling. This requirement to justify the analysis process and my overall thinking has proved invaluable. My commitment to this in-depth study is evidenced and further enhanced by my work with trans clients at the gender clinic and the psychosexual service. The well-being of the participants has been rigorously observed, and throughout this work I have demonstrated my commitment to the ethical and professional guidelines laid down by the BPS and the HCPC.

Accountability is an intrinsic dimension of this study. Transparency and coherence have, therefore, been essential components. My sustained and detailed reference to previous research findings has demonstrated consistency and coherence. My motives and inspiration for undertaking this work are evident, and my methods of investigation clearly laid out in the methodology chapter. Transparency was further ensured by my rigorous self-questioning and reflection, which occurred throughout the process. Thus, I hope, the intellectual journey I have undertaken in this thesis has been clearly and authentically presented.

The importance of the health and psychological care of trans people was impressed upon me during my time at the gender clinic. The urgency for a detailed and thorough scrutiny of the care provided and received was clearly needed, and my hope was that the confidential, profound, and honest interviews would generate debate and academic discourse, and eventually initiate changes to practice and modifications with services.

4.6 Strengths

The current project adds to the growing body of literature about trans people's perceptions of healthcare and psychological services. The findings of the study indicate potential areas for improvement, and emphasize certain factors that could help trans people feel more comfortable and supported when accessing healthcare. The findings also identify topics that could come up in therapy, and highlight the benefits of helping trans people build resilience by acquiring coping strategies and learning to be assertive. Using IPA allowed for an in-depth and detailed exploration of the subjective experiences of a small group of trans people living in the UK.

Counselling psychology is grounded in humanistic values and appreciates the subjective experience of individuals. Counselling psychologists are committed to understanding the unique inner worlds of their clients through shared exploration and “a process of mutual discovery” (Woolfe, Dryden, & Strawbridge, 2003, p. 12). Participants talked about the personal value of taking part in the current study. They described being able to reflect on and communicate their experiences as helpful. Therefore, one potential benefit of the study is that it afforded the participants the opportunity to share their stories.

Participants were recruited through charities as opposed to via NHS gender clinics. This allowed for more diversity amongst participants, as it did not limit the sample to a specific geographical location, but included participants from across the UK. Additionally, recruiting through charities meant that the sample was made up of people who had transitioned privately, as well as through the NHS. The current study incorporated a range of ages, suggesting that the experiences discussed were not limited to a particular age group. One participant was 18, two participants were in their 20s, three were in their 30s, two in their 50s, and one in their 60s. Previous research has highlighted the need for projects that include younger trans people (Applegarth & Nuttall, 2016; Heredi, 2013). By including younger adults, this study contributes to bridging this gap in the literature.

A significant strength of the study was that most participants had started transitioning relatively recently, suggesting that the findings are particularly pertinent to the current circumstances. Out of the nine participants, six reported that they began their transition over the last 4 years. Of the remaining three, one had transitioned 6 years ago, one 7 years ago, and only one over 10 years ago.

4.7 Limitations

Although there are significant benefits to employing a qualitative methodology such as IPA, one potential drawback relates to the lack of generalizability. Due to the method chosen, the current findings cannot be generalized to the wider transgender population. Additionally, this research only included trans people who answered the participation request circulated by the charities previously mentioned. It is worth noting that the people who chose to respond may have had particular motives that they did not share, or were at a specific stage in their life

(Richards, Barker, Lenihan, & Iantaffi, 2014). For these reasons, it is not possible to make broad claims based on the findings of this study. However, it is still possible to highlight potential areas for improvement and suggest ways of working with trans people, particularly when taken in conjunction with the findings from previous research projects.

Participants were selected on the basis that they had begun a social transition and had started hormone therapy. As previously mentioned, one of the main aims of the project was to gain a better understanding of participants' perceptions of support. Therefore, this recruitment criterion was included in order to ensure that the participants had had sufficient exposure to healthcare and psychological services. However, this could be viewed as a limitation, as it restricted the sample to participants who had already accessed support, and excluded trans people who did not wish to medically transition. It is possible that this is why no participants involved in the current study identified as non-binary. Broadening the inclusion criteria might have given rise to more accounts of experiences related to non-trans-specific healthcare and allowed for a broader range of trans identities.

Another limitation relates to the absence of black, Asian, or minority ethnic participants. The study used purposive sampling, and the self-selected participants were all white British. Although the sample consisted of participants from across UK and from a range of age groups, there was significantly less diversity in terms of culture and ethnicity.

A further potential limitation pertains to participant validation. Obtaining feedback could have helped ensure that the findings were an accurate representation of participants' perceptions. It could also be argued that this might have helped participants feel more involved in the research process as a whole. However, on reflection, and after discussing this with my supervisor, I realized there were a number of drawbacks related to participant validation. First, asking for feedback from nine people would have considerably slowed down the analytic process. Since I was working to a strict deadline, adding steps that could cause significant delays seemed inexpedient. Additionally, Finlay (2006) points out that data emerges within a specific interpersonal context, and that findings are heavily influenced by the researcher's interpretations. Furthermore, since IPA analysis involves integrating/collating the experiences of a number of participants, it would be tricky for each individual to validate the findings as a whole (Horsburgh, 2003).

4.8 Suggestions for Future Research

As mentioned above, no black, Asian, or minority ethnic people took part in the current research project. It would be interesting to examine the perceptions of trans people of colour in relation to healthcare and psychological services, as this could illuminate both common and divergent experiences. This is particularly important, since people of colour are often underrepresented in trans research (Nodin et al., 2015).

As the transgender rights movement grows, and trans people become increasingly visible in the mainstream media, further research is needed to monitor progress in relation to service user experience. As previously discussed, it would be interesting to see whether the online training on gender variance recently launched by the Royal College of General Practitioners improves support at a primary care level. It could be useful to measure provider attitudes towards trans people by replicating the Canadian study conducted by Ali, Fleisher, and Erickson (2016). Routinely measuring clinicians' attitudes could be particularly helpful in assessing the effectiveness of trans-specific training.

Given the particular value that participants attributed to resilience and assertiveness, future research in this area is indicated. As previously mentioned, there is a lack of research exploring therapeutic interventions for transgender individuals (Austin & Craig, 2015). The findings of this study support previous research that emphasizes the value of helping trans clients identify and develop resilience strategies. In order to add to these findings, it could be useful to conduct research that looks at the efficacy of specific interventions. In particular, it could be interesting to evaluate the effectiveness of adopting a CBT approach, especially since CBT has not yet been empirically tested with this client group. TA-CBT was developed with the aim of helping transgender clients build resilience, and includes assertiveness training as part of the proposed programme. This could prove especially useful, as it would have clinical implications for policy makers and could influence the development of NICE guidelines.

4.9 Methodological Reflexivity

IPA recognizes that it is impossible to access the subjective experience of participants directly. It views research as a dynamic process in which the researcher's own world-view will inevitably impact the analysis in some way (Willig, 2013). Reflexivity is therefore an essential part of the research process. I tried to remain aware of how my own preconceptions and beliefs could be influencing my understanding of the participants' experiences. As a novice to qualitative research, I initially found reflecting on my potential to influence the data daunting, as I realized that I could no longer hide behind objectivity. However, since continual reflection has been an important part of my counselling psychology training, I soon became comfortable with this idea and was able to acknowledge and accept the active role that I, as the researcher, would play in the process. In fact, I believe that adopting a qualitative approach has enabled me to become more reflexive and more comfortable critically evaluating my work in relation to research, but also to clinical practice.

As discussed in detail during the methodology chapter, one thing that I frequently reflected on was the potential impact that my position as an outsider could be having on the findings. Being an outsider meant that I was able to approach the interviews and conduct the analysis with an open mind and without being influenced by any past personal experiences. Conversely, I suspect that if I had been trans myself, this might have afforded me alternative insight and perspective that, as an outsider, I was not privy to. Furthermore, this might have helped participants feel more comfortable during interviews and subsequently impacted how they responded to me. However, since it is inevitable that the researcher will influence the findings in one way or another, rather than making a judgement on whether this was a benefit or a drawback I endeavoured to remain mindful and reflexive of my position as an outsider throughout the process.

I remained acutely aware of the unavoidable obstacles and variables beyond my control. Certainly, my own age, gender, ethnicity, educational background, and general life experiences will have affected my reading and interpretation of the data. During interviews, I tried to bracket my assumptions as much as possible by adopting a not-knowing stance. However, despite my best attempts, my own responses to what I heard during the interviews could have affected the dynamic. Similarly, the impression I made on the interviewees might have influenced them, consciously and unconsciously, to filter their responses in some way.

Throughout the research process, I was mindful of my sense of responsibility to faithfully represent the participants' accounts. This motivated me to conduct the analysis diligently and precisely, even when I found the work demanding. As this was my first time using IPA, I relied on the guidelines set out by Smith, Flowers, and Larkin (2009), particularly during the early phases of the analysis.

I recognize that adopting a different qualitative approach, such as discourse or narrative analysis, would likely have yielded different results. Although I was initially tempted by discourse analysis, I felt that IPA would best answer my research question and help me understand how my participants experience their reality. In addition, I felt that IPA was in line with my epistemological position as a critical realist.

Willig (2013) proposes three potential limitations of IPA, which I will briefly address below in relation to the current study. First, Willig (2013) argues that language, rather than simply describing reality, contributes to its construction. Not only the selection of aspects of the narrative, but the specific choice of words all add to the expressed meaning presented by the participants. In *Through the Looking Glass*, Lewis Carroll captures the subjectivity of linguistic communication through Humpty Dumpty's comment, "When I use a word […] it means just what I choose it to mean – neither more nor less" (Carroll, 1872, p. 124). This quote highlights the importance of intent, and the additional complexity that this brings to language. Consequently, language cannot provide us with direct access to the subjective experiences of others owing to the personal meaning that the speaker may give a word or phrase. It can, therefore, be argued that participant transcripts tell us more about how they talk about their experiences rather than the experiences themselves. During the interviews, I attended to non-verbal cues, and when listening to the audio recordings, I paid attention to the way participants said things, their tone of voice, and the overall context in an attempt to partly alleviate an over-reliance on specific words and infer the underlying meaning.

The second challenge discussed by Willig (2013) relates to the suitability of accounts. IPA attempts to gain access to the quality of the lived experience of the participants and to be able “walk in their shoes”. However, individuals may vary in their ability to articulate their accounts and to express the texture of their experiences. This idea is perfectly captured by Wittgenstein (1974) when he states, “The limits of my language mean the limits of my world” (p. 56). The educational background will influence not just the choice of words or language, but how comfortable individuals might feel with this particular medium. Some might have a greater capacity to elaborate on their experiences. Others might have fewer resources, and this could limit their ability to fully conceptualize or describe their experiences. Even those with the facility to use sophisticated language might not be at ease or well-practised in verbalizing their feelings and thoughts. However, in relation to the current study, I did not feel this posed a significant limitation, since all of my participants were all able to coherently and vividly articulate their thoughts, feelings, and experiences.

Finally, Willig (2013) highlights the difference between description and explanation. She argues that in order to fully understand participants’ experiences, it is essential to go beyond the mere description to look for explanations as to why they have the experiences they do. What are the causes and background conditions that have contributed to how they perceive things and what they feel in response? Phenomenology needs to be combined with an investigative framework that considers origins and causes in order to answer these questions. However, since the primary focus of this research was to understand the lived experiences of the participants, to attempt to answer the question why these experiences occur, although a worthwhile task, is perhaps beyond the scope of this project.

4.10 Personal Reflexivity

Richards et al. (2014) emphasize the importance of recognizing both trans people and clinicians as multidimensional individuals, and they caution against reducing either to a single identity. The authors point out that some researchers assume that trans people are not clinicians, and vice versa, when of course this is not the case. I was mindful of this throughout the process, particularly when I discovered that two of my participants were health professionals, although not themselves gender specialists, and were both working in healthcare settings when they transitioned.

Although a number of the experiences recounted by participants related to negative interactions, it is important to note that all participants also described many positive encounters within healthcare and therapeutic services. Although this research has indeed highlighted certain shortcomings within the health system, this is by no means an attempt to attribute blame or to identify one group as "victim" and the other as "wrongdoer". For example, participants raised GPs' lack of knowledge as a concern. As a result, it was recommended that doctors, and specifically GPs, receive specific training related to working with trans people. However, this is not to say that all GPs are ill-informed or uncooperative. It would be unhelpful and incorrect to generalize the failings of certain clinicians as representative of the profession as a whole.

Conducting this research has been a lengthy and challenging yet rewarding process. Since first deciding to embark on this project in 2014, I have learnt a tremendous amount, and my learning continues to this day. First, it has helped inform my own practice enormously. When I began working with my first trans client, I knew nothing about the experiences of trans individuals. I was unaware of the correct terminology, unfamiliar with the transition process, and completely ignorant of the struggles that many transgender people face on a daily basis.

Working with trans clients and conducting these interviews has not only taught me a great deal about the transgender community, but also about gender in general. I uncovered preconceptions that I had formerly been unaware of, and was able to thoroughly explore and question my personal notions of gender. Having never questioned my own sense of gender, I had previously assumed that it was both binary and fixed. I now see gender as existing on a scale in the same way that sexuality does, and view it as something that can be both fixed and fluid.

Listening to the experiences of my clients and participants, I have begun to understand how pervasive gender privilege actually is in our society. I have become aware of the transphobia that exists both explicitly and implicitly and the devastating impact this has on the trans population. Working with this client group has highlighted the importance of listening and remaining open-minded at all times. Although I had worked with a number of trans clients before I began conducting participant interviews, the role of researcher afforded me a new perspective and helped me better understand the service user experience. I have been humbled by the strength and determination shown by all those I have worked with, and I am especially grateful to all my participants for agreeing to share their stories with me.

4.11 Conclusions

After initially deciding to embark on this research project, my time at the gender clinic and my subsequent reading and researching further motivated and inspired me. I was keen to investigate trans people’s experiences of healthcare and psychological services in order to help improve my own clinical practice, as well as to further inform counselling psychologists and other health professionals of the specific needs of this client group. Using IPA facilitated an in-depth and detailed exploration of the subjective experiences of a small group of trans people living in the UK.

The findings of this study support previous research that indicates that transgender people frequently encounter discrimination, stigma, and rejection often leading to significant psychological distress. When working with trans people, it is imperative to be aware of the challenges faced by this client group and remain sensitive to the impact of minority stress.

Participants expressed both positive and negative experiences within healthcare, and explored what they had found especially helpful and unhelpful. They reported feeling frustrated and demoralized due to waiting times, provider ignorance, and administrative errors. They described feeling disempowered by clinicians who they perceived as controlling, antagonistic or confrontational. They also talked about the negative impact of having to deal with health professionals who appeared hostile or transphobic. Conversely, participants described feeling encouraged and empowered by clinicians who were knowledgeable, open-minded, respectful, and empathic.

Participants emphasized the importance of cultivating a solid support network and finding a therapist who is informed, non-judgemental, and supportive. They identified building resilience and improving assertiveness as useful coping strategies. In light of these findings, the potential benefit of adopting a trans-affirmative CBT approach has been considered.

Several recommendations have been made; however, it is acknowledged that due to financial constraints, particularly within the NHS, there exists a gap between what is ideal and what is feasible. For example, in an ideal world, all health and social care professionals would receive at least basic-level training on gender diversity. However, I am aware that the funding and resources are simply not in place to make this happen, and especially not in the near future. Therefore, the responsibility inevitably falls to the individual psychologists, health professionals, and academics to educate themselves and others to advocate for the transgender community, and to continue to fight for the inclusion of gender diversity training within services and on training programmes wherever possible.

Throughout this project, my intention was to convey compassion and respect towards my participants and the trans community. Listening to the narratives and journeys of the nine participants was an honour and a privilege. It gave me the opportunity to develop a deeper understanding of their experiences, and my hope is that I can share this learning with other counselling psychologists, therapists, and healthcare professionals.

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Section C: Publishable Article

Exploring trans people’s experiences of ‘survival’ whilst accessing healthcare and psychological services during transition

Abstract

This research explores trans people’s experience of healthcare and psychological services in the UK. This project aims to further inform Counselling Psychologists and other healthcare providers of the specific needs of this client group, with implications for improving future treatment and support in this area. Semi-structured interviews were conducted with nine participants and the data was analysed using Interpretative Phenomenological analysis (IPA). The sample consists of 4 trans men and 5 trans women between the ages of 18 and 62 years old. “Survival” emerged as a master theme. This finding is explored in relation to existing theory and literature. Implications for clinical practice and considerations for working therapeutically with trans people are discussed. Specifically, recommendations aimed at helping trans people feel more visible and empowered were presented. The importance of helping trans clients build resilience and develop coping strategies is considered.

*This article is intended for submission to the International Journal of Transgenderism and therefore follows the guidelines for manuscripts set out by this journal (see Appendix 18)

*All names and identifying biographical details have been changed or omitted to ensure confidentiality

* KEYWORDS
Transgender; trans; counselling psychology; affirmative therapy; resilience; IPA

Introduction

Many authors have noted that psychologists, therapists, and other health professionals rarely receive formal training in transgender issues (Bess & Stabb, 2009; Carrol, Gilroy & Ryan 2002; Ettner, 1999; Gainor, 2000; Hope, Mocarski, Bautista, & Holt, 2016; Lev, 2004; Raj, 2002). As a result, clinicians are often poorly informed about the unique difficulties faced by trans people, and are therefore ill-equipped to meet the needs of these clients (Carroll et al., 2002; Lev, 2004; Raj, 2002). It is important that therapists develop a good understanding of transgender people's experiences so that we can be fully prepared for the complexity of issues that these individuals may bring (Carroll et al., 2002). Chavez-Korell and Lorah (2007) suggest that training is important as it is likely that most therapists will see at least one transgender client during their career, and even more likely that they will see a family member of a trans person. Bess and Stabb (2009) argue that this lack of understanding and awareness amongst healthcare professionals has led to trans people finding it difficult to trust clinicians.

There is limited research that has examined trans people's lived experiences of psychotherapy in the UK. When I initially embarked on this research project in 2014 I was unable to find a single UK study relating to this topic. However, a more recent literature search revealed that two studies have since been published. This suggests that the importance of exploring trans people's attitudes and experiences in relation to therapy is finally beginning to be recognised.

Hunt (2014) explored trans people's experiences of seeking and receiving therapy outside of gender clinics within the UK. The study took a mixed-method design and involved an online survey completed by 74 participants, and five semi-structured interviews. Survey responses revealed that the majority of participants felt accepted by (61%) and able to trust (64%) their therapist. However less than half of respondents felt understood by their therapist (44%). Four of the five interview participants recounted positive experiences in therapy which were associated with feeling heard, understood, accepted and affirmed. However, four participants also reported feeling either misunderstood or rejected by their therapist. These findings support the notion that a strong therapeutic relationship is more important than technique or modality (Hunt, 2014). Participants indicated that how therapists dealt with gender issues during therapy was a major concern. Only 35% of survey respondents felt that their therapist had a good understanding of gender identity issues. The authors highlight the importance of therapists approaching gender concerns with clients sensitively and appropriately (Hunt, 2014). Most participants who took part in the study were white, British, and over the age of 40, therefore potential limitations relate to the lack of diversity within the sample.

Applegarth and Nuttall (2016) looked at six trans people's experiences of talking therapy within the UK. Some of the participants had accessed therapy via specialist gender clinics whilst others had received therapy privately or through a charitable organization. Their findings indicated that transgender clients often experience anxiety around transition and this can be intensified during therapy and subsequently affect the therapeutic relationship. The authors suggest that in order to help them overcome their anxiety, therapists should help trans clients to cultivate a sense of hope and acceptance (Applegarth & Nuttall, 2016). Participants described therapy as beneficial when it helped them rethink and accept their personal sense of gender. They emphasized the importance of a good working relationship, and explained that feeling connected to a therapist helped them feel safe, while feeling disconnected resulted in resistance, fear, and anger. The importance of moving beyond therapy was also emphasized, as participants were keen to avoid getting stuck in ongoing therapy. Participants explained that successful therapy continued to have a positive impact even after it had ended. One possible limitation of Applegarth & Nuttall's (2016) study was the relatively narrow age range (32–48). Including younger participants who could have benefited from recent improvements in societal attitudes might have produced alternative findings.

Despite the fact that transgender people are often in particular need of therapeutic services, they have consistently been underrepresented in academic texts and professional journals (Lev, 2004). The lack of research aimed at educating psychologists about the difficulties faced by transgender individuals has been previously highlighted (Chernicoff, 2002). Although increasing attention is being paid to the experiences of LGBT clients, there continues to be a lack of research that focuses solely on trans people (Ellis et al., 2015). Collectivizing the experiences of LGBT people results in the *unique* needs of trans people going largely unnoticed (Ellis et al., 2015; Hope et al., 2016). Although they face similar difficulties in relation to minority stress, there is a range of issues distinct to the transgender community that is likely to be ignored if research continues to generalize all LGBT experiences.

Laird (1999) asserts that, as therapists, we have a responsibility to take the stories of our transgender clients into the professional literature and on to the streets. Coolhart et al. (2008) argue that more research is needed to assist therapists working with this client group. Although there has been an increase in transgender awareness in recent years, there continues to be a substantial gap in the literature (Benson, 2013). Hope et al. (2016) emphasize the need for "high-quality research that focuses on topics of particular relevance to transgender persons" (p. 362). Similarly, Winter et al. (2016) argue that "much research remains to be done in the field of gender incongruence". Elder (2016) suggests that researchers and providers are only just starting to understand the specific needs of the trans community, and therefore more research is needed to access the effectiveness and efficiency of the services currently on offer and to explore potential obstacles to treatment. The high rates of suicidal behaviour reported amongst the transgender population reinforces the need for psychologists and therapists to continue to learn more about the challenges this group faces so that they are equipped to provide appropriate and effective support.

Despite the introduction of new guidelines and regulations, recent research indicates that trans people continue to report negative experiences of healthcare services in the UK (Ellis et al., 2015; McBride, 2011; Miller, 2015; Whittle et al., 2007). This is problematic, as trans people are reliant on the medical profession in order to receive gender affirming treatment (Ellis et al., 2015). Recent research conducted in the UK indicates that transgender people often find engaging in therapy anxiety provoking (Applegarth & Nuttall, 2016), and frequently feel misunderstood by their therapist (Hunt, 2014). Bearing in mind that trans individuals recount mixed experiences of healthcare and psychotherapy, it is imperative that we endeavour to better understand how they perceive these services and investigate in detail both what facilitates and hinders service-user satisfaction.

As trans people become increasingly visible, and more individuals begin seeking treatment for gender-related issues, it is important that allied professionals continue to attempt to improve the support that is currently on offer. Hope et al. (2016) point out that social attitudes and understanding around the experience of being transgender change so rapidly that literature can become quickly outdated. As mentioned above, only two qualitative studies exist that have looked at transgender people's experiences of therapy in the UK. Consequently, there is a need for further research conducted in the UK to examine in detail the variety of experiences that are described by trans people across services. This project aims to further inform Counselling Psychologists and other healthcare providers of the specific needs of this client group with implications for improving future treatment and support in this area. The present study, therefore, aims to extend the small body of research that has examined trans people's experiences of psychological and therapeutic services in the UK.

Methodology

Carroll et al. (2002) argue that using qualitative research methods allows "transgender people to speak for and about themselves" (p.134). This study employed Interpretative Phenomenological Analysis in order to capture the subjective experience of its participants. Since IPA uses direct quotes from the participants themselves, I hoped that this would help give these individuals a voice.

The study employed purposive sampling and participants were recruited through various London based charities, societies and support groups There were nine participants in total: five trans women, and four trans men. They were aged between 18 and 62. Some participants had transitioned privately, some via the NHS, and some a mixture of both. Similarly, some participants had received therapy at a gender clinic, some privately, and some through a charitable organization. All participants identified as trans and had begun hormone treatment. Demographic details relevant to the study can be found in Table 1 below.

Table 1

Pseudonym	**Gender**	**Age**	**Started transition**	**Started hormones**
Anna	Trans woman	56	2 months ago	19 months ago
Barbara	Trans woman	59	3 years ago	3 years ago
Caroline	Trans woman	34	2 years ago	2 years ago
Daniel	Trans man	18	7 years ago	1 year ago
Ethan	Trans man	24	3 years ago	1 year ago
Francesca	Trans woman	31	7 years ago	10 years ago
George	Trans man	29	4 years ago	4 years ago
Heather	Trans woman	62	13 years ago	10 years ago
Ian	Trans man	38	13 years ago	10 years ago

Data was gathered through semi-structured interviews with the aim of capturing the phenomenology of the participants’ individual experiences. Nine one-to-one interviews were conducted in person by the researcher, which lasted between 45 and 105 minutes. The interviews were all digitally recorded and later transcribed. The audio recordings were encrypted, and the transcripts were saved as password-protected documents. All participants were given pseudonyms in order to preserve their anonymity. Ethical approval for this study was obtained from the City University Research Ethics Committee.

Results

Three master themes and ten sub-themes emerged from the analysis of the data:

Table 2

Challenges of Living	**Negotiating Care**	**Survival**
In Limbo	Visibility	Finding the Strength Within
Stigma and Rejection	Battle for Treatment	Seeking Connection
Turmoil	Power	Choosing the Right Therapist
	Clinical Transphobia	

These themes offer insight into the subjective experiences of the participants. For the purpose of this paper I decided to focus on the master theme “Survival” which I believe has important implications for the field of Counselling Psychology. Additional, I felt that trying to do justice to the full findings within the word limit would be challenging, whereas focusing on one theme would allow for a richer and more in-depth exploration of the results.

The theme “Survival” highlights the importance of trans people developing specific coping strategies in order to manage the difficulties associated with transition and negotiate obstacles to treatment. Hearing how participants overcame challenges and fostered resilience is especially useful for Counselling Psychologists as it can help us understand how to better support trans individuals in therapy.

Finding the strength within

Whilst talking about ways of coping, all participants emphasized the importance of developing resilience and building assertiveness Ethan talks about the importance of having a good understanding of what he wanted from appointments in order to ensure that his were needs are met:

> *It's important to be quite insistent that ... basically, where your needs aren't being met, it's important to make clear that, you know, there's something that you need. Otherwise you're going to fall through the cracks. (Ethan, 30, 1266–1269)*

He implies that if trans people are unable take control of their care, no one else will. His metaphor of "fall[ing] through the cracks" serves as a warning: unless you are willing to fight for yourself, you are in danger of becoming lost in the system

Similarly, George talks about the importance of being assertive:

> *And I ... I think I could have been much more pushy [...] I think you have to be more ... much more assertive, especially because services are slow at the moment. And also I think you have to like look after yourself a bit. (George, 36, 1289–1295)*

George seems to feel that it is necessary to be not just assertive but forceful, particularly when subjected to slow services and long waiting times, as is often the case when dealing with the NHS. His final comment about having to "look after yourself" suggests that he believes it is a risk to rely on others.

Francesca's alludes to her own strength and determination for being able to come as far as she has:

> *Um, stick up for yourself; be as strong as you can; don't let people wear you down; don't give in, and fight and fight and fight. And then wake up in the morning and [...] do it all again. (Francesca, 34, 1342–1345)*

Francesca gives the impression that she has been fighting a perpetual battle against the world. It is clear that she has needed to find the strength within herself in order to prevent herself being worn down by others. Although she is talking about her ability to stay resilient in the face of adversity, there is also a sense of weariness in her comment.

In the following quote, Caroline describes the process of learning how to become resilient:

> *It becomes kind of self-affirming. You do it once, and you keep on doing it, and it gets easier and easier and easier, and you suddenly find that it's no longer a problem to do it, and, and that's ... that's really what made the biggest difference [...] I suppose you ... you suddenly learn how to be resilient because you ... you ... if you want to do it, you've got to. There isn't ... there isn't a kind of alternative. (Caroline, 23, 975–982)*

Caroline explains that she learnt how to be resilient by facing challenges head on and doing what she found difficult time and again. She describes this process as "self-affirming" and it is clear that she feels that this transformation and her own efforts were what got her through. She indicates that in order to survive she had no choice but to learn to become resilient since she was not going to get the support she needed from anywhere else

Daniel discusses the importance of being true to yourself and resisting the pressure to please others:

> *Be yourself and, yeah, you may get stick for it, but you're not out there to please other people in your life; you're out there to please yourself. (Daniel, 19, 681–683)*

He explains that although you might get “stick for it”, he believes that it is essential to put yourself first. His comment implies a determined belief in inner self worth and a capacity to succeed in spite of judgment from others.

Seeking Connection

Another factor that was identified by all participants as a important component of surviving the process was feeling connected to others and receiving support. Anna highlights the value of seeking social support below:

> *Find some support and maybe go along to one or two of the sparse support groups, you know, and find like-minded people and probably to confide in one or two good friends. [...] Um, so, yeah, I think, yes you should seek proper support. Never, never, never do it alone, and always make sure that, you know, in those dark, dark days that you’ve got people who you can talk to rather than do something to yourself. (Anna, 25, 1142–1153)*

Anna seems to be emphasizing the importance of integrating with those who have had similar experiences and are likely to share similar values. She urges people to try attending support groups as well as utilizing close relationships. Her final comment comes as more of a warning than a suggestion. Her repetition of the word “dark” eludes to moments of bleakness, despair and struggle during her own journey during when having someone to talk to was perhaps the only thing that prevented her from harming herself.

Daniel also refers to the positive impact of social support. He seems to feel that he would have been unable to cope without the support of people from his LTGB youth group had on him:

> *I feel like if I didn’t have this youth group, I feel like I would either be on the street, be in a riot, or in prison, if I didn’t have the support from here. (Daniel, 17, 597–600)*

His assertion that he would have either resorted to violence, criminality, or disintegrated to the point of homelessness points to how desperate he must have felt at times, and emphasizes the significant role that the support group played in helping him survive.

Ethan discusses the potential benefit that having a mentor brings:

> *I think ... I think it's really hard, um, without the support of a kind of a mentor or someone pushing you like in ... in a positive way, outside your comfort zone, with the reassurance that you've got someone on hand if it all, you know, goes pear-shaped. (Ethan, 31, 1323–1326)*

He explains that without the encouragement and guidance from someone you look up to and trust, transitioning can be extremely difficult. He alludes to the need to push himself and move beyond his comfort zone during this time, and evidently feels that having someone to guide him would have helped him through those tough times.

Choosing the Right Therapist

When talking about their experiences in therapy, most participants seemed to feel that it was important to find the right therapist who was able to understand their specific needs. Caroline discusses the importance of having a therapist who was understanding and non-judgement:

> *It was useful to able to talk to someone who was.. was understanding, and who I felt I could say anything to without the fear of them then turning round and suddenly ... suddenly saying, "You're not committed" kind of thing, which is what I was getting. (Caroline, 23, 1020–1024)*

She expresses a sense of being liberated knowing that she could talk openly and honestly without fear of being questioned or challenged.

Anna describes how her therapist also helped her address her feelings of guilt:

> *She said that she was going to concentrate on my guilt feelings, and, I*

> *mean, she wasn't saying to me, well, I shouldn't feel guilty; she was just saying we'll explore where they've come from and how to deal with them in a functional way, which she did do, and I found that useful. Um, and, you know, and therefore she was supportive and nurturing of my situation. (Anna, 21, 965–971)*

It appears that Anna appreciated that her therapist was able to help process her emotions in an open and non-judgmental way. She seems to felt that her specific needs had been identified and therapy had been tailored accordingly. She describes her as "nurturing" which implies that she was able to provide a safe and containing environment within which Anna felt able to tackle her difficult feelings.

Similarly, George talks about his therapist being able to identify his fears around not being masculine enough:

> *He saw that the issues were to do with like fear, and he also saw that I was sort of struggling to accept my own masculinity like I kept comparing [myself] to some sort of ideal that didn't exist, so he was good at like working ... I felt like he really helped me work through those problems in a relatively short amount of time, and then at the end of that I could sort of start to transition, or like change my name and start all this. (George, 9, 326–332)*

George explains that his therapist was able to recognise this fundamental issue and how by drawing his attention to this and helping him talk it through he was able to realize that his concerns were unfounded. It is evident that he saw the work he did with this therapist as crucial in allowing him to progress to the next stage of his transition and that without this support it might have taken a lot longer.

Barbara talked about feeling that her therapist was not present during their sessions:

> *With him, it was more just his lack of ... I felt he wasn't in the room with me, um, and if ... When that's, I suppose, when you're paying money, it ... it can be ... You feel a bit cheated. (Barbara, 14, 502–508)*

Barbara describes feeling disappointed that her therapist seemed distant and unable to engage with her concerns or give her his full attention. Furthermore, the fact that she was paying for his time appeared to rub salt into the wound. This seems to have left her feeling conned in some way.

Discussion

Discussion of Findings in Relation to Existing Literature

Participants described both positive and negative experiences in therapy. They discussed the importance of having a therapist who was present, engaged, and non-judgemental. In line with previous findings, participants reported that feeling connected to their therapist helped them feel safe and supported, while feeling disconnected resulted in them feeling hurt and angry (Applegarth & Nuttall, 2016). Helpful and healing experiences were facilitated by therapists who were perceived as respectful, caring, good at listening, knowledgeable, and affirming (Bess & Stabb, 2009; Elder, 2016; Israel, Gorcheva, Burnes, & Walther, 2008). These findings support the notion that a strong therapeutic relationship is more important than technique or modality (Hunt, 2014). Participants also frequently described feeling misunderstood during therapy. This suggests that some therapists still do not know how to work appropriately with trans clients. When therapists do not have sufficient knowledge, it is especially important that they adopt a sensitive and empathic attitude. Receiving unconditional positive regard and feeling accepted is arguably especially important for trans clients, as they will likely have been exposed to rejection and discrimination in their everyday lives.

As outlined in the literature review, there has been a recent move towards trans affirmative therapy (Chavez-Korell & Lorah, 2007; Lev, 2004; Raj, 2002), and participant accounts certainly provided support for this type of approach. In line with previous research, participants emphasized the importance of being able to acknowledge their gender identity and to have it affirmed even when it was not the focus of therapy (Benson, 2013). Being able to explore gender identity and gender expression was identified as particularly helpful. A number of participants described feeling that their gender identity was not acknowledged or affirmed during therapy. Several participants talked about the damage that can be done when therapy was conducted by someone who was not comfortable with gender variance. This suggests that in some cases it is useful for clients to seek out specialist gender therapists.

Several participants highlighted the value of being able to explore the impact that transition had had on their family. One participant reported that she had stopped attending sessions with a previous therapist because he seemed unwilling to explore this with her. Another participant talked about a positive experience with a therapist who helped him explore and work through his fear that transition would harm his family. Similarly, previous literature has emphasized the importance of normalizing family disruption and helping clients work through these concerns in therapy (Lev, 2004).

All participants talked about the importance of developing coping strategies to manage the difficulties associated with transition and to negotiate obstacles to treatment. Resilience is defined as an individual's ability to cope with adversity through the use of a set of resources and learned behaviours (Harvey, 2007). Building resilience has been identified as an important factor in counteracting minority stress (Hendricks & Testa, 2012; Singh, Hays, & Watson, 2011). Hearing how participants overcame difficulties and fostered resilience is especially useful for Counselling Psychologists as it can help us understand how to better support trans individuals within therapy. This is particularly important for this population as there is a shortage of research exploring therapeutic interventions for transgender individuals (Austin & Craig, 2015).

Singh et al (2011) identified 5 resilience strategies which were common to all participants: evolving a self-generated definition of self, embracing self-worth, awareness of oppression, connection with a supportive community, and cultivating hope for the future. They suggest that therapists working with trans people should incorporate a trans affirmative approach with interventions that facilitate empowerment and resilience.

Participants from the current study emphasized the value of connectedness and developing good social supportive networks. They talked about the importance of fostering close relationships with others who were able to provide acceptance and encouragement. This finding is in line with previous research that has stressed the significance of social support (Lev, 2004; Singh et al., 2011). The positive impact of social support was discussed in relation to managing general stresses associated with transition as well as frustrations with the healthcare system. This finding indicates that, whatever therapeutic approach is used, signposting support groups and encouraging trans clients to seek social support is important.

Participants also talked about internal resilience strategies. They described learning how to build self-worth and foster hope. One of the most commonly identified strategies for coping with life stresses and dealing with the healthcare system was assertiveness. Participants discussed the value of being able to communicate clearly what they needed during appointments with clinicians. They talked about needing to be proactive and insistent in order to ensure that their needs were not dismissed or ignored.

Implications for Clinical Practice

Although all participants reported experiencing symptoms of anxiety and depression, their distress was usually associated with maltreatment from others. Psychologists and therapists should be aware that although some trans people may experience mental health difficulties during their lifetime, psychological distress is often a result of minority stress rather than pathology (Hendricks & Testa, 2012; Kelleher, 2009). Communicating this to clients can help normalize their experiences and reduce shame and self-blame. Singh et al. (2011) suggest that encouraging clients to critically examine society norms helps build resilience and reduce the impact of negative societal messages.

The findings of this study support previous research that highlights the importance of building a strong therapeutic relationship, which enables the client to feel affirmed and supported (Chavez-Korell & Lorah, 2007; Lev, 2004; Raj, 2002). Participants emphasized the value of having a therapist who was respectful, caring, good at listening, and empathic. According to Wester et al. (2010), conveying empathy is especially important when working with trans clients, as they may perceive their therapist to be part of the general culture that rejects them and their gender diversity.

Psychologists and therapists working with trans clients should adopt an affirmative approach that validates gender diversity (Chavez-Korell & Lorah, 2007; Elder, 2016; Hunt, 2014; Lev, 2004; Raj, 2002). In order to do this, it is essential that the therapist clarifies how the client defines their gender identity and what their preferred name and pronouns are (Chavez-Korell & Lorah, 2007; Hendricks & Testa, 2012; Raj, 2002). According Carroll et al. (2002), therapists working with trans clients should adopt an “informed not knowing” stance. Participants talked about disappointing encounters with therapists who lacked knowledge and awareness around trans issues. Therapists unfamiliar with transgender issues should spend time reflecting on their own values and preconceptions around gender and sexual diversity in order to ensure that they separate their own views from those of their clients. If therapists feel either too unfamiliar or too uncomfortable with gender diversity, they should be willing to acknowledge their own limitations and signpost appropriately.

Lev (2004) suggests that when working therapeutically with trans clients, it is useful to be aware of specific topics that might be brought up. Participants in the current study identified several themes that they had addressed in therapy. They talked about the benefits of being able to explore the impact that transitioning had had on their families. They discussed the value of working through feelings of guilt. Additionally, being able to explore issues around masculinity and femininity was also recognized as a useful intervention.

During the interviews, participants highlighted the difficulties associated with transition. They talked about their battle for treatment and having to fight to be recognized within the healthcare system. They also mentioned having to deal with negative reactions from others. They described being rejected by family and friends, harassed by strangers, and discriminated against both professionally and personally. In the final master theme, "Survival", participants emphasized the importance of cultivating personal strength. Bearing in mind the level of adversity and stress that many trans people have to deal with, affirmative therapists working with this client group should be prepared to help build resilience as well as facilitate positive gender belonging. Budge, Adelson, and Howard (2013) argue that therapists working with transgender individuals should focus on interventions that increase social support and facilitate positive coping styles.

Participants identified assertiveness as an important coping strategy. They described becoming assertive through necessity as they realized that there was no other way to ensure that their needs were met. Although participants seemed to improve their assertiveness over time through trial and error, assertiveness can also be worked on during therapy. Building assertiveness through skills training is used to facilitate behavioural change in CBT (Beck, 2011). Assertiveness training teaches clients how to recognize what they want, and how to communicate this clearly and confidently to others. It is also helps improve confidence and build self-esteem (Powell, 2009).

Participants talked about the importance of feeling connected to others and building a strong social support network. CBT adopts a structured and goal-oriented approach (Beck, 2011). It involves designing behavioural assignments for clients to complete as homework between sessions (Westbrook, Kennerley, & Kirk, 2011). CBT is therefore ideally suited to clients who need help fostering social relationships, as it helps them think practically about creating opportunities and practising the necessary skills.

Much of the existing literature on working therapeutically with trans people has discussed the benefits of adopting a humanistic or person-centred approach (Brown & Rounsley, 1996; Ettner, 1999; Lev, 2004; Livingstone, 2008). Other therapeutic approaches that have been discussed include existential (Richards, 2011; Richards, 2016) and, more recently, CBT (Austin & Craig, 2015). Austin and Craig (2015) introduced a transgender-affirmative adaption of cognitive behaviour therapy (TA-CBT). The manualized programme includes a number of adapted CBT interventions such as psychoeducation and cognitive restructuring. Specific resilience building interventions are proposed such as creating a hope box, growing social networks, maintaining important relationships, learning to be assertive and practicing how to respond to discrimination. Although CBT has not yet been tested empirically with trans clients, Austin and Craig (2015) argue that it represents a promising approach for relieving stress amongst minority clients. Bearing in mind the value that participants placed on building assertiveness and resilience, adopting a CBT approach that includes skills-training interventions could be useful. Considering the strain on funding and resources currently within the NHS, the fact that CBT is structured and time limited serves as another potential benefit.

Training

The findings of this study support the notion that therapists and other health professionals should receive specialist training to ensure that they can competently and sensitively work with trans people (Bess & Stabb, 2009; Carroll et al., 2002; Chavez-Korell & Lorah, 2007; Coolhart, et al., 2008; Ellis et al., 2015; Ettner, 1999; Gainor, 2000; Hendricks & Testa, 2012; Lev, 2004; McBride, 2011; Raj, 2002; Somerville, 2015; Whittle et al., 2007). Training should include information regarding the use of pronouns, as well as on the general needs and rights of trans people (McBride, 2011).

Strengths

The current project adds to the growing body of literature about trans people’s perceptions of healthcare and psychological services. The findings identify topics that could come up in therapy, and highlight the benefits of helping trans people build resilience by acquiring coping strategies and learning to be assertive.

Participants were recruited through charities as opposed to via NHS gender clinics. This allowed for more diversity amongst participants, as it did not limit the sample to a specific geographical location, but included participants from across the UK. Additionally, recruiting through charities meant that the sample was made up of people who had transitioned privately, as well as through the NHS. The current study incorporated a range of ages, suggesting that the experiences discussed were not limited to a particular age group. Previous research has highlighted the need for projects that include younger trans people (Applegarth & Nuttall, 2016; Heredi, 2013). By including younger adults, this study contributes to bridging this gap in the literature.

A significant strength of the study was that most participants had started transitioning relatively recently, suggesting that the findings are particularly pertinent to the current circumstances. Out of the nine participants, six reported that they began their transition over the last 4 years. Of the remaining three, one had transitioned 6 years ago, one 7 years ago, and only one over 10 years ago.

Limitations

Although there are significant benefits to employing a qualitative methodology such as IPA, one potential drawback relates to the lack of generalizability. Due to the method chosen, the current findings cannot be generalized to the wider transgender population. Additionally, this research only included trans people who answered the participation request circulated by the charities previously mentioned. It is worth noting that the people who chose to respond may have had particular motives that they did not share, or were at a specific stage in their life (Richards, Barker, Lenihan, & Iantaffi, 2014). For these reasons, it is not possible to make broad claims based on the findings of this study. However, it is still possible to highlight potential areas for improvement and suggest ways of working with trans people, particularly when taken in conjunction with the findings from previous research projects.

Another limitation relates to the absence of black, Asian, or minority ethnic participants. The study used purposive sampling, and the self-selected participants were all white British. Although the sample consisted of participants from across the UK and from a range of age groups, there was significantly less diversity in terms of culture and ethnicity.

Suggestions for Future Research

As the transgender rights movement grows, and trans people become increasingly visible in the mainstream media, further research is needed to monitor progress in relation to service user experience.

As mentioned above, no black, Asian, or minority ethnic people took part in the current research project. It would be interesting to examine the perceptions of trans people of colour in relation to healthcare and psychological services, as this could illuminate both common and divergent experiences. This is particularly important, since people of colour are often underrepresented in trans research (Nodin et al., 2015).

Given the particular value that participants attributed to resilience and assertiveness, future research in this area is indicated. As previously mentioned, there is a lack of research exploring therapeutic interventions for transgender individuals (Austin & Craig, 2015). The findings of this study support previous research that emphasizes the value of helping trans clients identify and develop resilience strategies. In order to add to these findings, it could be useful to conduct research that looks at the efficacy of specific interventions. In particular, it could be interesting to evaluate the effectiveness of adopting a CBT approach, especially since CBT has not yet been empirically tested with this client group. TA-CBT was developed with the aim of helping transgender clients build resilience, and includes assertiveness training as part of the proposed programme. This could prove especially useful, as it would have clinical implications for policy makers and could influence the development of NICE guidelines.

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Appendix 1: Introductory email

Dear (name of organisation)

I am conducting research into how self-identified trans people perceive the support offered by healthcare and psychological services. The aim of this study is to help enhance the care they receive in the future. This research project has been ethically approved by City University London.

I would like to interview between 6-8 participants in order to learn about their individual experiences. I wonder whether you would consider supporting this project and helping me recruit from within your organization? Please find my recruitment flyer attached.

I would be grateful for any help and advice that you might be able to offer me.

Kind regards,

Miriam Grant

Trainee Counselling Psychology
[redacted]

Appendix 2: Recruitment flyer

CITY UNIVERSITY
LONDON

Department of Psychology
City University London

TRANS PARTICIPANTS NEEDED

Would you like to share your experiences of the healthcare and psychological support you received during your transition

This is an opportunity to take part in a research project that aims to contribute to future healthcare psychological services offered to the transgender community

Your participation would involve taking part in an interview lasting 60-90 minutes

Participation will be anonymous and you will have the right to withdraw from the study at any time

For more information about this study, or to take part,
please contact:
Miriam Grant (under the supervision of Dr Pavlos Filippopoulos)
Email: [redacted]

This study has been reviewed by, and received ethics clearance through the Research Ethics Committee, City University London

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email:
[redacted]

Appendix 3: Participant information sheet

CITY UNIVERSITY
LONDON

We would like to invite you to take part in a research study. Before you decide whether you would like to take part, it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Do ask us if there is anything that is not clear or if you would like more information.

Title of study
How do trans people experience healthcare and psychological services during gender affirmation?

What is the purpose of the study?
The purpose of this study is to increase understanding of how trans individuals experience healthcare and psychological services with the view of improving the standard of care in this area.

The study is part of a professional Doctorate in Counselling Psychology and will be submitted as part of the researcher's final piece of work at City University London. The estimated duration of the study is 8-10 months.

Why have I been invited?
You have been chosen based on the following:

- You identify as trans
- You have begun hormone treatment
- You are over the age of 18

Do I have to take part?
Participation in this project is voluntary and you have the right to withdraw at any time. If you choose to withdraw from the study you will not be penalized or disadvantaged in any way. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any point and without giving a reason. You may also avoid answering any questions if you find them too personal or intrusive. Participation in this study will not affect any future support you receive.

What will happen if I take part?

- Participation in the study will last between 1-2 hours in total.
- The participant will meet the researcher once however you may contact the researcher, via email, with any further questions, comments or feedback.
- The meeting will occur at a time and place convenient for the participant.
- Personal information will be gathered, followed by a semi-structured interview that will last approximately 60-90 minutes.
- This study will be using a qualitative research method, which means that interviews will be conducted and later analyzed for common themes.
- The research is taking place at City University London.

Expenses and Payments
All travel expenses will be reimbursed.

What do I have to do?
Participation will involve talking and answering questions about your experiences of healthcare, psychological services and transitioning in general. You may refuse to answer any questions that you do not wish to answer.

Here are some examples of questions you might be asked:

- Can you tell me about how you came to make the decision to transition?
- Can you tell me about your experiences with healthcare services during this time?

What are the possible disadvantages and risks of taking part?
It is possible that participants may find the subject matter distressing. Great attention will, therefore, be paid to the well being of the participants throughout the interviews. Contact details of relevant organizations can be found bellow in case any additional help or support is needed.

Gender Trust: 01527 894838 - www.gendertrust.org.uk
Beaumont Society: 01582 412220 - www.beaumontsociety.org.uk
Gender Matters: 01902 744424 - www.gender-matters.org.uk
Samaritans – 08457 909090 - www.samaritans.org

What are the possible benefits of taking part?

- The opportunity to have your voice heard
- Reflecting on your experiences may be beneficial
- Contributing to research that aims to improve support and treatment offered to the transgender community in the future.

What will happen when the research study stops?
If the research is published data will be kept for 5 years. All the audio recordings of the interviews and all identifying information will subsequently be destroyed.

Will my taking part in the study be kept confidential?

- All personal information shared during the interview will remain anonymous and confidential unless the researcher is concerned for the safety of the participant or someone else.
- Only the researcher and the authorized person who transcribes the tapes will have access to the audio recordings.
- Only the researcher and research supervisor will have access to the transcripts and personal information.
- All data will be stored securely and anonymously and will be destroyed after 5 years.

What will happen to the results of the research study?
The data will be published as part of the researcher's thesis in the City University London library and potentially in a relevant psychological journal. All names and identifying information will be changed so that participants can remain anonymous.

What will happen if I don't want to carry on with the study?
The participant is free to withdraw from the study at any time without an explanation. Withdrawing from the study will not incur any type of penalty.

What if there is a problem?
If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: How do transgender individuals experience healthcare and psychological services during gender affirmation?

You could also write to the Secretary at:

Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB

Email: [redacted]

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?
This study has been approved by the Psychology Research Ethics Committee at City University London - Reference: PSYCH (P/F) 14/15 201.

Further information and contact details
If you have any further questions regarding the study you may contact Miriam Grant at [redacted] or Pavlos Fillippopoulos at [redacted]

Thank you for taking the time to read this information

Appendix 4: Consent form

CITY UNIVERSITY
LONDON

Title of Study: How do transgender individuals experience healthcare and psychological services during gender affirmation?

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher • allowing the interview to be audiotaped	
2.	This information will be held and processed for the purpose of this research project only. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organization.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

Ethics approval code: [*Insert code here*]

Please initial box

Name of Participant Signature Date

Name of Researcher Signature Date

When completed, 1 copy for participant; 1 copy for researcher file.

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

Appendix 5: Background information sheet

It would be helpful if you could provide some background information before we start the interview. This will not be used to identify you in any way, but will help set my research in a specific context. Please note there is no obligation to answer these questions.

DOB:

At what age were you aware that you wanted to transition?

How long have you been living in your preferred gender?

Have you had a name change?

How long have you been taking hormones?

Have you had or are planning on having any gender re-assignment surgery (e.g. chest, genital, facial etc.) please specify?

Have you had any other types of treatment in relation to your gender transition?

Have you had any psychological therapy?

Have you attended any therapy groups / support groups?

Appendix 6: Interview schedule

Can you tell me about your first medical appointment / referral process?

Can you tell me the healthcare services that have been involved in you transition?
(Private vs NHS, GP, psychological services, specialist services)
What was your experience?
What was best?
What could have been better / more useful?
What would you change / is there anything you would want to be done differently?

Can you tell me about any therapeutic or emotional support that you accessed?
(Private vs NHS, 1:1 therapy, group therapy, support group)
What was your experience?
What profound or healing experiences in psychotherapy have you had?
What unhelpful or disappointing experiences, if any, in psychotherapy have you had?
What would you change / is there anything you would want to be done differently?
Comparing your previous experiences and more recent experiences in psychotherapy, have you noticed a change in the way therapy is conducted? Any similarities?
As a transgender person who has had experiences in psychotherapy treatment, what else would you like to share with other transgender consumers of psychotherapy?

What, if any, changes would you like to see in the healthcare support offered to you and others?
As a transgender person what else would you like to share with mental health workers?
What advice would you give to someone else going through this process?
What advice would you give to your younger self (5 years ago)
Is there anything you would have done differently?

Prompts
Paraphrase
Can you me a bit more about that?
What do you mean by ____?
Tell me what you were thinking?
What was that like for you?
How did that feel?

Appendix 7: Debrief

CITY UNIVERSITY
LONDON

How do trans people experience healthcare and psychological services during gender affirmation?

DEBRIEF INFORMATION

Thank you for taking part in this study! Now that it is finished we would like to explain the rationale behind the work.

In order to improve the healthcare and therapeutic support that is offered to the transgender community, it is useful to hear from individuals such as yourself so that we can better understand your experiences and what you found helpful and unhelpful.

It is expected that hearing about your experiences will help healthcare providers identify those things they are doing right, and those areas where they need to do things differently. Hopefully this will lead to better policies and an improved standard of care for trans people.

If you would like any additional support or help, following your participation in this study, here are some organisations you can contact:

Gender Trust: 01527 894838 - www.gendertrust.org.uk

Beaumont Society: 01582 412220 - www.beaumontsociety.org.uk

Gender Matters: 01902 744424 - www.gender-matters.org.uk

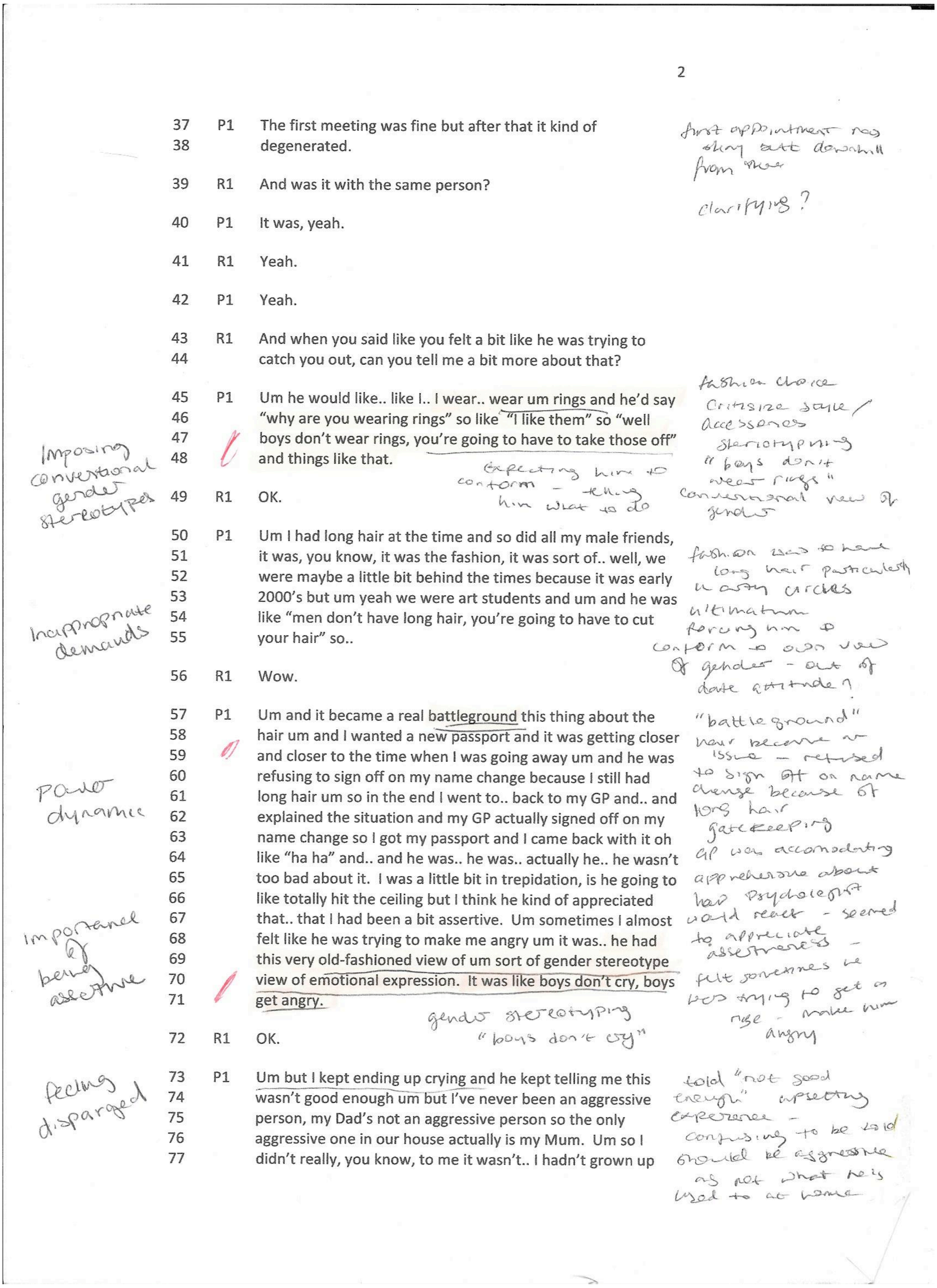
Samaritans – 08457 909090 - www.samaritans.org

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Miriam Grant (researcher) [redacted]
Pavlos Fillippopoulos (research supervisor)
[redacted]

Ethics approval code: PSYCH (P/F) 14/15 201.

Appendix 8: Example – initial stages of analysis



2

P1 The first meeting was fine but after that it kind of degenerated.

first appointment was okay but downhill from there

R1 And was it with the same person?

clarifying?

P1 It was, yeah.

R1 Yeah.

P1 Yeah.

R1 And when you said like you felt a bit like he was trying to catch you out, can you tell me a bit more about that?

P1 Um he would like.. like I.. I wear.. wear um rings and he'd say "why are you wearing rings" so like "I like them" so "well boys don't wear rings, you're going to have to take those off" and things like that.

Imposing conventional gender stereotypes

Expecting him to conform – telling him what to do

fashion choice
Critisize style / accessories
steriotyping
"boys don't wear rings"
conventional view of gender

R1 OK.

P1 Um I had long hair at the time and so did all my male friends, it was, you know, it was the fashion, it was sort of.. well, we were maybe a little bit behind the times because it was early 2000's but um yeah we were art students and um and he was like "men don't have long hair, you're going to have to cut your hair" so..

Inappropriate demands

fashion was to have long hair particularly in arty circles
ultimatum
forcing him to conform to own view of gender – out of date attitude?

R1 Wow.

P1 Um and it became a real battleground this thing about the hair um and I wanted a new passport and it was getting closer and closer to the time when I was going away um and he was refusing to sign off on my name change because I still had long hair um so in the end I went to.. back to my GP and.. and explained the situation and my GP actually signed off on my name change so I got my passport and I came back with it oh like "ha ha" and.. and he was.. he was.. actually he.. he wasn't too bad about it. I was a little bit in trepidation, is he going to like totally hit the ceiling but I think he kind of appreciated that.. that I had been a bit assertive. Um sometimes I almost felt like he was trying to make me angry um it was.. he had this very old-fashioned view of um sort of gender stereotype view of emotional expression. It was like boys don't cry, boys get angry.

Power dynamic

Importance of being assertive

gender stereotyping
"boys don't cry"

"battleground"
hair became an issue – refused to sign off on name change because of long hair
gatekeeping
GP was accomodating
apprehensive about how psychologist would react – seemed to appreciate assertiveness – felt sometimes he was trying to get a rise – make him angry

R1 OK.

P1 Um but I kept ending up crying and he kept telling me this wasn't good enough um but I've never been an aggressive person, my Dad's not an aggressive person so the only aggressive one in our house actually is my Mum. Um so I didn't really, you know, to me it wasn't.. I hadn't grown up

Feeling disparaged

told "not good enough" upsetting experience – confusing to be told should be aggressive as not what he's used to at home gender stereotyping

with those sort of gender stereotypes um and besides which what I found once I did start taking the hormones and it was a year before I could start um was that actually it kind of controlled my crying, I didn't cry as much because I thought this seems to be um linked to hormones um and talking to people transitioning the other way um female to male and um no um male to female.

didn't match own experience

hormones controlled crying - didn't cry as much once on T - understands this is common amongst trans people

R1 Yes.

refers to difficulty of keep up w/ terminology

P1 Even I get mixed up with the um with the terminology um they say that when they start taking the oestrogen they can get very tearful so it can be like um it can make you tearful, it seems. Um but yeah, I mean, he seems a bit stuck in the 1950's.

~~sometimes~~ gets confused with terminology
"even I get mixed up" suggests it can be confusing?
discusses link between oestrogen & tearfulness

clinician stuck in the past

Psychologist seemed stuck in the past

R1 Yeah.

P1 Um.

R1 So whil.. whilst you were having these appointments, how.. how were you feeling about them at the time?

psychological/ emotional impact of negative experience w/ clinician

P1 Really bad. Um, I mean, I actually started um self-harming again which was something I hadn't done for years um but I just felt so much stress and I felt like he was watching me all the time um and I knew it was irrational, he's not watching me all the time, he's not tracking me but I just felt like everything I did, he was somehow watching me to see if it was ticking the right gender boxes.

found appointments highly distressing
started self-harming because of stress
felt he was always being watched / monitored to check he was "ticking the right gender box"

aware that its irrational

difference between knowing & feeling

R1 Right.

Feeling pressured

P1 Um and one.. one of the things I found particularly difficult was that um having to use public.. the men's public toilets before I'd had any hormones or anything and I said to him, you know, "this is.. this is stupid, you know, I should have the hormones before I do this" and he said "no, no, no, no, no, you've got to show some commitment." Um, so, I mean, I could have.. I could have completely cheated on that, I could have just turned up to the appointment and said "yeah, yeah, yeah, I've been using the men's toilets."

especially struggled using male public toilets
felt forced to do it even though not comfortable
"have to show commitment"
could have lied but didn't feel able to
always answered honestly - does he think this was right decision?

R1 Yeah.

imbalance of power

P1 But I had this sense of being watched so I.. I did it completely honestly but it was.. it was a ropey thing because people can get aggressive about you sort of being in what they see as the wrong toilets. I.. and I only had a couple of instances of hassle, sort of like men getting.. and it never got physical it was just like them sort of mouthing off at me um but, you know, I.. I was getting so nervous that I would stand outside and watch all the men going in and out for about ten minutes

felt being watched so always answered questions honestly
- felt what he was asking was potentially dicey as some men can get aggressive
"mouthing off at me"
felt so nervous would wait outside for 10 minutes

Forced to use male toilets

so that I was sure that there wasn't any men in there who looked like they would be aggressive types.

to check there weren't any aggressive looking men in the toilets

R1 Right, yeah.

making unreasonable demands

P1 So um but, you know, comparing experiences with other people, some people said "oh no, I didn't have to do that until I had started on hormones."

Where as others weren't encouraged to do this until after starting HT

R1 Right. You.. it sounds like it was.. it was.. that you felt like you had to do the.. these sort of certain things in the way that he wanted.. what.. what did you feel would happen if you didn't?

talked with others & compared experiences

Power

P1 That he would.. he had all the power.

power dynamic "he had all the power"

R1 Right.

P1 It's like he was the only um gender psychologist in my region.

no other options "only gender psychologist in my region"

R1 OK.

P1 Um and I didn't have the money to go travelling far off to some other one um so I needed him to sign off on me to go to the endocrinologist um he.. yeah, he just had all the power and just.. it was just a really horrible feeling um..

couldn't afford to go elsewhere need him to sign off – "he just had all the power"

at his mercy "horrible feeling"

R1 So you felt like if you didn't do what he said he wouldn't sign off on your treatment.

P1 Yeah, yeah. I mean, he.. he.. he would openly say that, so..

Seen as gatekeeper of treatment openly stated

R1 Ah.

Withholding treatment

P1 But um after I got the passport and everything um he kind of backed off a little bit but he wouldn't finally send me to the endocrinologist until I did have a hair cut.

backed off a bit but wouldn't sign off to endocrinologist until he had a hair cut

old fashioned view of gender roles & expression men = short hair

Old-fashioned gender stereotypes

R1 Really?

P1 Yeah.

R1 Wow.

P1 But because I'd won the battle with the passport I felt like I'd won a bit and OK I'll sacrifice the hair so yeah, so I got a hair cut and I got signed off and yeah.

felt empowered after passport was favour "ill sacrifice the hair"

R1 Wow and that was um how long ago?

P1 That was about thirteen years ago.

R1 OK.

P1 I'm trying to work out, twelve, thirteen years ago, yeah.

13 years ago perhaps things have changed since then?

Appendix 9: Example – summary table for transcript 7

Difficulties living		
Difficulty coming out	I sort of came out in that year to my friends and had kind of a mixed reaction but at a certain point I just kind of stopped.. I stopped talking about it	5, 152-157
Psychological distress	I just became really ill basically like I had panic attacks all the time, I just couldn't really function any more.	6, 203-206
Psychological distress	I did feel um social anxiety from being mis-gendered quite often and I felt like really self-conscious in public.	11, 380-382
Discrimination / rejection	I had a feeling at work that.. because I never got to go to any kind of events, I had a feeling that I was like kept in the office because I looked a bit strange.	21, 752-755
Insecurity / self-esteem	Yeah I think for a few years I felt like I wasn't sort of legitimately trans enough, like I wasn't male enough,	3, 102-103
Feeling vulnerable / exposed	I just felt like in a really vulnerable pos.. when you come out and then you're living, you know, in your gender for however many months	20, 707-711
Feeling others do not see being trans as legitimate	it would be good if, yeah, I think that not looking at trans as a symptom but just understanding there's a real.. that it really exists.	36, 1268-1270
Experiences in therapy		
Ill-informed therapist	She was really strange… clearly not well-informed	6, 210-211
Misunderstood by therapist	I felt like she.. she didn't have, sorry, the therapist didn't have sort of a basic understanding.	29, 1031-1032
Misunderstood by therapist	Just that it was just really unhelpful. I was like.. I mean if you get.. if you start at that point you're just basically at complete odds with an understanding of what it means to be transgender like you don't really think being transgender is a thing.	31, 1101-1105

Client as educator	I didn’t feel like it would be a therapeutic experience, I felt like I would have to explain a lot and she maybe didn’t understand so.. I think I found that quite a few times with therapists.	29, 1044, 1047
Dramatizing	he started dramatizing it and saying, you know, “your life is going to be really terrible and why.. why are you doing this”	9, 316-321
Made to feel like an “interesting” client	the first person I saw clearly thought my story was really interesting and was like intrigued and I was like I don’t think this is the right kind of person so after that I didn’t bother.	29, 1017-1020
Importance of choosing the right therapist	Yeah, tried to find better therapists	38, 1336
Importance of choosing the right therapist	Um I suppose based on my experience of counsellors or therapists I think you should be careful.	40, 1405-1406
Importance of choosing the right therapist	‘Cause it can be very expensive and it can be possibly more harmful than helpful if you’re in a vulnerable position.	40, 1424-1425
Helped explore masculinity	He saw that the issues were to do with like fear and he also saw that I was sort of struggling to accept my own masculinity	9, 324-327
Time-efficient	I felt like he really helped me work through those problems in a relatively short amount of time	9, 328-332
Explored impact on family	talked a lot about families because I had that fear of like coming out to my family and he sort of figured out that it was something to do with I thought it would really harm them in some way.	30, 1075-1078
Coping strategies		
Importance of assertiveness	And I.. I think I could have been much more pushy	36, 1289
Importance of assertiveness	I think you have to be more.. much more assertive, especially because services are slow at the moment and also I think you have to like look after yourself a bit	36, 1293-1295
Importance of	I’ve had to kind of push for everything	37, 1318

assertiveness		
Building resilience	So to try and find that strength within yourself or..	37, 1315
Social support	And like seek support maybe outside	25, 899-901
Trans support groups	So I'd recommend it. It was useful to just go there and see other trans men, which I'd never really done before.	39, 1364-1365
Using online recourses	Yeah. There's a lot of people transitioning and making videos about that which is good, you know.	39, 1379-1380
Using online recourses	So it's a good space and like you can learn a lot there, you know, there's a lot of information sharing.	38, 1361-1362
Experiences of healthcare		
Administrative delays	because I feel like they kind of want it to be a therapeutic service but because the.. because it's so slow administratively because there is.. the process is so long and they demand quite a lot I think it ends up having a kind of detrimental effect on people's mental health.	22, 798-802
Administrative errors / waiting times	Mainly kind of administrative errors along the way so it took like three.. it took a couple of years, it's like a ridic.. like I think three years altogether.	7, 249-251
Waiting times	I think you have to be prepared for like long delays, you have to be prepared for bureaucracy	37, 1301-1302
Waiting times	And that was a whole.. sort of getting that referral was such a long, drawn out process	7, 246-247
Waiting times	I just had this sense of the NHS process was going to be really slow and I just couldn't.. I felt like 'cause I'd waited so many years, you know, from nearly twenty just to start and I.. I couldn't really wait any more.	10, 351-354
Assessment as stressful	I found that.. the sec.. that kind of mental health assessment quite stressful because I found the.. I think the psychiatrist quite pushy and like really argued about definitions of gender quite a lot.	2, 45-57
Feeling evaluated	I found out my first assessment when I'd been younger at the.. the.. the hospital in Cambridge was much more like an	11, 394-400

	assessment in the sense that they were asking you questions and like reading into what you said	
Assessment as pathologizing	I mean, the strange thing is after the appointment you get the re.. like the report from the assessment which is really pathologising because, you know, they have to prove that you meet this diagnostic criteria	12,417-421
Assessment as alienating	It is like.. because they send it to your GP, you know, you've just told someone all this personal information and then it becomes really medicalised… It's quite alienating.	12, 435-441
Feeling disempowered	I suppose it is to do with mental health and like how much you have to disclose and then how much becomes like public knowledge but you basically have no choice, that's what you have to say in order.. that's the amount of detail you have to go into.	13, 449-453
Feeling disempowered	.. so I think that's a bit, what's the word, sort of disempowering	13, 465-466
Feeling pressure to justify self	actually you have to like justify that you're trans enough basically for them	14, 496-497
Pressure to fit narrative	She wasn't fully convinced that I was.. I felt like there was a sort of right answer that she was going for	3, 88-91
Pressure to fit the narrative	Your history like proves that which I think goes back to that original point of like missing certain pieces of information out um because you want to kind of.. you need to have this like coherent narrative	14, 499-502
Pressure to fit narrative	I think a lot of people do, not lie, you know, but fudge.	14, 516-517
Pressure to fit narrative	Cause some, I think some doctors I've seen are.. are really like that like you.. they want the right answers and if you say something different then it's like you're wrong,	15, 548-551
Hoop jumping	.. it's so clearly like hoop jumping	15, 139
Desire for more flexible thinking	doctors really need to sort of change, yeah, change the understanding of what transitioning looks like. They think it looks like one thing.	17, 619-621
Lack of care	I think it's stressful because you feel like no-one like fully cares apart from you	28, 982-983
Transphobic	slightly sadistic	32, 1127
	You've got to chase them up constantly	24, 850

Battle for treatment		
Lack of protocol	Certain things that happen sort of every once in a while. Once you're off that.. 'cause well I've.. um you, I mean, you have to ask them to voluntarily be off that.. stop receiving those letters but there's not like an alternative, there's not like a special trans like.	28, 997-1001
Lack of awareness	And the GPs aren't fully aware of like protocol	25, 875
Desire for increased awareness	there's something quite fundamental in just learning the basic just, yeah, sort of terminology or getting a basic grasp so if someone says	35, 1250-1253
Lack of awareness / invisibility	it's like there's not one standard body of information that all doctors are following, they're just like piecing it together.	26, 921-924
Invisible	feel like you're kind of falling through the cracks.	35, 1237-1238
Feeling seen / visible	I had a GPs appointment last week and my GP was really good about it, he used like the right terminology.	33, 1178-1180
Affirming	Sort of respectful, he was like positive, kind of understood what I was doing and had a bit of knowledge about what was happening which was good.	33, 1182-1184

Appendix 10: Example – searching for connections across themes

Transcript 1 (Anna)
Transcript 2 (Barbara)
Transcript 3 (Daniel)
Transcript 4 (Caroline)
Transcript 5 (Ethan)
Transcript 6 (Francesca)
Transcript 7 (George)
Transcript 8 (Heather)
Transcript 9 (Ian)

Experiences in therapy
Desire to talk
Dealing with anxiety
Desire for therapeutic support
Desire for acceptance
Desire for depth
Desire for empathy
Importance of therapy
Desire for therapy to follow patient's pace
Therapy to address self-harm
Focus on body dysphoria during therapy
Therapist as damaging
Therapist as reassuring
Therapist lacking understanding
Ambivalent about therapy
Desire for therapy to be more regular
Therapist who checks in regularly
Desire for therapy to follow patient's pace
Desire to be treated as human being
Desire for reassurance
The importance of exploration in therapy
Exploring difficult feelings (guilt)
Trying to make sense of the process
Exploring emotional impact of transitioning
Questioning self/identity
Promoting compassion towards self and others
Desire for more empathy
Need for reflection
Acknowledge humanity of other
Importance of active listening
Therapy serve as stepping stones

Therapy as unhelpful
Therapy as a chore
Issue with cost (feeling cheated by therapist)
Wanting more input from therapist
Difficulty with ending
Lack of structure / focus in therapy
Therapist as rigid
Lack of clarification / transparency
Mislead by therapist
No "end game" (lacking clear goals or aims)
Mis-gendered by therapist
Lack of engagement
Therapist not listening (client not feeling heard)
Feeling therapist is not present
Therapy gets you from A to B
Therapy should help build assertiveness
Therapy should help build confidence
Therapy as helpful and supportive
Therapy helps with practicalities
Chewing things over in therapy
Helps with gaining perspective
Helps make sense of process
Helps to become more reflective
Good relationship with therapist
Ambivalent about therapy
Therapy as helpful
Therapy as reaffirming
Therapy as reassuring
Therapy providing confirmation
Therapy should help with assertiveness
Explore problems of living vs problems of being
Talking is not always helpful
Feeling understood
Addressing fear in therapy
Pragmatic approach in therapy
Exploring gender identity in therapy
Therapy facilitating transition
Building courage in therapy
Helping challenge gender stereotypes in therapy
Therapist helping with coming out to family
Lack of therapeutic support
Misunderstood by therapist
Ill-informed therapist
Client as educator

Ill-informed therapist
Psychodynamic approach as inappropriate
Dramatizing
Made to feel like an “interesting” client
Therapist lacking basic understanding
Patient having to be the teacher in therapy
Therapist unable to see past gender identity
Therapist trying to interpret gender identity
Desire for therapist who is a gender specialist
Importance of choosing the right therapist
Feeling understood
Therapist as interested & open
Helped with meaning making
Helped clarify own thoughts and feelings
Opportunity to articulate thoughts
Desire to discuss feelings in abstract terms
Preferred focus on the present
Feeling listened to
Therapist tuned in
Therapist not willing to listen
Not feeling listened to
Therapists need to be educated

Appendix 11: Example – clustering emergent themes

Transcript 1 (Anna)
Transcript 2 (Barbara)
Transcript 3 (Daniel)
Transcript 4 (Caroline)
Transcript 5 (Ethan)
Transcript 6 (Francesca)
Transcript 7 (George)
Transcript 8 (Heather)
Transcript 9 (Ian)

Power
Imbalance of power
Imbalance of power
Imbalance of power
Imbalance of power
Power imbalance
Power imbalance
Power of clinician
Disempowering
Power of gatekeeping
Gatekeeping
Gatekeeping
Withholding treatment
Informed consent vs gatekeeping
Informed consent
Questioning informed consent
Feeling disempowered Feeling helpless
Feeling disempowered
Feeling disempowered
Treated like mental health patient Being trans seen as mental illness
Felt need to lie during appointment Pressure to fit narrative Apprehensive about being honest / Withholding information during assessment
Needing to fit clinician's narrative
Pressure to bend truth Felt pressure to fit narrative
Feeling pressured
Tick boxing
Hiding self-harm

Fear that reporting depression can interfere with access treatment
Fear that mental-health issues will affect access to treatment
Pressure to be 'stable' (from clinicians)
Self-harm as a barrier to transition
Endless hoop jumping
Hoop jumping
Pressure to be out to family
Fixed view of what transition looks like
Clinicians never seem satisfied
Having to justify yourself
Accused of not being committed
Forced to disclose information
Imposed expectations
Process as reductionist
Process as crude

Appendix 7: Ethics Application Form

CITY UNIVERSITY LONDON

Psychology Department Standard Ethics Application Form: Undergraduate, Taught Masters and Professional Doctorate Students

This form should be completed in full. Please ensure you include the accompanying documentation listed in question 19.

Does your research involve any of the following? ***For each item, please place a 'x' in the appropriate column***	**Yes**	**No**
Persons under the age of 18		X
Vulnerable adults (e.g. with psychological difficulties)	X	
Use of deception		X
Questions about potentially sensitive topics	X	
Potential for 'labelling' by the researcher or participant (e.g. 'I am stupid')		X
Potential for psychological stress, anxiety, humiliation or pain	X	
Questions about illegal activities		X
Invasive interventions that would not normally be encountered in everyday life (e.g. vigorous exercise, administration of drugs)		X
Potential for adverse impact on employment or social standing		X
The collection of human tissue, blood or other biological samples		X
Access to potentially sensitive data via a third party (e.g. employee data)		X
Access to personal records or confidential information		X
Anything else that means it has more than a minimal risk of physical or psychological harm, discomfort or stress to participants.		X

If you answered 'no' to all the above questions your application may be eligible for light touch review. You should send your application to your supervisor who will approve it and send it to a second reviewer. Once the second reviewer has approved your application they will submit it to psychology.ethics@city.ac.uk and you will be issued with an ethics approval code. You cannot start your research until you have received this code.

If you answered 'yes' to any of the questions, your application is NOT eligible for light touch review and will need to be reviewed at the next Psychology Department Research Ethics Committee meeting**.** You should send your application to your supervisor who will approve it and send it to psychology.ethics@city.ac.uk. The committee meetings take place on the first Wednesday of every month (with the exception of August). Your application should be submitted at least 2 weeks in advance of the meeting you would like it considered at. We aim to send you a response within 7 days. Note that you may be asked to revise and resubmit your application so should ensure you allow for sufficient time when scheduling your research. Once your application has been approved you will be issued with an ethics approval code. <u>You cannot start your research until you have received this code.</u>

Which of the following describes the main applicant? ***Please place a 'x' in the appropriate space***	
Undergraduate student	
Taught postgraduate student	
Professional doctorate student	X
Research student	
Staff (applying for own research)	
Staff (applying for research conducted as part of a lab class)	

1. Name of applicant(s).
Miriam Grant
2. Email(s).
[redacted]
3. Project title.
How do transsexuals experience healthcare and psychological services during gender transition?
4. Provide a lay summary of the background and aims of the research. (No more than 400 words.)
How do transsexuals in the process of transitioning experience the support offered by healthcare professionals? This study aims to give the transsexual community a voice by exploring their individual experiences. The number of individuals presenting with gender dysphoria is growing at an estimated yearly rate of 15% (Reed, Rhodes, Schofield & Wylie, 2009). Numerous studies have found that transgender populations report lower quality of life, particularly in relation to mental health (Newfield, Hart, Dibble & Kohler, 2006). In addition, accessing primary, emergency and specialist healthcare is often problematic for transsexual or transgender individuals (Bauer, Hammond, Travers, Hohenadel and Boyce, 2009). This highlights the need to understand better how transsexual individuals perceive the support and treatment offered to them during their transition. Despite the fact that gender dysphoria and gender transitioning are becoming increasingly common there still seems to be a lack of research surrounding this phenomena. Chernicoff (2002) comments on the lack of literature aimed at educating psychologists on how to support transsexuals through their coming out process. This research intends to help improve counselling psychologists' understanding of how this group experience healthcare and psychological services with a view to improving treatment in this area.
5. Provide a summary of the design and methodology.

This research aims to explore the lived experience of a group of transsexual individuals who are in the process of transitioning from one gender to another. This study will employ Interpretative Phenomenological Analysis (IPA) in order to capture the subject experience of its participants. IPA is especially valuable when the research topic in question involves complexity, process or novelty (Smith & Osborn, 2003). The phenomenon of gender transitioning would therefore seem particularly suited to IPA, as it is both complex and a process. For the purpose of this research it will be necessary to adopt a constructivist paradigm which views knowledge as constructed and interpreted by individuals.

6. Provide details of all the methods of data collection you will employ (e.g., questionnaires, reaction times, skin conductance, audio-recorded interviews).

Data will be gathered through semi-structured interviews with the aim of capturing the participants' individual phenomenological experiences. The interviews will be conducted in person by the researcher and will last approximately 60-90 minutes. The semi-structured interview schedule will be developed based on the protocol outlined by Smith, Flowers and Larkin (2009). Semi-structured interviews are useful as they allow the researcher to modify their questions as they go alone and peruse interesting areas that may arise (Smith & Osborn, 2003). In order to generate suitable data, interview questions must be open-ended and non-directive (Willig, 2013). Interview questions should also be clear, avoid jargon and be neutral rather than leading (Smith & Osborn, 2003)

7. Is there any possibility of a participant disclosing any issues of concern during the course of the research? (e.g. emotional, psychological, health or educational.) Is there any possibility of the researcher identifying such issues? If so, please describe the procedures that are in place for the appropriate referral of the participant.

It is possible that participants may find the subject matter distressing. Great attention will, therefore, be paid to the well-being of the participants throughout the interviews. The following contact details of relevant organizations will be provided in case any additional help or psychological support is required.

Gender Trust: 01527 894838 - www.gendertrust.org.uk
Beaumont Trust: 07000 287878 - www.beaumont-trust.org.uk
Beaumont Society: 01582 412220 - www.beaumontsociety.org.uk
Samaritans – 08457 909090 - www.samaritans.org

8. Location of data collection. (If any part of your research takes place outside England/Wales please also describe how you have identified and complied with all local requirements concerning ethical approval and research governance.)

All data collection will take place in England, at a time and place previously agreed by the participant and researcher. Interviews will take place in public locations e.g. at City University or in a meeting room of a library/office building.

9. Details of participants (e.g. age, gender, exclusion/inclusion criteria). Please justify any exclusion criteria.

Participants will be selected based on the following:
-They identify themselves as transsexual
-They have begun hormone treatment
-They are over the age of 18
-They have been brought up in the UK

The above inclusion criterion has been set in order to ensure that participants represent the group of individuals being investigated.

10. How will participants be selected and recruited? Who will select and recruit participants?

The researcher will select and recruit participants. Participants will be recruited through various UK based transgender and LGBT charities, societies and support organization, e.g. The Gender Trust, Gender Matters, The Beaumont Society, Pace and Chrysalis. Word of mouth networking and 'snowballing effect' may also be employed. However, the researcher will not approach anyone directly to ask them to participate in the study.

11. Provide details of any incentives participants will receive for taking part.

No incentive will be offered to participants for taking part.

12. Will informed consent be obtained from all participants? If not, please provide a justification. (Note that a copy of your consent form should be included with your application, see question 19.)

All participants will be asked to sign a consent form before taking part in the study.

13. How will you brief and debrief participants? (Note that copies of your information sheet and debrief should be included with your application, see question 19.)

Before taking part, participants will be given an information sheet outlining why the research is being done and what is involved. After the semi-structured interview has been completed, participants will be given a debrief sheet which will briefly outline the purpose of the study and provide contact details of the researcher as well as various organizations in case further help or support is required.

14. What potential risks to the participants do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

Participants may find reflecting on their life experiences distressing. Great attention will, therefore, be paid to the well-being of the participants throughout the interviews. The researcher will be particularly alert to any signs of distress and will maintain a respectful, non-judgmental and empathetic manner throughout the process. It will also be made clear that participants may stop the interview at any time. The debrief sheet will provide the following contact details of relevant organizations in case any additional help or psychological support is needed.

Gender Trust: 01527 894838 - www.gendertrust.org.uk
Beaumont Trust: 07000 287878 - www.beaumont-trust.org.uk
Beaumont Society: 01582 412220 - www.beaumontsociety.org.uk
Samaritans – 08457 909090 - www.samaritans.org

Health and safety risks to the participants are not considered to be greater than in their everyday life.

15. What potential risks to the researchers do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

A potential risk to the researcher is meeting up with an unknown person alone. In order to ensure the safety of the researcher, interviews will take place in public locations e.g. at City University or in a meeting room of a library/office building. In addition, a contact time will be agreed with a friend or relation both before and immediately after the meeting.

16. What methods will you use to ensure participants' confidentiality and anonymity? (Please note that consent forms should always be kept in a separate folder to data and should NOT include participant numbers.)

Please place an 'X' in all appropriate spaces

Complete anonymity of participants (i.e. researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification.)	
Anonymised sample or data (i.e. an *irreversible* process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates.)	
De-identified samples or data (i.e. a *reversible* process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location.)	X
Participants being referred to by pseudonym in any publication arising from the research	X
Any other method of protecting the privacy of participants (e.g. use of direct quotes with specific permission only; use of real name with specific, written permission only.) ***Please provide further details below.***	

17. Which of the following methods of data storage will you employ?

Please place an 'X' in all appropriate spaces

Data will be kept in a locked filing cabinet	
Data and identifiers will be kept in separate, locked filing cabinets	
Access to computer files will be available by password only	X
Hard data storage at City University London	X
Hard data storage at another site. *Please provide further details below.*	

18. Who will have access to the data?

Please place an 'X' in the appropriate space

Only researchers named in this application form	X
People other than those named in this application form. *Please provide further details below of who will have access and for what purpose.*	

19. Attachments checklist. *Please ensure you have referred to the Psychology Department templates when producing these items. These can be found in the Research Ethics page on Moodle.

Please place an 'X' in all appropriate spaces

	Attached	Not applicable
***Text for study advertisement**	X	
***Participant information sheet**	X	
***Participant consent form**	X	
Questionnaires to be employed		X
Debrief	X	
Others (please specify, e.g. topic guide for interview, confirmation letter from external organisation)		

20. Information for insurance purposes.

(a) Please provide a brief abstract describing the project

How do transsexuals in the process of transitioning experience the support offered by healthcare professionals? This study aims to give the transsexual community a voice and to further inform counselling psychologists of the needs of this group. The number of individuals presenting with gender dysphoria is growing at an estimated yearly rate of 15% (Reed, Rhodes, Schofield & Wylie, 2009). Numerous studies have found that transgender populations report lower quality of life, particularly in relation to mental health (Newfield, Hart, Dibble & Kohler, 2006). In addition, accessing primary, emergency and specialist healthcare is often problematic for transsexual or transgender individuals (Bauer, Hammond, Travers, Hohenadel and Boyce, 2009). This highlights the need to better understand how transsexual individuals perceive the support and treatment offered to them during their transition. Despite the fact that gender dysphoria and gender transitioning are becoming increasingly common there still seems to be a lack of research surrounding this phenomena. Chernicoff (2002) comments on the lack of literature aimed at educating psychologists on how to support transsexuals through their coming out process. This study aims to explore the lived experience of approximately 8 transsexual individuals who are in the process of transitioning from one gender to another. This study will employ Interpretative Phenomenological Analysis (IPA) in order to capture the subject experience of its participants. Data will be gathered through semi-structured interviews conducted in person by the researcher and lasting approximately 60-90 minutes. This research intends to help improve our understanding of how this group experience healthcare and psychological service with a view to improving treatment in this area.

Please place an 'X' in all appropriate spaces

(b) Does the research involve any of the following:	**Yes**	**No**
Children under the age of 5 years?		X
Pregnant women?		X
Clinical trials / intervention testing?		X
Over 5,000 participants?		X
(c) Is any part of the research taking place outside of the UK?		X

If you have answered ‘no’ to all the above questions, please go to section 21.

If you have answered ‘yes’ to any of the above questions you will need to check that the university’s insurance will cover your research. You should do this by submitting this application to [redacted] before applying for ethics approval. Please initial below to confirm that you have done this.

I have received confirmation that this research will be covered by the university’s insurance.

Name …………………………………………… Date……………………………

21. Information for reporting purposes.

Please place an ‘X’ in all appropriate spaces

(a) Does the research involve any of the following:	**Yes**	**No**
Persons under the age of 18 years?		X
Vulnerable adults?	X	
Participant recruitment outside England and Wales?		X
(b) Has the research received external funding?		X

22. Declarations by applicant(s)

Please confirm each of the statements below by placing an ‘X’ in the appropriate space

I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.	X
I accept the responsibility for the conduct of the procedures set out in the attached application.	X
I have attempted to identify all risks related to the research that may arise in conducting the project.	X
I understand that **no** research work involving human participants or data can commence until ethical approval has been given.	X

	Signature (Please type name)	**Date**
Student(s)	Miriam Grant	01/06/2015
Supervisor	Pavlos Filippopoulos	25/06/2015

Reviewer Feedback Form

Name of reviewer(s).			
Committee			
Email(s).			
Psychology.ethics@city.ac.uk			
Does this application require any revisions or further information?			
Please place an 'X' the appropriate space			
No Reviewer(s) should sign the application and return to psychology.ethics@city.ac.uk, ccing to the supervisor.		**Yes** Reviewer(s) should provide further details below and email directly to the student and supervisor.	**x**
Revisions / further information required To be completed by the reviewer(s). PLEASE DO NOT DELETE ANY PREVIOUS COMMENTS.			

Appendix 8: Ethics approval letter

CITY UNIVERSITY
LONDON

Psychology Research Ethics
Committee
School of Social Sciences
City University London
London EC1R 0JD

1st July 2015

Dear Miriam Grant

Reference: PSYCH (P/F) 14/15 201
Project title: How do transsexuals experience healthcare and psychological services during gender transition?

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval
Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments
You will also need to submit an Amendments Form if you want to make any of the following changes to your research:
(a) Recruit a new category of participants
(b) Change, or add to, the research method employed
(c) Collect additional types of data
(d) Change the researchers involved in the project

Adverse events
You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee ([redacted] in the event of any of the following:
(a) Adverse events
(b) Breaches of confidentiality
(c) Safeguarding issues relating to children and vulnerable adults
(d) Incidents that affect the personal safety of a participant or researcher
Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Karen Hunt
Departmental Administrator
Email: [redacted]

Katy Tapper
Chair
Email: [redacted]

Appendix 14: Table showing the appearance of each theme per participant

Theme	**Participant**
Challenges of Living	All
In Limbo	Anna Barbara Daniel Ethan Francesca George Ian
Stigma and Rejection	All
Turmoil	All
Negotiating Care	All
Visibility	All
Battle for Treatment	All
Power	All
Clinical Transphobia / Discredited	Anna Caroline Ethan Francesca George Ian
Survival	All
Finding the Strength Within	All
Seeking Connection	Anna Daniel Ethan Francesca George Heather Ian
Choosing the Right Therapist	Anna Barbara Caroline Daniel Ethan George Ian Francesca