Failing to ask the ‘bare minimum’: Why do NHS Mental Health Professionals lose therapeutic curiosity when gender diversity enters the room?

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Abstract.

This thesis explores how transgender and gender diverse (TGD) people feel their gender is understood in UK mental health services (MHS) and how Mental Health Professionals (MHPs) consider gender and its influence on the experience of the service users (SUs) they support. The thesis focuses primarily on TGD experiences, but also how cisgender and normative gender narratives influence interactions with MHS.

Drawing from social constructivism, Queer Theory, and Minority Stress Theory, the study uses Reflexive Thematic Analysis to analyse two rounds of 1:1 interview with SUs and MHPs. It incorporates autoethnographic reflections of the lead researcher, a non-binary clinical psychology trainee navigating TGD research and starting their medical transition amongst the increasing hostility against TGD in the UK.

The Findings explore TGD participants' experience of rigid gender norms and the stifling impact of rigid gender norms on TGD identity actualisation. Pathological norms are frequently tightly upheld by MHS, which has an inhibiting effect on gender curiosity in MHPs, even among self-identified allies. MHPs' reflection of their own experience of gender identity, in and outside of professional contexts. Significant improvement for the inclusion of TGD voices in MHS training and training development is needed, advocating a shift away from didactic and categorical models of teaching toward a more socially constructed, flexible, and intersectional approach to gender. MHPs need to be taught to respect the testimony of TGD people's description of their identity so that they might provide their TGD clients with the bare minimum of non-judgment and empathic understanding.

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Chapter 1: Introduction

Societal understandings of gender have gradually evolved over the past few decades and the fight for gender equality has brought change in many different areas of public life. However, the benefits are predominantly reaped by those who fit reductive biological characterisations of sex and gender. The gender binary has become mythologised into a morally superior truth (Morgenroth & Ryan, 2021). Diverse gender identities are now used as a teleological tool, seeking the suppression of bodily autonomy. Institutional systems of power fight to dictate the reality and validity of an individuals' right to describe and express their gender identity in ways that feel right to them (Turyn, 2023).

Transphobic hate crimes and promotion of gender traditionalism are rising across the UK and internationally, fuelled by media and political campaigns (Trans Actual, 2021). The complex, diverse and intersectional nature of trans lives, reduced to a hegemonic mob. Villainised by the fragility of white feminism, crying wolf on TGD people allegedly infringing on women’s rights and ‘safe spaces’ (Horbury & Yao, 2020). Research has consistently shown that TGD people report higher levels of psychological distress than their cisgendered counterparts (Pinna et al., 2022) (cisgender; refers to identifying as the same sex assigned at birth).

Writing a thesis on TGD identities from a clinical psychological perspective presents inherent tensions. Central to this is the ideological conflict between affirming gender diversity and the field's historic framing of non-normative gender identity as something requiring psychological assessment or diagnosis. This research frames gender as an expansive and fluid construct that resists reductive static categorisation. Clinical psychology exists within healthcare settings, still largely dominated by the medical model of understanding the human experience, which makes it challenging to produce findings that drive macro-system change without excluding key nuances.

The mental health system has historically inflicted harm on TGD individuals, with clinicians often serving as gatekeepers to gender-affirming care while lacking adequate training (Pearce, 2018). TGD researchers must contend with dominant narratives that pathologise their identities, framing them through lenses of distress. Clinicians frequently report limited confidence in working with gender identity, often attributing this to inadequate training. Low reported levels of clinical preparedness to work with TGD people have predicted lower interest in forming therapeutic relationships with clients seeking to explore their gender in therapy (Schmidt et al., 2024). This demonstrates that a lack of engagement with TGD topics is not merely a systemic failure but is indicative of a deeper level of passive and active anti-TGD attitudes within MHS.

Traditional research methodologies expect to ‘show both sides of the debate’, as though that other side does not seek to erase and destroy our very existence. This research seeks to add layers of understanding and meaning relating to:

a) How TGD people feel understood when seeking support for their mental health (MH), regardless of whether they are seeking any gender affirming care (GAC).

b) How MHPs conceptualise gender, and how and if it is discussed in the MHS they work in.

c) Whether increasing understanding of gender identity for cisgender and TGD people can help inform training and break down the barriers to empathy and genuine curiosity that TGD people frequently encounter when they meet with MHPs.

Historically, clinical psychology’s focus on diagnosis and pathology has been part of the driving force in limiting the self-expression of TGD people, negatively impacting their wellbeing. In the UK, the hostile environment and inaccessible pathways to GAC have actively contributed to the loss of life for the TGD community (Baraitser, 2025). This research takes a staunchly anti-pathological stance and centres clinical psychology as a discipline that can follow relational formulations of human experiences, rather than relying solely on psychiatric and medical frameworks (Spandler, 2014).

1.1 Conceptualising Gender in this Research

‘Trans and Gender Diverse’ (TGD) was selected as an umbrella term in this study to describe the diverse range of terms one could use to categorise gender identity. The study participants may individually align with a particular term over this, which will be described, but the identities listed throughout the research should not be considered an exhaustive list. Not all gender diverse people identify as transgender; instead, they align with definitions and explanations of identities situated outside of binary categorisations or do not identify with any categorisation of gender at all, such as non-binary and gender queer identities. TGD was selected to attempt to capture these experiences.

TGD people can be categorised within the LGBTQIA+ community. However, transphobic and gender critical beliefs exist within the community, seeking to close the trapdoor behind them, seeking assimilation and exclusivity to obtain the hard-fought-for rights, which TGD transgressions from cisheteronormative ideals are perceived to threaten. The LGBT+ Foundation (2020) reported increased incidents of transphobia and stigma from TGD people’s LGBTQIA+ cisgender siblings and attacks from those in and outside of their community.

This research does not seek to devalue, redefine or provide a neat, updated glossary of terms for professionals. It aims to demonstrate the complexity of gender. Saketopoulou & Pellegrini (2023) write on the importance of moving away from the ‘Born-this-way’ narrative, which was created to protect the LGBTQIA+ community. It fundamentally upholds a biological essentialism that suggests there is a ‘right’

way to be a particular gender. Butler proposed that gender is a sociocultural construct in 1990; transgender research has continued to uphold that gender has inherent biological or psychological origin. To try to define gender in a way that is static and applicable to a normative population would be reductive and inaccurate. Language shifts and changes with society, constructs like “born this way” still hold meaning and emotional relevance to many, as with the authors above. This research seeks not to devalue this term or coin its own, but to acknowledge that terms and categories provide a lens through which to see gender and should be respected. When categories become concrete constructs perceived as unchangeable and separate from the socio-cultural context they originated in, they lose nuance and become shallow, restricting understanding and limiting the complexity of the TGD experience. Each of us has a GI (gender identity). Our GI will invite societal pressure to conform to gender norms (Swim, Gills & Hamaty, 2020).

> *“GI is constituted by gender subjectivity through a process of phenomenological synthesis. However, this process is underdetermined because particular gender subjectivities are compatible with multiple gender identities. To use an architectural analogy, gender identity is the form of the building, whereas gender subjectivity is its material. Although the building is constituted and made possible by its material, it is impossible to infer what the final building will look like merely from its input material”. (Ashley, 2023)*

Ashley goes on to say that, unlike buildings, the construction of gender is an ongoing process that continually evolves with us. Even in cisgender narratives, this concept holds true with gender norms shifting and changing from childhood, adolescence, adulthood and later life in how masculinity and femininity are performed and perceived. GI can be both the qualities of appearance and preference for pastimes, and simply because you identify as a man, woman or TGD identity. Gender holds the potential for a kaleidoscopic infinity of possibilities, limited only by the restrictions imposed by those unable to conceptualise realities outside of their own understanding.

Those aligned to the traditional and socially accepted norms, particularly cisgender people, experience a positive impact on their self-esteem and receive perceived socio-cultural benefits, such as being worthy of care and safety for the feminine and access to power and resource for the masculine. These norms feel concrete and unchanging tenets of everyday life. Traditional gender normative roles within patriarchal societies have consistently been associated with negative outcomes regardless of individual alignment to their assigned gender (Connell, 2005). Western gender norms typically exclude those of other ethnic backgrounds, sexual orientations and those with disabilities, increasing individual experience of loneliness, isolation and worsened mental health (Andermann, 2010). Physical characteristics and facets of appearance, such as hair and clothing, are the tip of the iceberg of sociocultural expectations that crystallise to form gender norms. Western norms are inherently tied to heterosexuality, which is believed to have a

biological root. Masculinity is perceived as inherently dominant and biologically superior, and femininity framed as inherently submissive and physically and cognitively inferior (Kitzinger, 2005).

White, cisgender, assigned male at birth (AMAB) people appear to have the most social, financial and relational power to gain through maintaining these roles; however, not meeting these standards also means they can lose the status and privileges associated with ‘maleness’ (Walby, 1990). Assigned female at birth (AFAB) people can receive some conditional praise for performing traits associated with masculinity (within certain parameters, praise only exists if societal power dynamics remain unthreatened), with evolving modern and capitalist values. For example, women assuming leadership positions at work, gaining power and independence. Female-identified children can be ‘tomboys’, playing ‘rough and tumble’ or with ‘boy’s toys’, and display signs of strength and adventure outside of the quiet, sensitive play oriented around practising motherhood with her dolls.

AMABs displaying or performing femininity are framed as losing power and status; they become weak or ‘sissy’, ‘effeminate. Association with femininity for the masculine is seen as shaming and even in childhood, little boys must show they will become strong men (Neilson et al., 2020). There is no direct synonym for ‘tomboy’, or a masculine equivalent of effeminate; a woman does not become emasculated, as masculinity is only something that can be taken from men. Linguistically, the feminine cannot truly be categorised into the power of masculinity, which perhaps reflects the underlying societal perspective of the matter. Deviations from the norm are still strictly punished on either side of the cisgender binary; narrow definitions leave AFABs & AMABs struggling to fit into the prevailing definitions.

Advancements in cisgender equality have led to more freedoms for cisgender women and queer cisgender men. The ramifications of resistance to this societal change are starting to be seen in unrest and increasing narratives of extreme hegemonic masculinity. Professing that masculinity is entitled to female submission and sex. Online subcultures have nurtured increased violence against feminine people. At its core, these movements demonstrate the toxicity of concrete definitions of masculinity, reducing maleness to only muscular strength and financial success (Vallerga & Zubriggen, 2022). The desire for the place at the top of the perceived hierarchy and the associated power it brings, changing sociocultural-economic times, leads to a vicious cycle of self-punishment and lashing out at the women seen as prioritising economic success, which is labelled as a masculine pursuit. The feminine is relegated to a subservient homemaker, without economic autonomy. Pascoe (2012) writes that the masculine upholds the very norms that wound cisgender men so deeply, as deviations are framed as a greater loss of status. Feminine identities tend towards a more communally constructed lens, creating more acceptable subcategories/cultures to define femininity, whereas western masculine identities tend to be focused on individual agency and competition with each other, excluding those differing from the dominant narrative (Boytos, Costabelle, Austin & Short, 2020).

Male and female are seen as mutually exclusive tribes; one cannot hold allegiance to both.

Many cisgender people may have slightly more expansive understandings of their own gender and that of other cisgender people, but still strongly align with traditional gender typicality. Gender typicality is how closely their gender is aligned and performed to meet the societal norms they are living in. Typicality is measured by how similar the gender presents to its counterpart in the gender binary model. The higher the typicality, the more pressure to conform will be experienced (Neilson, Schroeder, Martin & Cook, 2020). People who maintain high gender typicality have been found to hold higher levels of prejudice against TGD groups. They go on to say; High typicality individuals report finding interactions with people deviating from the norm to trigger feelings of loss of social currency and disruptions of power.

Gender itself as a social construction is structurally comprised of power, diffused through the different facets of identity. As power dynamics in society evolves power shifts influenced by politics, environmental and generational trends, threatening those who wish to keep men holding dominance and women subordination, which TGD people threaten by subverting these polarised power positions with their more fluid existence (Butler, 2024).

1.2 Pathologisation

The pathological or disease-based model of TGD identity assumes gender diversity exists due to a disconnect from ‘normative’ gender identity development, causing dysphoria and other symptoms of distress. This pathologisation requires that TGD people undergo a diagnostic assessment of Gender incongruence/gender dysphoria to receive gender affirming care (GAC). Across the world, many states and systems operate under a ‘self-determination’ or self-identification model which assumes gender variance as a normal part of the human experience and that distress is incurred due to enforcement of normative gender roles and transphobic beliefs in society (Cannoot & Schoentjes, 2023). Some might argue the move away from out and out pathologisation into more ‘benevolent’ and paternalistic narratives of medicalised distress (Malatino, 2022) is a positive one; however, gender dysphoria remains in the DSM and ICD and is associated with being disordered and other to acceptable norms (WHO, 2019, APA, 2022).

This research focuses on how gender is understood from both a service user (SU) and professional perspective, rather than GAC pathways. Pathologisation will be explored to some extent in this context of Minority Stress Theory and cisnormativity in chapter 2, which are central to the research’s aim in understanding both the experiences of accessing therapy and how aware MHPs are of the experiences of TGD people and how gender is explored in mental health settings.

Health inequality research tends to ‘fix’ or essentialise identity; the medical model ranks positivist, differential categories as the gold standard. Avoiding categories altogether is not possible or necessarily helpful. In some ways, even with mental health, diagnostic categorisation can help with managing a range

of health outcomes. However, the reductive and moralistic application of gender norms (GN) creates a barrier to nuanced understandings of identity (Huda, 2020). The homogenisation of categories within LGBTQIA+
(Motschenbacher & Stegu, 2013), especially by combining the transgender/non-binary into one category obscures nuance. Research prioritises a hegemonic LGBT+ identity and ignores other interlocking systems of oppression/power relating to class, age, disability and race/ethnicity (McDermot, Nelson & Week, 2021).

Moon’s (2024) review of psychologists’ experiences in NHS adult Gender Identity Clinics (GICs) reported feeling trapped and fighting against the neo-liberal reductionist model, that rejects the lived experience of those the service is designed to serve and privileges the ‘expert’ knowledge of the clinic. This system disregards longstanding conceptualisations of gender as socio-cultural phenomena, instead prioritising biological narratives that are more based in political control than scientific validity. The clinicians described feeling undermined and trapped within a system unlikely to see improvements related to funding and waiting lists, alongside bumping up against the elder, cisgender, dogmatic gatekeeper clinicians, leaving predominantly younger clinicians aligned to affirmation and expansive understandings of gender.

1.3 Normativity

Research into TGD identities shows gender transitions do not always follow linear paths, particularly those with non-binary identities, compared to the projective social narrative of ‘born in the wrong body’, i.e. transitioning from gender assigned at birth to a gender that aligns with an internal self, in a way that fits more neatly with the cisgender conceptualisation of development (Rankin & Beeym, 2012; Bettcher, 2013).

Healthcare systems remain fundamentally shaped by cisnormativity, the assumption that cisgender identities are normative and non-cisgender identities deviant. Cisnormative models pathologise gender diversity, embed binarised views in diagnostic categories, and diminish the legitimacy of self-knowledge (Clannchy, 2024). The pervasiveness of cisnormativity means well-intentioned MHPs may hold implicit biases rooted in societal norms, which influence clinical interaction and outcomes (Albuquerque et al., 2016).

Johnson (2016) defines transnormativity as a hegemonic social framework by which TGD people’s presentations and experiences of gender are held accountable based on a medicalised binary framework. Johnson theorises that transnormativity structures transgender identities into a hierarchy of legitimacy which privileges some trans identities and marginalises others. In other words, transgender people may only be affirmed in their legitimacy if they identify within the gender binary and choose to medically transition.

Bradford & Syed (2019) observe the isolation of transgender identities from broader research and theoretical conceptualisations of gender. Current prevailing narratives assert the normality or correctness of cisgender identities, and TGD must negotiate with professionals’ binary expectations of gender, even when seeking medical GAC pathways; TGD need to ‘pass enough’ in their gender in order to get past gatekeepers.

Heteronormativity is an umbrella term used to conceptualise the sociological experience upheld by societal and traditional gender and sexual identities. Anything differing from this norm is perceived as an aberration (Robinson, 2016). Heteronormativity is maintained within the healthcare system as MHPs are taught to understand, assess and diagnose from within the gender binary even when there is limited empirical evidence to back this up (Ansara & Hegarty,2012, Horton, 2025). Even if a MHP does not identify holding any transphobic views, heteronormative beliefs can be deeply implicitly held and maintained (Albuquerque et al., 2016).

The intersection of race, class, culture, and gender traditionalism adds a layer of meaning and complexity for how someone understands their gender identity (GI) and how their GI is perceived by others. Intersectionality, a theory first coined by Crenshaw (1999) that considers that identity over-lapping facets, like gender, age and class that a person can exist within and navigate the world and experience oppression. A TGD woman who is also a person of global majority (POGM) and who has a long-term health condition will have a very different experience to a White TGD woman or a cisgender White or POGM woman. To receive the best care possible, social support systems should consider all intersecting aspects of a person’s identity. Burnham et al. (2018) built upon Crenshaw’s work with the Social ‘GRAAAACEs’ theory which is increasingly taught to MHPs to consider their own identity and lens of awareness. It suggests that we all have ‘blind spots’, leading to possible missed opportunities when considering a person needs. This research confirms that TGD people appear to frequently fall in this blind spot across MHPs and services.

Gendered prejudice is exacerbated by ignoring someone’s intersectional identity, increasing the risk for the experience of oppression (Allen & Mendez, 2018). Transnormativity is also made further unattainable in the UK for those not fitting white Eurocentric beauty standards and those unable to perform gendered behaviours to acceptable standards.

1. 3.1 Normativity & Neurodiversity

Neurodivergence is observed at higher rates in TGD people compared to the cisgender population; this observation has resulted in a surge of research in the area (Bonazzi et al., 2025). This research has not always been framed through TGD affirmation or the voice or desires of TGD autistic people at its centre. Neurodivergent people, particularly autistic people and those with intellectual disabilities, frequently have their experiences neglected and the testimony of their own experience disrespected, especially when their

behaviour and presentation do not align with typical gender norms. Discrepancies from the perceived norms quickly become pathologised or minimised in line with practitioners’ perception of individuals diagnoses (Moore et al., 2022).

How GI is ‘validated/measured’ and how autism is assessed are recently evolving fields, as such this area is in its relative infancy, especially in respecting the voice of those it is researching (Rea et al., 2024). When writing this research, I was already aware of the prevalence of TGD neurodivergent people and the struggles faced by both populations when accessing mental health (MH) support and how holding a multifaceted identity of the neurodiverse, gender diverse person might further complicate accessing MH services. Several of the research participants recruited also fit this description and supported this idea.

The positivist language of medical conceptualisations of gender and neurodiversity and the language of co-morbidity conflate a “cause and effect” between the two, inferring that the presence of neurodiversity negates the ability to self-determine identity. Or assumes that the presence of gender identity transgression is symptomatic of neurodiversity, negating its legitimacy, often linking it to obsession or developmental immaturity due to infantilising ideas and assumptions (Strang et al., 2018).

Neither formulation allows for the social construction of gender and neurodiversity, disconnecting individuals from the pressures of cisheteronormative life, and both groups share experiences of marginalisation and the blockades to developing positive self-esteem from being othered (Bornstein, 2022).

Neurodiverse presentations are also historically and presently impacted by gender stereotypes, with cisgender women being underrepresented in diagnosis and not thought of in treatment development (Gross et al., 2023). In neurodiverse research the white, heterosexual, cisgender male is the baseline, anyone who does not conform to this presentation becomes either ignored or misdiagnosed and denied appropriate support (Moore et al., 2022). Autism and TGD identities are frequently labelled from a psychiatric deficit model and when they intersect, paternalistic pathologising approaches increase, allowing ableist and transphobic narratives to prevail (Shapira & Granek, 2019).

When it comes to providing MH support to TGD and neurodiverse people, misunderstandings are doubled as the use of gender stereotypes to guide understanding cannot be applied when they present for support (Jackson-Perry, 2020). Shaw et al. (2024) write of the triple empathy problem faced by autistic people seeking healthcare support. The triple empathy problem states that non-autistic people feel autistic people do not understand their emotional world, without empathising with the emotional world of the autistic person. Shaw et al. go on to add that the added set of social rules, scripts and jargon used in healthcare settings further alienate autistic people who may often feel invalidated and confused when interacting with healthcare professionals. This research seeks to gain further insight into the added layer of

gender diversity to neurodiverse people’s experience of feeling understood in MH settings and if MHS seek to adequately accommodate their needs.

1.4 Identity development & Psychological Safety

Bockting (2016) proposed one conceptualisation of TGD identity development that could be used to help Mental Health Professionals (MHPs) understand GI outside of a pathological presentation with an aetiological origin. Bockting proposed a non-linear stage model in which some stages might be occupied simultaneously or might be moved between depending on different factors in a person’s life.

Pre coming out, where the individual might be coming to terms with their gender or in various stages of denial and repression. **Coming out**, which might almost be staged and take place in different social contexts of a person's life. **Exploration**, here it is clear where a stage might be occupied at the same time as another, where community resource relates to gender expression and presentation played within, and comfort is found in a new gender role. Bocking highlights the role of **intimacy** as an important stage, but one that might come sometime after others, where intimate relationships are sought with less fear of rejection and abandonment, being linked to gender presentation and being accepted in the new sense of self. This results in periods of **integration,** in which private and public selves are cohesively combined in many dynamic areas of the person’s life (Bockting & Coleman, 2016). This is not the only model of identity development to exist, but one that offers understanding to GI formation.

Like-minded and visibly similar others for TGD people to see themselves mirrored in, receiving validation from similar others and relatable connections through which to mirror our actions to form a sense of self are integral parts of identity formation (Devor, 2004). Minority stressors like negative comments, redirecting away from preferred activities and overt bullying, motivated by others attacking transgressions from gender norms or the exhaustion of masking the authentic self to feel safe.

At each stage, the TGD individual is faced with messaging that non-normative identities are not acceptable. This is the case especially for children, where gender roles are less clearly defined and experimentation with play and expression is acceptable up until a point, and then social rules are quick to correct. For little boys, this often comes quicker, as little boys must not become feminine through play with dolls. Girls might climb trees but must eventually achieve maturity quicker than little boys to become carers and mothers. Such play is regulated by peers but supervised by adults (Edwards, Knoche & Kumuru, 2001). Stories of gender start in the family; mothers and parents are more expressive in telling stories with daughters than sons, offering a more flexible and expansive narrative to imagine a feminine identity compared to the more restrictive social stories about masculinity (Fivush & Zaman, 2014). Rather than tell stories of expansive and exploratory gender expression and happy children, the myth of ‘natural and normal’ biological gender is blindly accepted, blocking acceptance and promoting the maintenance of minoritisation.

TGD staff in the current pathological model risk prejudice and have harmful narratives of disorder projected onto them by their colleagues. NHS staff report increasing rates of transphobia between colleagues, and 14% of staff survey respondents feel their workplace responded swiftly and meaningfully in response to complaints of LGBTQ+ discrimination (McCay, 2024).

1.5 Curiosity

A broad definition of curiosity is as a multidimensional mechanism that motivates the person towards ‘knowing’, filling gaps in understanding across different experiences and types of knowledge about the self, the world and others (Loewenstein, 1994). Curiosity manifests through self-assessment of knowledge and an awareness of potential gaps. Such reflection enables growth and motivation to engage with others and the world around a person (Kashdan et al., 2020).

Curious engagement with the self and others promotes stronger social bonds and is fundamental to forming a sense of belonging that creates the stability for humans to move beyond ‘basic survival’ and feel at their best ability to be themselves (Baumeister & Leary, 2005). Relational safety is essential to nurture both internal and externally motivated curiosity. Without these, individuals might experience fear of judgment and feel unable to truly express their sense of self (Wanless, 2016). Lack of acceptance, through cultural narratives of the normative-ness of cisheterosexual identities and associated acceptable gendered life trajectories, limits the opportunity and ability for TGD people to safely explore their sense of self and feel safe in their interpersonal explorations (Spencer et al., 2021).

1.5.1 Therapeutic Curiosity

TGD staff and service users (SUs) experience discrimination in and outside of MHS and the NHS. TGD SUs must frequently endure medical investigations or invasive questioning by professionals, with their bodies and experiences used to satisfy the curiosities and training needs of staff without their consent. TGD SUs get treated as bizarre and fascinating curios, dehumanising them in their time of need (Cardenas-Castro & Salinero-Rates, 2024). Many MHPs rarely consider the importance of gender or expansive gender exploration, as firmly held cisheteronormative biased beliefs prevent them from curiously acknowledging gender as a gap in their knowledge (McDaniel & Meng, 2021). Curiosity is a skill that can be developed to help clinicians improve their practice and think more expansively, and for TGD people to help unlearn internalised stigma they have absorbed through the unaccepting world (Vaughan et al., 2014).

Whilst expressing prejudice is considered highly punishable in healthcare settings, prejudicial views continue to thrive and are often overtly and inadvertently maintained by the system itself (despite moral value being ascribed to the helping professions) (Johns et al., 2008). When professionals are more aware of

their biases and attuning to the barriers faced by TGD people, it enables a more empathic curiosity that can authentically combine both the needs of the client and MHS, as well as the wider MH system.

Surveys indicate that TGD clients experience persistent misunderstandings, topic avoidance, or even explicit invalidation by some MHPs (Price et al., 2022). Stonewall (2018) reported that 84 % of TGD people experienced intrusive or inappropriate questions framed as “professional curiosity”, such as demands about assigned sex or genital surgery intentions irrelevant to the intervention offered, fostering experiences of prejudice rather than care.

Dere (2025) writes on teaching ‘informed curiosity’ (IC) as an impactful approach to teaching students about the intersection of culture and mental health, and critically and compassionately engaging with mainstream models of psychology. IC is not a naïve detour from empirical processes but rather a means of fostering existing knowledge and self-awareness of one’s own culture and values, to develop perspectives of hypothesis building and question seeking as opposed to accumulating information to an endpoint.

Whilst many therapists do hold an empathic, curious stance when TGD clients are novel, gendered novelty invokes feelings of uncertainty. Those unable to hold an open curiosity frequently respond with hostility and irritation, framing the TGD cultural movement as a ‘fad’ or a sign of modernity or a symptom of other pathology (Mollitt, 2022). Unfamiliarity is an unavoidable part of working in client-centred roles, as knowledge and culture evolve. However, when it comes to incurious professionals encountering TGD, too often their harmful responses are enabled by the system around them. Lack of curiosity is frequently linked with lack of knowledge, and even when these deficits are not associated with prejudice, they result in treatment delays for the TGD due to uncertainty. TGD people are left expending energy and emotional effort to better educate their therapists, but often with little improvement in support for themselves (Willis et al., 2020).

1.6 Positive therapeutic rapport

A positive therapeutic relationship has been defined as one of, if not the most influential, factor for meaningful therapeutic outcomes (Baier Kline &Feeny, 2020). TGD clients will have faced multiple sources of prejudice across their lives and are therefore attuned to recognising overt and covert expressions of prejudice by clinicians (Ellis et al., 2020). Similarly, clients are sensitive to tokenistic or surface level assertions of allyship, accompanied by paternalistic and cisheteronormative attitudes towards their life stories (Anzani et al., 2019). Practitioners who had engaged in training and reflected upon their own relationship with their own-GI and gender as a socio-cultural construct, were received better by clients (Schofield et al., 2024). Therapists who helped clients shape a narrative of their gender identity development across their lifespan without pathologising or assuming that they could decide the validity of a TGD person’s identity were also highly valued (Shipherd et al., 2010).

Heteronormative values are deeply ingrained into societal systems. Maintaining traditional gender stereotypes reaps positive social benefits even at a cost to cisgender individuals (Li, Liu & Song, 2022). MHPs who have not questioned their own relationship with gender may perceive these benefits as ‘natural’ and conforming to these standards as indicative of well-adjusted development. This makes questioning and learning about the nuanced topic of gender very hard to conceptualise in MH training programs. TGD clients report clinicians lacking a basic knowledge of TGD identities and ignorant to the prejudice and social backlash TGD people experience when navigating their lives (Burgwal et al, 2021, Frost & Meyer, 2023). Lacking this context frequently proves to be a critical barrier to forming a positive therapeutic rapport (Kanamori & Cornelius-White, 2017). Singh & Burnes (2010) highlight counsellor training programmes would benefit from incorporating social justice and empowerment philosophies of feminist scholars when supporting TGD clients. According to the authors, exposure to such critical approaches would help clinicians unpick the internalised biases they may hold and cisheteronormative and patriarchal barriers faced by their clients..

Researchers analysing access to gender affirming healthcare in the UK and abroad found that despite self-identifying as lacking specialist knowledge, MHPs frequently assume the role of gatekeeper (Johnson, 2016; Anzani et al., 2019; Dickey & Singh, 2020). Believing they are duty-bound to judge the validity of a person’s gender can lead to blocking opportunity to curious and non-judgemental discussions of gender and threatening the removal of access to GAC **(**Norton et al., 2024**).** This finding was supported in the present research. Gatekeeping exponentially exaggerates the power dynamic between TGD clients and care providers. Gatekeeping threatens not only potential hopes of access to GAC but threatens the validity of TGD individual lived experiences. This leaves TGD uncertain and fearful of how safe it is to be their authentic selves in therapeutic spaces (Schmidt et al., 2024). Openness and congruence around individual awareness of TGD issues is important, and MHPs’ ability to acknowledge that gender diversity is not a ‘new’ or ‘modern’ affliction are also highly valuable when nurturing a positive therapeutic environment (Singh & Burnes, 2010).

Empathic awareness of the heightened risk of violence and abuse and prevalence of MH conditions faced by TGD groups also strengthens therapeutic rapport (Ellis et al., 2020). Professionals and services having visible allyship and outreach engagement to the TGD community in tangible and sustained ways was also noted as creating a safer foundation for TGD clients to feel welcome and less fearful of stigma (Dickey & Singh, 2020). Specialist knowledge of the ins and out of GAC pathways is not seen by TGD clients as essential, especially when they are seeking therapy in parallel to or outside of this context. However, assumptions by MHPs of non-affirming and gatekeeping approaches hinder the development of positive therapeutic rapport. Clients’ desire to be met with gender affirming approaches can be understood as the expression of a need to feel safe in a therapeutic context, and essential for their ability to better

explore their presenting problems and be able to reflect on how they are impacted by their GI and experiences of discrimination (Puckett et al., 2023).

1.7.1 Affirmation

Gender affirmation has a double meaning; one referring to gender affirming medical care and the other gender affirmation of being seen and recognised as the gender you are. This research primarily centres on the second meaning. Affirmative approaches to working with TGD people can be applied to any modality. Affirmation embraces a positive view of TGD identities. It does not doubt or negotiate with the validity of their existence. It celebrates different forms of gender expression whilst actively acknowledging and seeking to address the negative influence of cisheternormativity on the lives of TGD clients (McGeorge et al., 2020, Spencer et al, 2021).

The GAC system acts as a barrier to affirmation due to TGD people having to fit within a limiting diagnostic criterion created by cis and transnormative assumptions. Even in the hypothetical cases where an individual decides they do not want to pursue medical affirmative procedures or social interventions (name changing etc.) around their GI following contact with a MHP, these instances are low, as are regret rates which are amongst the lowest of any medical intervention. Research continues to show under 1% of regret across different gender-affirming surgeries (Bustos et al., 2021), compared to 14.4% across average surgical procedures regret (Barbee, Hassan & Liang, 2024). Types of regret are frequently related to social rejection or acceptance of a more non-binary identity in relation to surgery than a ‘true’ regret of the procedure itself (Thornton, Edalatpour & Gast, 2024).

MHPs report feeling it is their ‘duty’ to protect people from the wrong path, which is always embracing TGD identities, rather than protecting someone from the existential misery of feeling trapped in cisgender normative life. Curiosity is lost when TGD identities are conceptualised as evidence of distress or the ‘hard’ path to be circumvented as the preferable outcome.

Empirical studies reveal a stark deficiency in gender-diverse health training, with less than 20% across a range of MH disciplines encountering relevant and detailed teaching materials during undergraduate and postgraduate training, and 25% personally sought out training or received linked training during their clinical placements (Stryker et al., 2022). Bristol et al. (2018) also reviewed interdisciplinary training for healthcare staff, finding that 85% had no LGBT+ content across their training or in their population-specific training process. Bristol et al. concluded effective training involves multi-modal learning approaches with online, classroom and reflective small group discussions. Materials built knowledge, checked in with awareness of intersectionality, social health disparities and participant attitudes. Training materials were also tailored to specific workplaces where possible.

1.7.2 Teaching your therapist to feel understood.

TGD people frequently report having to teach their healthcare providers about the basics of queer and TGD identities and support needs (McDermott, Nelson & Weeks, 2021; Baldwin et al., 2018). Professionals’ lack of knowledge and a persistent perceived absence of ‘expertise’ on gender identity is frequently cited in research on the TGD group’s experience of therapeutic support. TGD clients report professionals avoid the topic of gender identity and demonstrate a continual ‘misunderstanding’. Some MHPs are intentionally ignorant and invalidating, leading clients to feel misunderstood and uncared for (Price et al., 2022).

Stonewall (2018) reported 84% of TGD people experience inappropriate and intrusive questions framed as ‘professional curiosity’, such as an insistence to know a person’s birth sex/ genital status, when it has no bearing on the intervention. This reflects an underlying lack of nuanced understanding of GD identities and experiences, promoting the sense of rejection and prejudice from those who are supposed to be providing help.

English and Sterling (2010) summarised the educational theorists, Rousseau, Dewey, and Freire’s conceptualisations of discomfort and learning. Rousseau (2010) warned against safety to the point of sterility in a learning environment and that to learn about differences, learners should be guided through tolerating discomfort and fear and attempts to block all discomfort impede learning. To understand what is wrong, you must experience being wrong. Dewey saw the provocation of discomfort as an essential part of learning, and for students to learn about themselves and their feelings. Freire (1998) argued the importance of separating yourself from the fear of your own inability to deal with the situation. Freire saw learning as a social experience, and students needed the ‘intellectual discipline’ to overcome the fear of the subject materials and engage with peers and educators with curiosity beyond the ‘text’ itself. Freire emphasises the role of the teacher's fear and political positioning when tackling subjects that invoke discomfort, and the educator’s own discomfort with the subject material. English and Sterling suggest educators anticipate pitfalls and tailor approaches to each cohort and topic, avoiding a one-size-fits-all approach to avoid learning paralysis. Staff across multidisciplinary professions in MH services report having little to no TGD training at all. The MH services and wider society find safety in maintaining an epistemic ignorance surrounding TGD people in which it feels safe and secure, and the wheels of social power control can continue turning unencumbered by difference. Chapter two will explore concepts of epistemic ignorance and injustice in more depth.

Mollitt (2022) explored UK therapists’ attitudes toward TGD people; only a minority actively oppose TGD people, many express confusions evoked by the political uproar and continual avoidance of the government to include TGD in the conversion therapy ban. Younger and more recently trained therapists

were affirmative and open, compared to the older generation and psychoanalytically trained therapists. Moon (2011) reviewed BPS accredited training programs and found only two hours worth of content teaching about minoritised identities like faith, ethnicity and sexuality over the six years most psychologists receive over their training. Generational and socio-cultural context feels an important maintaining factor of epistemic ignorance, further disadvantaging trans young adults and children trying to navigate the power dynamics of age and professional privilege when accessing MH support. Within the context of the NHS’s highly limited and inaccessible GIC’s and not having resources or a plethora of private GAC to access, TGD SUs can feel hopeless in the face of supposedly specialist services with limited understanding of GI.

It could be argued that ‘teaching’ your therapist about your lived experience is a natural and essential part of therapy. Therapists should understand that everyone has a unique lived experience and therefore ask their clients for clarification to better understand them. However, attitudes like this neglect the reality of people with marginalised identities seeking to be understood by the privileged group of cisgender professionals. MHPs receive a wide range of training so are pulling from knowledge and experience when seeking to know clients in other contexts. TGD people are met with complete ignorance and biased and prejudicial attitudes towards GI. Positioning the client as the total expert in their gender in ways that alleviate any responsibility from the clinician to further their own understanding of gender is not patient centred and perpetuates the epistemic injustice of the MH systems failure to provide empathic, knowledgeable and high-quality care for TGD people.

1.a Theoretical approach

1.a.1 Social constructivism

Social Constructivism is at the core of this research. Social constructivism works to acknowledge the individualistic framing that dictates much of western psychology and highlights that not incorporating historical and cultural context in which a person or community exists leaves in the dark much of how much of emotional and behavioural experiences are formed (Johnstone & Dallos, 2006). Social constructivism centres the meanings we create together through our interactions that have temporality, shifting and evolving with culture and advances in scientific understandings.

1.a.2 Constructing gender in Mental Health settings.

Gender and sex are frequently conflated in the public consciousness and in psychological research. Social constructions of gender have become more widely accepted, in that cultural and social norms are perceived to influence personal gender expression. However, these are often still viewed as having a biologically inherent aspect to them and children are raised in a way where they learn the norms that align with internal biological traits, little boys can be boisterous and it is normative to be loud and aggressive,

whereas little girls should be quiet and demonstrating caring behaviours even through early play behaviour (Wigginton, 2017).

Butler (1990) was one of the first to propose that gender is not solely biologically inherent, they propose biology has its influence but gender should also be understood through the medium of social performance. Categorical assumptions of normativity are socially constructed so people ‘act’ in accordance with these notions. Those who fail to meet the normative assumptions are met with prejudice. There is not a ‘natural’ link between sex and gender, only social rules, stories, archetypes and expectations associated with what specific societies believe to be normal.

The British Association for Counselling and Psychotherapy (BACP) professional practice guidelines refer to chromosomes, hormones and bodily characteristics assigned to gender labels at birth. They centre a biopsychosocial model of understanding sex and gender and acknowledge gender identity as socially constructed, centred around cultural norms and the importance of understanding characteristics outside of the binary (Baker, 2023). TGD expression is also often conflated with themes of sexual orientation. The British Psychological Society (BPS) discussing working with gender and sexual orientation in the same guidelines without much clear distinction between the two (BPS, 2017).

‘Traditional’ psychological research focused on understanding gender through the study of ‘individual differences and personality traits,’ frequently centring around finding behavioural difference between male and female seen as opposite categories (Lippa, 1990). Research such as this still exists, however more modern psychology centres gender as a sociologically informed construct.

Psychological research continues to try and conceptualise gender as a data category, something that can be directly compared to sex and to other trait variables. To try and define gender in a way that is static and applicable to a global normative population is inaccurate, reductive and exclusionary of non-normative cisgender people and the entirety of the TGD population.

Despite this, as explored in Chapter 1’s literature review, TGD people still report MHPs’ widespread misunderstanding of their identities. Professional bodies' guidelines suggest their members educate themselves on TGD identities and experiences, yet MHPs continue to report lacking the opportunity throughout every stage of their professional development to engage in and seek out such training (Mulqueen, 2025, Kreines et al., 2022). Stryker et al. (2022) examined reasons why MHPs sought out information and resources TGD experiences 58% did so due to having a personal connection to TGD people, with only 10.8% citing being inspired to seek more information following a course in educational setting or training experience. 80.8% of professionals were almost entirely self-taught on TGD issues but had personally sought out training sessions, with the most utilised resource being a professional

conference. Lack of training has repeatedly been shown to decrease MHPs’ sense of competence and increase uncertainty in supporting TGD groups (Canvin, 2022).

In a UK study, clinicians reported feeling ‘deskilled ‘and fearful of ‘getting it wrong’. Participants cited discussions within teams that other professionals felt the skills they did possess could not be applied to TGD populations, highlighting how TGD people can quickly become dehumanised in MH settings (Canvin, Twist & Solomons, 2023). Canvin et al.’s (2023) findings suggest that professionals struggling to relate to their clients’ identities impedes rapport building. Professionals actively avoid discussing gender with their clients, fearing being perceived as ignorant, which may threaten their status as the professional in the power dynamic.

Dembroff (2020) writes on the void of understanding TGD identities, especially around identities outside of the binary or ‘genderqueer’ transition stories. Genderqueer individuals express themselves in a way that completely transgresses gender, defying binary definitions and categorisations, frequently leading to rejection in those unfamiliar, rather than a curiosity to understand from a different perspective. Poteat, German & Kerrigan (2013) similarly found lacking knowledge in TGD experiences upset the sense of safety professionals found in holding an expert status when attempting to help their clients; in these instances, thoughts and feelings associated with stigma provided a means to reinforce feelings of power and authority for many professionals.

Research has consistently shown that cis heterosexual men hold the most anti-TGD views, but less research has focused on the cis women who hold anti-TGD views ((Nowaskie & Najam, 2022). This may be an important factor when considering overcoming prejudice in mental health professionals (MHPs), a stereotypically feminine dominated group of professions.

1.a.3 Minority Stress Theory (MST)

The systematically marginalised become epistemically privileged in understanding the social world, especially that of the dominant social group. Inversely the dominant social group are frequently less skilled in understanding the social world of the marginalised (Henckle, 2025). Meyer (2003) distinguishes minority stress from general stress as the distress experienced by marginalised identities, linked to stigma, prejudice and discrimination which form a hostile social environment.. MST outlines the defensive responses to the minority stressors (MS) proximal factors resulting hiding and concealing parts of the self to blend in with normative expectations. Stigma becomes internalised to how the individual views their identity, sense of self and their and their communities place in wider society. Alongside the distal factors of actual violence and prejudice and discriminatory policies created by governing bodies and institutions, demonstrates the harmful nature and systemic prejudice like racism and transphobia.

MS are experienced through distal factors of external experiences of prejudice and stigma that become internalised as proximal factors and further compounded by a broader internalisation of the negative societal attitudes. . Systems of social support, the role of identity, individual self-image and personal and community resilience all act as ameliorating factors for MST (Meyer, 2003).

In Meyer’s original model, proximal and distal factors are depicted as separate components. Rivas-Koehl et al. (2023) propose that distal and proximal stressors can occur simultaneously. Highlighting the importance of taking an intersectional approach to working with MST through an intersectional lens, those from marginalised identity groups, experience stressors through multiple facets of their identity with varying degrees of experience and societal internalisation influencing how they are processed.

Hendricks and Testa (2012) wrote on adapting MST to TGD populations, highlighting their increased risk of sexual violence, other forms of relational trauma and high rates of suicidality compared to LGB peers. They also highlight the previously under-researched role of intersectional identities on the various factors for TGD and MST. Frost and Meyer (2023) highlight the lack of social safety created by MS and how having a safe social environment is an essential part of wellbeing.

Proximal stressors experienced by TGD people might include negative beliefs about one’s own gender identity (GI) and expectation of rejection presently and in the future due to transphobia, the need to conceal identity, which are both subjective experiences and influenced by the internalisation of societal attitudes. (Jones et al., 2022).

Lorusso et al. (2025) wrote on the minority stressors actively experienced by TGD when engaging with the healthcare system and professionals in relation to GAC. Distal stressors included active experiences of aggression, invalidation, and the cognitive burden of dealing with uneducated professionals. Proximal stressors might accumulate through vicarious stress of shared experiences of unsafe institutions and having no choice but to access help from a place you know other TGD people have been mistreated. There was also a need to downplay more fluid or non-traditional elements of GI and omit elements of life stories to avoid gender invalidation and self-gate keeping, increasing feelings of being ‘not trans enough’, gender dysphoria isn’t ‘bad enough’. Desires needed to fit with established medical pathways rather than a more individual approach to gender transition. Their work highlights the plethora of MS experienced whilst directly in contact with healthcare service on top of the MS TGD people arrive at services with.

1.a.4 Gender Identity Erasure, Identity Development & Minority Stressors.

How we form our sense of identity is related to the environments we live in and how we interact with the stressors around us. Burke (1991) wrote that interpersonal feedback that is experienced as incompatible

with the internal sense of self causes distress which he terms ‘identity interruptions’. For TGD people, examples of identities like their own are erased from the world around them and the societies tend to police and harshly critique non-normative expressions of gender identity. Being able to make intergroup connections with people like you helps to form a positive sense of self. This positive witnessing and being witnessed nurtures confidence in your future self to find acceptance and influences the perception of external influences on social stability. Both of which are important to identity development (Tan et al., 2019).

Puckett et al. (2021) wrote about varying experiences of TGD people cross-generations and differing experiences of gender identity milestones through an online study. Commonly reported milestones were: feelings of difference in gender than the expectations associated with assigned sex at birth, identifying as TGD, living in affirmed gender and, for some, accessing medical pathways for affirmation. Puckett et al. (2021) reviewed different studies of TGD milestones, age attainment varied for first noticing a difference in their gender, with one study observing a range between 5-21. Other studies reported age 3 as the youngest time noticing difference. Earlier gender difference awareness often resulted in higher levels of internalised stigma due to prejudicial experiences and exposure to anti-TGD narratives. Fear of rejection and risk from harm were frequently noted as barriers and cause for ‘regression’ between milestones. However, TGD youth who were able to socially transition and feel more affirmed in their GI reported fewer depressive symptoms compared to cisgender youth. Those who accessed medical transition reported expansive improvements in MH symptoms and less need for MHS.

TGD people are erased from public life, just as historically LGB identities were erased in the name of censorship, reducing the complexity and diversity of the queer human experience into something sexualised, that children need protecting from. Prejudicial narratives create unsafe environments andwithout psychological safety, children and adults become unengaged in opportunities that might enable learning about the self and others (Wanless, 2016), limiting TGD people’s chance to develop their sense of self. Risk and exposure to rejection are a normative part of identity formation, however those from marginalised groups witness systemic oppression and casual day-to-day rejection such as microaggressions alongside witnessing and experiencing acts of violence. Marginalisation during youth development has been linked to a wide variety of negative health outcomes and increased avoidance of healthcare, further increasing detrimental outcomes (Causadias, Updegraff & Overton, 2018).

This erasure is then mirrored in MH trainings and education; you cannot teach on that which has become unseen. Identity erasure takes two forms, active and passive. Passive erasure occurs in the MH system through the lack of knowledge on TGD healthcare which maintains assumptions that information is neither important or necessary to learn and ask about. Active erasure has multiple domains, responses of discomfort at the topic, refusal of services and responses designed to intimidate and harm. The

combination of erasures creates the systemic barriers that block TGD individuals and suppress trans communities (Bauer et al., 2009). Alcoff (2024) demonstrates that in the context of race, erasure of experiences and the ignorance they create, is not just neglectful ignorance or the passive act of not knowing or lacking opportunity to learn. Rather, it is intertwined with the systems of power that perpetuate exclusion & oppression.

Research has shown that ignorance on TGD identities exists, but this has not been enough to promote change. Narratives of gender diversity in MH were created by cisgender professionals and privileged groups are least able to understand their complicity in practices that maintain inequality (Mikulak, 2021). Tuana (2006) writes on women’s health, and the historic paternalistic control medical institutions have exerted over the feminine through white androcentric research and neglecting many elements of female-centric health care, labelling dissidents as hysterical and multiple health concerns experienced by feminine people taking many years to diagnosis or mislabelled as psychological concerns. Tuana writes that not knowing becomes sustained and built by the fields investigating them. Tuana suggests researchers ‘know that they do not know, but do not care to know more’, ‘not even knowing that knowledge is missing’, so investigations do not ever take place and ‘they do not want to know’, the systemically maintained ignorance, which keeps some groups ignorant or not worthy as a data source such as avoidance of starting or improving feminine contraception. Concepts can fit multiple of these categories, like TGD gaps in knowledge due to erasure of TGD from the public eye meaning there is no sense of their needs, conflating TGD with pathology and sexual behaviour and prejudicial attitudes and white cis-patriarchal systems of power benefiting from ignorance being maintained.

Well designed, co-produced education helps to counter misinformation and enable MHPs to unlearn beliefs entrenched in stereotype and prejudice. Trainings need to be meaningfully integrated from the undergraduate level through to continuous professional development to reduce discrimination (Connolly et al., 2025).

1.a.5 Epistemic Injustice

Fricker (2007) formulates epistemic injustice as when a person is wronged in their “capacity as a knower” cumulating in epistemic and ethical dysfunction, where anyone listening to a TGD speaker describing their gender identity, the listener is given credibility prejudicially over the TGD teller to either affirm or deny the person’s story of the lived experience of their gender. The TGD person is then placed in a double bind in which the listener holds the power to grant access to affirmation but the more they claim and express the truth of their gender, the more the listener feels entitled to discredit them.

Epistemic norms instruct us to appraise the world and manifest our beliefs in a variety of different ways (Turyn, 2023). Clinical psychology and the MHS at large have been making moves to account for

the epistemic harm that can come from norms upheld too harshly. Broadly, this has been through ‘decolonising’ training curriculums and trying to acknowledge how systemic racism is upheld by pathologising those who fall outside of what professionals and the system at large feels entitled to label as deviant.

The model of Gender Affirming Care (GAC) in the UK requires a diagnosis by a MHP of Gender Dysphoria (DSM-5) or Gender Incongruence (ICD-11) to receive any form of medical intervention and forms of legal recognition (Crapanzo & Mixon, 2022) Although in this research I choose to try to focus on TGD experiences of seeking MH support, this context provides an unavoidable backdrop to the TGD lived experience in the UK. For those seeking medical pathways, you must seek permission and validation of your own lived experience from an MHP. Pathologising models remove autonomy from TGD people. Pathological models can be associated with centralised government funded intervention as in the UK. However, across Europe, centralised GAC pathways have long waitlist and are staunchly gatekept and limit choice (Kiely et al., 2024), restricting who can access affirming care and penalise those with multiple intersections to their identity, such as mental health diagnosis, rural living and socio-economic class to travel and access care.

Globally, many other countries operate under a ‘self-identification model’ in which medical care is accessed through specialists under informed consent and TGD people have the right to ‘self-determine’ their identity (Kiely et al., 2024). This model has operated functionally for many years without seeing any surge in regret rates as gender critical naysayers might pontificate about.

Hermeneutic injustice is a process by which a person must make oneself intelligible to someone else through shared concepts to access resource, but the other is able draw meaning from what is shared from their own frame of reference rather than what is shared and bar access to the resource. Hermeneutic injustices block access to knowledge and blocks the flow of knowledge from the marginalised to those in privileged positions (Fricker, 2007). TGD people need to make themselves intelligible to multiple different professionals who exist in heterosexist cisnormativity, meaning progress and macro change is often stalled as GD people are not respected as reliable sources to learn from. At least not on a systemic level (Clanchy, 2024). TGD clients are expected to educate individual MHP’s repeatedly in individual interactions, satisfying personal curiosities rather than improving and applying learning to future interactions.

1.a.6 Queer Theory

‘To queer’ or ‘queering’, as the practice of questioning and deconstructing heteronormative norms and other upheld norms (Pennell, 2020). Queering seeks to deconstruct the influences of capitalism and white supremacy as well as gaining a richer understanding of queer communities.

This study looks at how TGD people form their Gender Identity (GI) through the lens of Queer Theory (QT). QT, like gender, is inherently hard to define, whilst simultaneously being simple to conceptualise. QT is a multidisciplinary approach seeking to research the queer experience to provide understanding separate from the lens of cisheteronormativity and many of its researchers seek to provide understanding to the gender diverse experience (McCann & Monaghan, 2020).

Many QT theorists argue that QT needs to retain a level of indefinable ambiguity to allow the open and subversive nature of queerness itself (Jagose, 2013). “Queer” itself demonstrates the shifting power of language and culture. What was once a slur became reclaimed, allowing people a more expansive way to understand and define themselves. For some, queer can refer to both sexual orientation and gender identity all at once, a label to transcend a specific category. QT seeks not to create concrete terms in which to define what is or is not queer. Love (2021) shares queerness needs to encompass the full intersectionality of human existence. Moving beyond the individual about connection and performativity, shame, and shyness the effect of society and the impact of neoliberalism.

QT has its foundations in social science, QT decisively moves away from pursuit of empirical biological categorisations of sex and gender body markers, preferring the explosive diversity of possibilities in sociocultural understandings of GI. It frames ‘queer’ not just as a way of being but a way of socio-political *doing* (Jakobsen, 1998). QT situates identity within the framework of social constructivism, where sexual orientation and gender identity are not biologically inherent. This is not a novel concept, but something frequently conflated in the cisheteronormative dominated world (Wigginton, 2017), setting these terms as distinct needs to be standardised practice to facilitate expansive exploration of GI in healthcare education settings.

1.a.7 Trans theory & studies

Trans theory represents a diverse range of academic approaches that centre the voice of trans researchers and theorists to make a marked shift away from TGD people being written about and theorised by cisgender researchers, made into comparison against the proposed cisgender norm. Trans led studies make the essential stand against the prevailing lack of knowledge in systems of power and wilful misunderstanding by TERF (trans-exclusionary radical feminist) debtors. TERFs exist in opposition to and within queer spaces, seeking to uphold and ‘protect the rights and needs of women’, further upholding normative and ‘moralistic’ norms of what it means to be masculine or feminine. The LGBTQIA+ community is not immune to the influences of white western cis heteronormativity, TGD people often face attack from within, often facing exclusion from spaces based on upholding cis gender binary ideals, leaving TGD people in a hinterland of no safe space save ones made by themselves, placing those with

multiple marginalised identities like TGD People of Global Majority (POGM) at even greater risk of abuse.

Horton (2024) summarises three key theories in trans studies: minority stress theory (MST), pathologisation and cisnormativity. Horton raises the importance of understanding the overpowering nature of the cisgender normative narratives from a multi-disciplinary perspective is critical to TGD resistance to cis supremacy in the MH system and achieving TGD equity and take steps towards social justice.

Where queer theorists are argued to situate social identities in the conflict between the social world and the determinates, we make of ourselves, trans theory seeks to transcend this, avoiding any notion that any aspect of social identity can be ‘fixed’. Trans theorists build on the foundation of queer and feminist scholars, incorporating the integral nature of fluidity of social identity and the dynamic integration of individual narratives of lived experience. Maintaining the importance of identity labels for overcoming systems of oppression, whilst questioning how such labels came to be (Nagoshi & Brzuzy, 2010).

Trans theory and studies were selected when approaching this work because they seeks to challenge the psychomedical construction of GI (Roen, 2001) that transgress the political and sociocultural oppression of people that transgress gender norms.

1.a.8 Brief overview of the Sociopolitical context

BPS (2024) guidelines state that psychologists should be “aware of the history of stigmatisation and oppression may affect both clients and psychologists and the continue inequalities in many global regions where gender, sexuality and relationship diversity are not support”. The guidelines refer to psychologists having trouble understanding those who are very different to them and highlight the responsibility of the psychologist to learn about diversity through continuous professional development (CPD).

Margaret Thatcher’s 1988 Section 28 banned any “promotion of homosexuality”, making it illegal for education centres to mention the topic. It was repealed in 2003, but this did not result in a sudden inclusive representation of LGBTQIA+ identities in education settings, which trickles into higher education settings (Ellis & High, 2004). In the following years, and particularly in 2025, the government continues to take an anti-sexual and gender minority stance, particularly regarding gender nonconforming matters (Stonewall, 2023). Section 80A of the Education Act 2002 and the Education Act 1996 made adaptations regarding teaching on relationships and sex education. Although not on an outright ban like section 28, it highlights the need to emphasise ‘significant debate’ around biological sex and gender reassignment and to not endorse any particular view, but in a separate point, reminds the reader of upholding the rights and equalities of all. The language around teaching TGD is obtuse and vague, but it specifically states to not encourage pupils to question their gender. Although this legislation is aimed at mandatory education,

substantive education materials are absent at all stages of education on TGD identities, and the culture of othering and avoidance is dangerously likely to fester and inhibit much-needed development in the field.

I frequently came face to face with the erasure of TGD stories and hermeneutic injustice when discussing my thesis with colleagues who identified as allies, many of whom were unaware that a diagnosis was mandatory for access to care and the lengths TGD have to go through just to be acknowledged, let alone validated in their identity. Surprise was frequently the response to explanations of transphobia. However, in these cases, my account was heard; it was in a peer-to-peer context, and it starkly reminded me of the barriers faced by TGD individuals when those charged with listening to their experiences are so far removed from the realities of their lives.

TGD people frequently report mistreatment and bias in their interactions as service users and in their working lives, for those who are MHPs (Elis, Bailey & McNeil, 2014, Peate, 2020). TGD SUs face uneducated systems that frequently ‘don’t know what they don’t know’, placing them at a significant disadvantage when responding to the complaints that might arise from harmful care experiences. TGD staff and allies face frequently hostile and insensitive environments to the realities and complexities of TGD lives.

1.a.9 Setting the context for this research

The ever-increasing blackhole of hopelessness that is the UK GAC and retreading my own lived experience of lacking training on TGD identities from the perspective of psychologists and other professionals, I hoped to add to the increasing richness of research centring the voices of TGD people and their perspectives. I also aimed to understand what sense professionals made of their own and others gender, not just their lack of opportunity to be adequately taught about the topic. One of my anxieties about undertaking this research was making it palatable to a cisheterosexual audience; I desired to communicate undiluted the epistemic injustice perpetrated by the TGD community whilst highlighting that gender is something that contextualises everyone’s lived experience. GI is often pigeonholed as a ‘queer issue’ or only important to those working in specialist gender services. Just as everyone has a gender identity, everyone is impacted by gender bias.

Despite cisgender women accessing healthcare at higher rates than cisgender men, research is still biased toward representing male bodies and experiences (Berner, Lund & Saunders, 2021). I hope by examining both cis and TGD perspectives of GI and accessing MHS, a broad perspective is gathered and the importance of MHPs having nuanced understanding of gender is highlighted to people of many different identities.

“In order to transform I set myself two laws greater than all the rules the patriarchal-colonial society tried to instil in me. The first law, which I considered self-evident during the whole process of my transition, was to do away with the fear of being abnormal that had been planted in my heart as a child…the second law the one that was rather more difficult to observe, was to be wary of all simplification. To cease to assume, as you do, that I know what a man is, what a woman is, what a homosexual or a heterosexual is. To free my thinking from these shackles and experience. Try to perceive, to feel, to name, beyond sexual difference” (Preciado, 2019, p33).

In this quote Preciado writes from a speech to a French psychoanalytic conference, trained as an analyst himself. In this speech, he was booed and heckled, unable to finish. The clear and contemptable disrespect showing the pathological framing of his trans identity. The invalidation of TGD people to speak for ourselves continues. Our opinions are labelled as invalid, tarred with the broad-brush strokes of mental distress, disregarding our lived experience, no matter our training or professional acumen.

Preciado reminds us that it not just radical queer activists that define gender as a social construct, but the World Health Organisation (WHO). The WHO openly state illegitimacy of binary genders both scientifically and across cultures that recognise non-binary categorisations of gender, against the differing international sociopolitical agendas purporting the naturalness of the gender binary. However, amongst the vast majority of MHPs, the validity of gender identity remains a debate, one that questions the nature of my own and my community’s right to exist. I hope this research begins the process of better understanding the experiences of TGD people feeling their identities are understood when seeking mental health support, how MHPs understand TGD genders, their own gender and how they address gender in their work.

Chapter 2: Literature Review

Narrative Synthesis: What facilitates rapport building and positive therapeutic experiences for trans and gender diverse people.

2.1 Introduction

Research has continually shown that Trans and Gender Diverse (TGD) people have worse outcomes than their cisgender and lesbian, gay and bisexual counterparts when accessing Mental Health Services (MHS) (LGBT Foundation, 2018). Therapeutic rapport has been highlighted as one of the most important factors for successful therapeutic outcome, over and above therapeutic modality (Lambert & Barley, 2001). TGD people face huge amounts of stigma and discrimination and face higher levels of mental health difficulties compared to cisgender populations (Pinna et al. 2022), meaning many seek psychological support for a variety of reasons. Research has shown a largely mixed response to therapy, with a wide range

of negative experiences being reported, however little research has been done on TGD populations’ experiences of therapeutic relationships (Scholfield, Dunnett & Gabriel, 2024).

The ability to relate to the client’s individual lived experience and how they navigate the world is consistently found to be the ‘curative component’ of therapy (Lambert & Barley, 2001). Mental Health Professionals (MHPs) consistently identify lacking confidence and expertise on TGD identities. MHPs also consistently report having next to no access or opportunity to engage with training on TGD identities to mitigate these feelings at any point in their career pathways (Carabez et al., 2015). MHPs frequently manage the discomfort evoked from their lack of knowledge through avoidance of exploring or acknowledging gender. TGD people easily become labelled as only manageable through ‘specialist’ services, disregarding that they might simply be seeking general MH support.

The structure of GAC pathways in the UK does not prioritise the service user voice or satisfaction, instead relying on practitioner gatekeeping. This attitude and the nature of a pathologising approach to GI bleeds into all areas of healthcare support (Benson et al., 2023). Many practitioners feel entitled to paternalistically questioning the testimonial experiences of TGD SUs, unlike other areas of healthcare that continue to modernise and prioritise the patient perspective(Eyssel et al., 2017).

Intolerant, negative and persecutory attitudes toward TGD people continue to be reported across healthcare professionals. ‘Personal lived experience’ with a TGD person is one of the most frequently reported reasons to mitigating negative attitude towards TGD, over and above training and educational experiences. Such educational experiences are also infrequently in place (Kanamori & Cornelius-White, 2017).

The pathologising nature of the UK’s approach to recognising TGD identities sets clinicians up as gatekeepers both to GAC pathways and legal recognition of a person’s GI (Newey, 2024). Even when not in GAC context, this places significant barriers towards developing a trusting relationship. TGD people may fear their identity being invalidated by the professional. The ‘patient-provider hierarchy’ remains highlighted.

The NHS has particularly long waitlists for services compared to the rest of Europe (James, Denholm & Wood, 2024). MHS have long waiting lists where TGD people are often funnelled through and Gender Identity Clinics (GIC), where access to legal and gender recognition is predominantly managed, have astronomically long waiting lists and face legislative dismantling and further removal of resources. The process of waiting for much needed support is inherently detrimental to wellbeing, increasing feelings of hopelessness and disenfranchisement that help will be useful (Yook, 2010). TGD people endure whilst

anticipating being met with gatekeepers who will disregard their identity and deny their access to care (Holti et al., 2024).

Invalidation is not only painful but there is fear that any invalidation might be used against the person in their future GAC journey (Eyssel et al., 2017). MHPs often fail to notice gender as an important theme in their client’s experiences for those still seeking to come to terms with their identity. Exploration of gender requires individualisation and care as TGD individuals also report therapists who continually focused on gender in ways that felt perverse, misattuned to what was brought to sessions could feel invalidating, especially for those confident in their identity and transition stage (Puckett, 2022).

These findings highlight the importance of practitioner knowledge of TGD issues with an intersectional lens to the needs of those who are TGD, and the ability to apply them in practice in ways that align to individual goals and needs. Due to the dearth of research in this area, more needs to be done to establish what factors contribute to positive therapeutic rapport building for TGD in therapeutic relationships.

Evidence for positive trans experiences of therapy are often from specific settings like LGBTQ+ third-sector organisations, GIC or sexual health services, which might limit the kind of participant who participated in research and only those who are confidently ‘out’ in their identity. Understanding TGD individuals from a wide range of contexts and background is important to get as representative a narrative of their experiences as possible. Narrative reviews allow for broader and critical perspectives on the contexts and commonalities between different complex and interrelated phenomena to create broader understandings to the proposed question; What facilitates rapport building and positive therapeutic experiences for trans and gender diverse people?

2.2 Methodology

A search was conducted in April 2025 by searching a range of databases; PsychINFO, PsychARTICLES, MEDLINE & CINAHL Ultimate via EBSCOHost at once using the search terms in Table 1. A PRISMA flow chart is shown in Figure 1 detailing the process of article selection. Initially, 24 papers were found, refined down to seven by the Lead researcher.

The guidance on conducting a narrative synthesis by Popay et al. (2006) was used to inform the analysis of the papers selected. Popay et al.’s method provides a narrative framework of the ‘whys’ and ‘hows’ of a particular population’s experiences, tabulating the findings between studies and identifying thematic patterns whilst assessing the robustness of each paper. Popay et al. provide a range of tools to guide how studies are grouped and consider the context in which the studies were conducted, helping to reduce bias

through demonstrating transparency in how interpretations were made. Narrative synthesis was the ideal approach as it provided a straightforward way to tabulate findings across the studies to enable thematic interpretation and explore the relationship of different themes and conclusions in the data. The robustness and quality of the studies can be critically appraised whilst centring the importance of meaning-making and conceptual frameworks (Snilstveit, Oliver & Vojtkova, 2012).

Table 1	
Search terms.	
"gender dysphoria" OR transgender OR "nonbinary" OR "gender diverse" OR "gender incongruence" or "gender fluid"	AND (“therapy feedback" OR "experiences of therapy" OR "experiences of mental health services" OR "mental health patient feedback”)

Table 2	
Inclusion Criteria	Exclusion Criteria
Adult participants 18+	Children and adolescents <18
Specifically looked at TGD populations	Assessing access to GIC
Experiential accounts of therapy/therapeutic intervention/mental health services	Accounts purely of medical transition/relationship to gender specialists
Feedback/effectiveness of the therapeutic relationship	Accounts of LGBT+ community broadly not specific to TGD people
Patient/participant account of therapist effectiveness working with TGD identities	
Available in English	

Figure 1

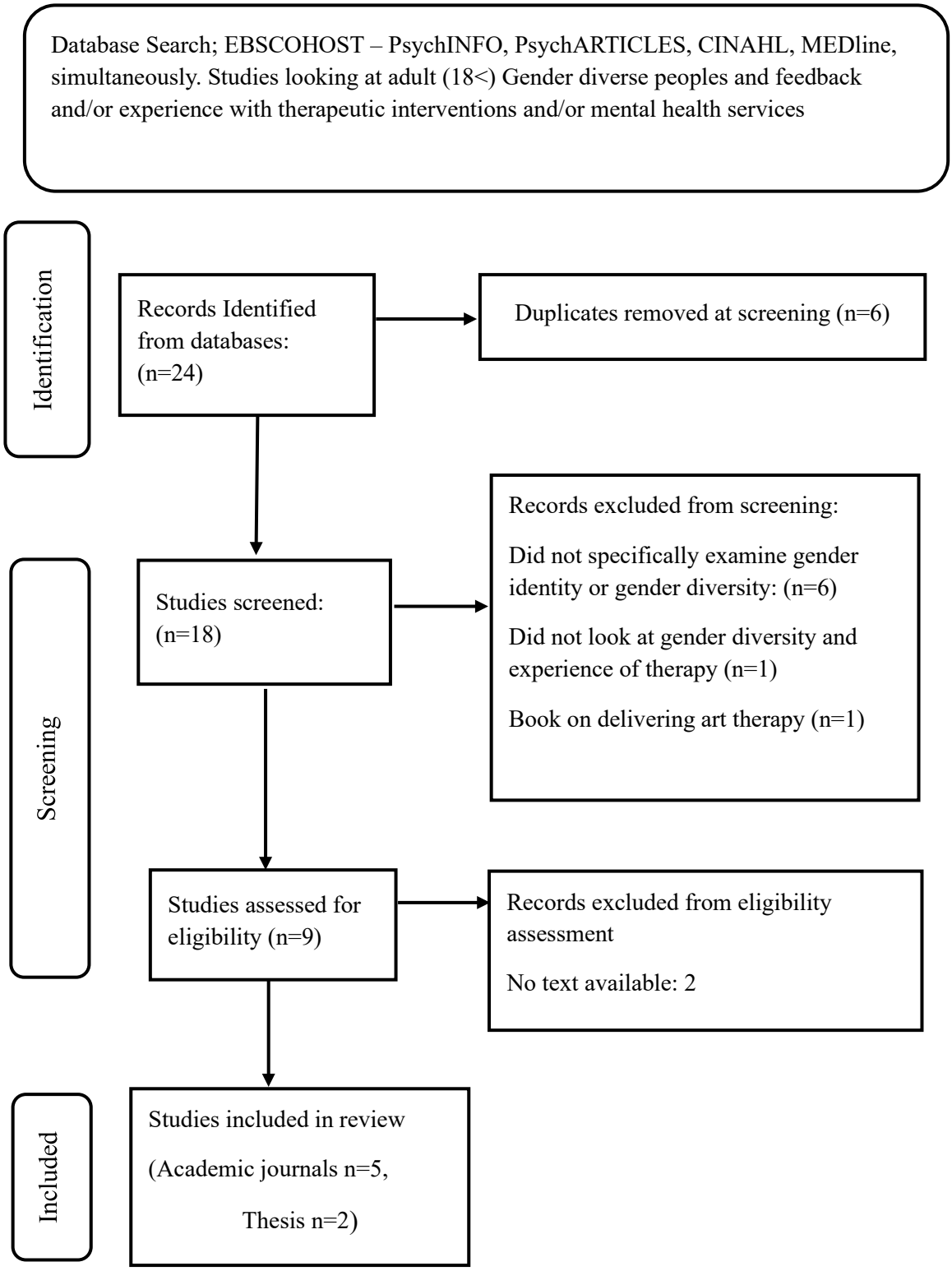
Database Search; EBSCOHOST – PsychINFO, PsychARTICLES, CINAHL, MEDline, simultaneously. Studies looking at adult (18<) Gender diverse peoples and feedback and/or experience with therapeutic interventions and/or mental health services
Identification
Records Identified from databases: (n=24)
Duplicates removed at screening (n=6)
Screening
Studies screened: (n=18)
Records excluded from screening:
Did not specifically examine gender identity or gender diversity: (n=6)
Did not look at gender diversity and experience of therapy (n=1)
Book on delivering art therapy (n=1)
Studies assessed for eligibility (n=9)
Records excluded from eligibility assessment
No text available: 2
Included
Studies included in review
(Academic journals n=5,
Thesis n=2)

Table 2 Summary of study papers.

Title	Author	Date	Methods	Participants	Setting/Context	Results
The mental health experience of transgender and gender diverse Colombians: Que la diversidad no cueste la vida. (thesis)	Acosta Canchila, M.N.	2024	Semi-structured thematic analysis interviews	40 trans+ adults accessing Colombians MHS ages: 19-53 (M=31). Snowball sampling.	Columbia, 60% currently employed, predominantly from major Colombian cities. Many regions and more rural regions not included. Cisgender LGBT researcher. Reflexivity statement included.	Thematic analysis 3 main themes, Experience with sub themes 7 sub themes, Perception with 2 subthemes and 3 Addressing Needs with 5 subthemes. Implications: MHS are overwhelmingly cisheteronormative and do not meet the needs of TGD people in their setup and training. Current systems enforce & uphold discriminatory practices. Minority stress theory & models of health belief can help inform future practice.
A phenomenological exploration of transgender people’s experiences of mental health services in Ireland	Delaney, N. & McCann, E.	2020	Interpretative phenomenological analysis (IPA); semi-structured interviews	4 adult participants, snowball sampling.	Ireland Interview schedule developed with TGD LGBT research expert. LGBT researcher, own identity not explicitly commented on.	Three themes: Affirmative experiences, non-affirmative experiences & MHP relationship. Implications; Lack of information and non-affirming experiences compound attrition & poor TGD client-MHP relationships
Transgender and gender diverse clients’ experiences in therapy: Responses to sociopolitical events and helpful and unhelpful experiences.	Puckett, J. A., et al.	2023	Qualitative survey data	107 trans+ participants, examining therapist integration of current events into qualitative therapy questionnaire over 12 months. Thematic analysis used to interpret data. Ages 19-66 (M=33.79). Gender; 21.5% trans men, 21.5% trans women, 27.1% non-binary, with several other identities represented like genderfluid 1.3%. Ethnicity 70% White. 54% reported sexual orientation as queer.	Data collected from a broader study. Across Nebraska, Oregon, Michigan & Tennessee. Between April 2020-March 2021. Aged 19+. Therapy experience items created by original investigators. TGD researcher involvement.	Different data points recorded each month over a year, for each theme, helpful experiences had the most recorded entries. Three main themes: Themes experience of therapist discussion of the sociopolitical. Themes for helpful experiences. Themes for unhelpful experiences.

Re-queering the trans binary: Gender nonconforming individuals' experiences in counselling and therapeutic settings. (thesis)	Stephens, M.	2018	Hermeneutic psychology, Hycner’s phenomenological research, semi structured interviews	9 participants (who identified outside of binary gender only) Aged 19-53, all but one participant college educated. Ethnicity Majority White sample. Purposive snowball sampling gathered through MHP networks, advertising at community centres and social media groups., Semi structured interviews on GNC people’s experience of MHS	Across the USA, predominantly urban. Cisgender LGBT researcher, explicitly reflected on own bias and ‘confusion’ around nonbinary experiences.	Themes: queer identity development, internal and external barriers for counselling, factors that promoted positive and negative experiences of counselling. The variation in identities under the GNC umbrella can be misunderstood and misrepresented by restrictive labels, researcher names challenging own assumptions. GNC populations can struggle to communicate their identities.
Therapist reactions to transgender identity exploration: Effects on the therapeutic relationship in an analogue study.	Bettergarcia, J.N. & Israel, T.	2018	Video vignettes of mock therapy;3 conditions, 2 affirming, 1 non-affirming. Measures: Counselor Rating form short (CRF-S), Session evaluation Questionnaire (SEQ), Attitude Toward seeking Professional Psychological Help Scale (ATSPPHS).	Recruitment via Amazon Mechanical Turk, a crowdsourcing platform. N=409. Aged 18-74, M=29.5, 39% genderqueer, 20% trans man, 17% trans woman, 6%-ciswoman, 4% cisman, 4% something else. Ethnicity, 78% White, Socioeconomic Class; 19% poor, 26% working class, 19% middle class, 23% 8% upper middle & upper class	USA, artificial setting. Researcher identity/bias not commented on, if the vignettes were created with/by TGD input. Researcher Positionality not commented on.	Non-affirming video condition had significantly negative effect on perception of therapist and quality of therapeutic relationship.
Experiences of older transgender and gender nonconforming adults in psychotherapy: A qualitative study.	Elder, A.B.	2016	Semi structured interviews thematic analysis	N=10 TGD people. Age: 60-83, at least one experience of psychotherapy, Ethnicity: 1 Black, 1 Chinese, 8 White/Caucasian.	Primarily San Franciso USA, via online advertising, Older TGD activist included as third reader for trans affirmative design. No explicit research reflexivity statement included.	Thematic Analysis: Themes covered positive and negative experiences of therapy, positive changes to therapy, transition, prejudice & older TGD issues and themes of family. Implications: More training on affirmative practice & intersectionality needed, reduce invasive medical questions, better awareness on MH impact of HRT.

Table 2 continued Title	Author	Date	Methods/Quality	Participants	Setting/Context	Results
Seeking support: Transgender client experiences with mental health services.	Benson, K.E.	2013	Feminist phenomenology informed thematic analysis	Recruitment via poster campaign. N=7, interviews with TGD people. Snowball sampling. Ages; 24-57 (M=39.85), 3 trans masculine, 3 trans feminine, 1 MTF. Education: Majority college educated. Ethnicity: Majority White American.	USA, Feminist informed phenomenology thematic analysis. Cis, LGBT researcher, includes positionality statement & shared with participants.	Thematic Analysis themes; Purposes for seeking mental health services, Problems in practice, Therapist Reputation, Transgender Affirmative Therapy.

2.3 Summary of Review Papers

A summary of each paper included in the review can be found in Appendix 3

2.4 Quality & Reliability

CASP checklists for qualitative research were completed. All papers conducting qualitative interviews, apart from Elder (2016), included explicit reflexivity/positionality statements in their research and how this was shared with participants. CASP checklists for cohort studies and Descriptive/Cross-Sectional checklists were used to appraise the two questionnaire-based studies for quality appraisal. Braun and Clarke’s guidelines for reflexive thematic analysis (RTA) were also consulted when RTA was used by study authors.

Interview based studies typically have smaller sample sizes and seek to gather more conceptual meanings from the data rather than trying to test specific hypotheses. Smaller samples inevitably increase the chance of homogeneity. Stephens (2018), Puckett et al. (2023) and Acosta (2024) all describe steps they took to increase diversity over their recruitment period. Purposive snowball sampling was the primary recruitment method with researchers describing TGD populations making a small percentage of the population and using care provider, third sector and professional and peer networks to find suitable participants. Themes developed by the qualitative interview studies are summarised in Table 3.

Samples were overwhelmingly White, middle class and either held or had attempted some form of university education. Studies were primarily based across the USA, with one in Colombia and one in Ireland. Most participants also identified along the spectrum of lower middle, to middle class although the socio-economic experience of this may differ regionally. Snowball sampling, although effective and sufficient, may have maintained a homogenous sample in some cases. The studies all captured participants within a similar age range, typically early twenties to mid-thirties, barring Elder (2016) who specifically interviewed older adults. It could be inferred that younger TGD might feel more socially safe to be visibly ‘out’ or engage online with recruitment campaigns for TGD people. Research typically took place around university through the researchers’ own personal networks, reducing the sample diversity in this respect.

Most of the research was completed by cisgender researchers and although those who identified themselves were part of the LGBT+ community, historically trans people have been institutionally pathologise and forced through conversion practices. These practices continue in present day: institutions perpetuate hermeneutic injustice, shutting out TGD voices from discussion concerning our rights and wellbeing. One example is the recent 2025 UK Supreme Court ruling regarding the ‘definition’ of a woman in the 2010 Equality Act, in which no transgender person was allowed to contribute to discussions on the ruling. Vincent (2018) writes on the importance of careful inclusion of TGD voices to academic research and its absence from much of the research done into TGD healthcare, maintaining prevailing binary

cisheteronormative narratives on TGD lives. Elder (2016) shares their inclusion of co-production with an older TGD person in reading their findings for quality. Puckett et al. (2023) also describe involvement of TGD people in the development of their research but, as with the other questionnaire-based study, no explicit positionality or reflexivity statement is made about their relationship to the community. It would have been beneficial if Bettergarica & Israel (2018) had shared how the mock therapy vignettes were developed and if they engaged TGD contributors or feedback in their creation to help with pragmatic validity in an artificial setting. Several of the authors specialise in and might be TGD community members but through a range of personal, political and safety reasons choose to have varying approaches to being ‘visibly out’ to their participants to create a sense of safety and community during interviews.

Acosta (2024) uses thematic analysis and although their study is grey literature as a thesis, rasing the wordcount that a traditional journal increasing the approximate recommendation of 6 subthemes for an 8,000-word report. The research has many subthemes, some of which feel overlapping and descriptive rather than conveying shared meaning making from the data. For example, Theme 1.2 “Painful ego and ignorance were perpetrators” and subtheme 1.2.2 “Gender police: I know better, I know what you need, I know how and who you should be”. Both communicate important experiences of mistreatment and systemic invalidation and rigid categorisation of TGD identities but overlap in what they are trying to communicate. Finlay (2021) writes that a high number of themes not clearly distinct from one another suggests a need for further processing. Insufficient processing of qualitative data increases risks that resulting analysis lacks critical depth.

A summary of themes extracted from the interview-based studies can be seen in Table 3 and themes from the questionnaire-based studies in Table 4.

Table 3 – Grouping of Interview based studies

Study	Qualitative analysis	Access & systemic barriers to MH care	Affirmation & Factors leading to positive therapeutic relationship	Negative experiences & barriers to rapport
The mental health experience of transgender and gender diverse Colombians (Acosta, 2024)	Thematic analysis	Two-fold access barriers; Structural issues to system itself & unique barriers for TGD people. Structural issues Need to be formally enrolled/access to subsidised healthcare plan. Long waits for first appointment. Long waits between sessions & little continuity with MHPs. MHPs seen as mechanical and uncaring. General stigma for accessing MH. I must be at crisis for it to be worth reaching out. Unique barriers for TGD people Need for a gender dysphoria diagnosis & MH session before access to GAC is granted. Having to plan & strategies to avoid prejudice. Fight for needs to be validated. Need to perform to binary heteronormative gender ideals to the standards set by the MH system. Participants felt unable to be their authentic selves. Why bother I know it will be bad, why expose myself to prejudice.	MHPs that accept private pay/third sector, government funded LGBTQIA+ programs are more likely to be affirmative due to choice and selection of affirmative MHPs. Peer networks of recommending MHPs who are understanding of TGD people. MHPs who do not make assumptions and meet you with curiosity and openness. Asking for preferred name and pronouns, despite official records. Not treating questions about GAC as showing signs of doubt, so not denying access. MHPs showing active awareness and commitment to overcoming barriers for TGD people. Affirming therapeutic spaces save lives. Psychology can do healing work in educating indigenous communities about TGD people. When MHPs stand by you and offer consistent support during transition. MHPs understanding discrimination faced during the changes brought by HRT.	MHPs’ multi-level ignorance of TGD needs and issues. MHP background creating a sense of ‘ego’: they understand client’s identity better than they know themselves. Gender Policing, Cruel and ignorant use of language (self-mutilate referring to GAC surgery). Lack of knowledge leads to confusion, reversion and misguided information. Denial of non-binary identities. Unclear guidelines/MHPs acting on opinion not following guideline for TGD care. Help comes from community & activism not the system.
Experiences of older transgender and gender nonconforming adults in psychotherapy: A qualitative study (Elder, 2016)	Thematic analysis	All participants had experienced negative and coercive treatment in earlier life due to their identity. Participants acknowledging more open approach to therapy and less conversion practices over their lives. Services not understanding the needs of older TGD people. TGD resource being tailored to younger people. Intersectional barriers of racism, age and TGD needs.	Flexible in theoretical approach and open. MHPs able to share own LGBTQ+ identity, self-disclosure on limited basis. Correct use of pronouns, not asking invasive medical questions. Respect how someone presents not their history. Appropriate use of transference, counter transference & dream work. Being able to work on life issues alongside and outside of transition. Non-pathological language use.	Historic and present stories of uninformed, transphobic and homophobic providers. Attempting conversion therapy Projected gender norms, endocrinologist only giving HRT to people he thought would ‘pass’. Using outdated theory and practice. Implications: providers need better understanding of mood changes on HRT,

Seeking support: Transgender client experiences with mental health services. (Benson, 2013)	Feminist phenomenological informed thematic analysis	Reason for seeking MH care Improving quality of life, emotional wellbeing, not just related to the process of transition but the impact of a transphobic world, experiences of stigma and other sources of emotional distress & stress. Needing MH MHP support and contact to access GAC Barriers Financial barriers Fear of prejudice and expectation to be misunderstood.	Having the role of GI acknowledged alongside and in the context of life circumstances. Peer networks of therapist reputation. Therapist visibility of being supportive of LGBT+ issues and trans advocacy. Therapist openness and demonstration of trans concepts and experiences. Therapist taking initiative to go away and educate themselves on trans issues. Respecting chosen name and pronouns without question.	MHPs being uninformed Heavy handed application of outdated theory or misguided beliefs about gender onto clients. Feeling like a learning tool for your therapist.

Study	Qualitative analysis	Access & systemic barriers to MH care	Affirmation & Factors leading to positive therapeutic relationship	Negative experiences & barriers to rapport
A phenomenological exploration of transgender people’s experiences of mental health services in Ireland (Delaney & McCann, 2020)	Interpretative phenomenological Analysis	Not able to find clinicians within the public health system that understand and are affirmative of TGD experiences and having to go private. Negative experiences and discriminatory treatment in inpatient and community settings leading to avoidance of services. Beliefs and peer communication that you have to ‘pass’ the system’s quiz to have your gender validated by the diagnostic process.	MHPs have knowledge of barriers to care and challenges for TGD people. Understanding the processes and experiences of transition. Shows understanding of the diversity of experiences under the ‘trans umbrella’.	Transphobic behaviour Clinicians spreading misinformation on transition Discriminatory and inappropriate conduct. Repeated misgendering. Lack of knowledge Termination of therapy after disclosure of self-medicating HRT. Recommended older TGD people use peer support and have an advocate for hospital visits and emergencies and be assertive when therapy is not working.
Re-queering the trans binary: Gender nonconforming individuals' experiences in counselling and therapeutic settings (Stephens, 2018)	Hermeneutic analysis	Not having shared language to describe gender. Unclear standards of a nontraditional gender transition with healthcare systems. Societal marginalization causes avoidance of MH services Lack of continuity due to high clinician turnover.	Respect and acceptance of gender identity/presentation. Therapist connection to trans community. Use of preferred terms. Validation & knowledge of GI. Flexibility in approach. Clinician offering up the ability to not have to explicitly label their GI. Therapy framed as continual journey of personal growth and reflection rather than based in pathological or fixed outcome.	Pressures to submit to a binary category. Sterile and medicalised therapy environments. Passive/distant therapy style leading to assumed non-acceptance Hostile/prejudiced reactions Having to educate clinicians Impact of a normative society and negative impact on connecting to own non-binary identity adding additional challenges to therapy.

Table 4 Studies collecting questionnaire data			
Study	Mental Health System factors	Positive & Affirming therapy experiences	Barriers to rapport & negative therapeutic
Puckett et al. (2023)	Positive experiences of therapy availability and shorter waits. Option for goal-oriented support. Adapting different therapeutic modality to suit the individual	Appropriate resources (e.g. following experience of hate crime) Empathy & validation for TGD experiences. Therapists show ability to research and understand TGD needs to better facilitate the coping skills offered. Integration of current events and impact on own coping and current relationships. Therapists understanding of intersectional identities, systems of oppression & daily living. Understanding of how other diagnoses (e.g. eating disorders) might be triggered and interact with GI. Specific use of self, therapist identity as also TGD or as an ally and context of political world. Explicit exploration of impact of heteronormativity & transnormativity. Therapists did not over emphasise TGD identity and acknowledge other needs and influences for need for therapy	Intrusive and overly body focused questions. Fixations on deadnames and familial responses to transition. Shallow or naïve responses like 'surprise' about experiences of discrimination. Common therapeutic tools like 'reframing' used on clients' experiences of discrimination and fears on queer and transphobia. Encouraged to be 'forgiving/accepting' of others anti-TGD political views. Lacking education and awareness of TGD issues. Inappropriate sharing of therapist own life. Acting as barrier/gate keeper to GAC Dismissive of client context (e.g. not releasing socio-economic limitations) Logistical issues (therapist late, therapist missed sessions, dislike for video sessions)
Bettergarcia & Israel (2018)	Analogue setting of mock therapy vignettes videos	Affirmative approaches are statistically significantly for positive feeling across different domains of a therapeutic relationship and client perception of session success.	Non-affirmative approaches have statistically significant negative account of therapist and session outcome from the client's perspective. Seen as less smooth, less deep and less positive.

2.5 Results

The content of the study papers was analysed by the lead researcher, developed into concepts that translated across all studies. The following were identified as meta-narratives; 'Expecting less than bare minimum and they still let you down' and 'Naming the obvious ingredients to affirmative experiences.' Each meta narrative contains a related subtheme that track across most studies but were not always universally shared.

Table 5	
Expecting less than bare minimum and they still let you down'	Naming the obvious ingredients to affirmative experiences.
Pathologising systems & access barriers	Allyship needs validation by our community.

2.5.1 Expecting less than bare minimum and they still let you down:

Therapeutic spaces purport to provide empathy and unconditional positive regard to those accessing them. Doctors and healthcare professionals make commitments to causing no harm (Helmich & de

Carvalho-Fiho, 2018), supposedly offering treatment in line with individual wants and needs, seeking informed consent, unimpeded by professionals’ personal bias or beliefs. TGD people arrive at MH spaces anticipating discrimination, hoping to only be misunderstood rather than experience acts of transphobic violence. The acceptance and affirmation of their identities was hard come by, and they must make the best of the bare minimum of simply not experiencing harm, rather than be empathically understood and met with attempts to make nuanced understandings of their lives.

Every study reported the impact of non-affirmative experiences (through direct acts of abuse through to simply ignoring or not noticing gender all) influenced feelings of invalidation and hopelessness. Acosta (2024) & Elder (2016) recounted participants’ traumatic experiences of conversion therapy and the mistrust in services actively perpetrating harm through these practices or the more prevalent and insidious acts of discrimination, gatekeeping and transphobia. Delaney and McCann (2020) hypothesise about non-affirmative, discriminatory experiences contributing to high levels of attrition across minority groups. Participants approached MHS feeling wary having already experienced discrimination across multiple domains of their lives.

The participants of the studies by Bettergarcia, Benson, Puckett, and Stephens, described that MH systems, from the very foundation, are not designed to meet the needs of TGD people. Frequently, this was reflected in TGD clients not being able to report their preferred name or pronouns on intake documentation and interacting with professionals who refused to respect the terms participants identified with. Many of the studies reported participants struggled to find affirming therapists and having to move or change providers, alongside challenges with high clinician turnover. Puckett et al. highlight their participants’ descriptions of needing to put in effort to find the right therapist and the limitation of their methodology in not capturing if participants stayed with the same MHP throughout the study period. Several of the other studies described participants’ processes of needing to seek out a knowledgeable and empathic therapist andalthough it could be argued to be the case for anyone seeking private therapy, for TGD people the journey is fraught with exposure to discriminatory and harmful practices and the possibility of the gate to GAC being slammed in your face.

Acosta (2024), Puckett (2023), Delaney and McCann (2016), report participants’ experiences of long waiting times and the challenges of finding supportive and TGD affirmative professionals within the public healthcare system. In the USA based studies, although all providers were private, it could still be challenging to find providers or independent clinicians with a therapeutic approach the participants preferred and who were knowledgeable and accepting of GI.

Elder shared a participant’s experience of having a TGD therapist, who perpetuated binary views of transition in line with her own experience, upholding cisheteronormative narratives of there being a ‘right way’ to transition that did not match the participant’s identity. Another story described an endocrinologist’s reputation for only providing hormones to those he thought would ‘pass’. Passing is a term referring to when a TGD person can ‘pass’ as cisgender. The participant shares this forces TGD people into white cisheteronormative standards of gender, frequently causing problems for trans feminine PoGM.

Affirmative therapists were valued when they showed competent knowledge about GI and current events impacting them (Trump 2020, etc). Participants also valued honesty and clinicians’ willingness to go away and educate themselves rather than expecting clients to educate them on everything.

2.5.2 Pathologising systems & access barriers

All studies, bar Bettergarcia and Israel due to their analogue design, explore the requirement for TGD to access MHS for medical or legal recognition of identity. Acosta (2024), Delaney and McCann (2020), and Benson (2013) share the frustration and invalidation felt by participants at having to seek ‘permission’ from a MHP who often had little understanding of the nuances of TGD experiences. Professionals acted as gatekeepers to legal documentation and GAC. Participants found it hard to feel cared for or genuinely validated in this context, powerless in the face of a system denying them the ability to determine their own identity.

Benson’s (2013) participants reported struggling to have their identities recognised as a multifaceted and complex mosaic alongside their gender. Clinicians fixated on gender and disregarded other factors or misattributed diagnostic presentations or would completely ignore the importance of gender. They reflected on the struggles and distress that can arise during and parallel to social and medical transition and participants’ reflections around historical MH issues were retrospectively linked to coming to terms with GI and not having this recognised.

Several studies outline the requirement of a diagnosis to validate gender is theoretically, historically and contextually explored in the wider context of models of GAC and in their participant’s lived experience. The grey literature searched have the benefit of higher word counts to provide this important context to those clinicians falling into the less educated category experienced by participants.

The change in the DSM-5 from gender identity disorder to Gender Dysphoria, supposedly recategorising it away from MH disorder and ‘distress’ associated with gender is named. The papers summarise a historic and current activist response to how this shift has changed very little in the

MH system pathologising and perpetrating transphobic practices for the reader, whilst sharing their participants’ thoughts and reactions. For many TGD people it feels deeply harmful for their identity to be recognised only in the context of distress and that the ability to self-determine their identities and bodily autonomy is denied (Acosta, 2024, Benson, 2013 Delaney & McCann, 2020, Puckett, 2023, Stephens, 2016).

Lack of education can lead to rupture without repair, but TGD people do not expect perfection from their practitioners and are frequently grateful for open admissions of personal limitations in experience and training. This is especially the case when coupled with a clear commitment to taking time to familiarise themselves with terminology and socio-political context outside of their session time. A lack of TGD awareness was universal, there was a dearth of even the most basic education on GI and TGD experiences, even amongst clinicians working explicitly as gatekeepers and practitioners of GAC (Acosta, 2024). Non-affirming and ignorant experiences were common, especially for nonbinary identities. The studies lacked an explicit exploration of how able participants felt to discuss gender. Participants did report needing to perform certain norms or present an edited version of themselves. Acosta (2024) describes the expectation is to be harmed so standards for affirmation are low. Puckett et al. wondered if low standards meant therapists were ranked well because therapy was needed to maintain mental stability rather than allowing for free gender exploration.

All interview studies reported the onus on the client to educate professionals on basic terminology and the sense of having to ‘convince’ MH services of the validity of their identity and of the discrimination they experience. Participants in subsidised or government funded services were left feeling hopeless and needing to turn to community sourced GAC. Private paying clients reported resent, feeling they were paying to further their therapist's personal development.

2.5.3 Naming the obvious ingredients to affirmative experiences.

This meta-narrative encompasses the way the papers captured the need for affirmation to be clear, assertive and specific to gender for TGD participants to feel safe to be their authentic selves. The studies paint a negative picture of the state of affairs and the implications highlight barriers like resource allocation but suggest things like ‘respect’ and ‘adequate’ training that give a sense of minimal expectations. However, positive affirming practices were still able to be identified across each study.

Participants had different strategies to check for the chance of affirming experiences. Researchers and participants reflected on the privilege of being able to undertake a search for the appropriate private provider and to be able to ‘shop around’ following a negative interaction. Those

forced to access nationalised healthcare systems where autonomy is further reduced and choice extremely limited. Accessing systems with government funded or subsidised care like Acosta and Delaney & McCann limits choice and increases attrition and feelings of hopelessness following non-affirming experiences.

Affirmation is not just about granting access to GAC, in fact, reducing GI to medical transition can be invalidating, participants welcomed curiosity about their individual context but also acknowledgements on the minority stress struggles associated with transitioning and the challenges associated with accessing GAC.

Benson, Elder and Stephens also reported a positive as therapists being flexible in their approach, in terms of therapeutic modality and not being prescriptive with their intervention. Being flexible in meeting the participants’ desires to be goal-focused or more exploratory work of personal histories and exploring the present and experience of GI was helpful.

Acosta, Puckett, and Stephens’ forefront Minority Stress Theory (MST) for TGD people and the added challenges navigating daily life in their approach. Failing to understand Minority stressors leads to clinicians missing many opportunities to build rapport and deepen understanding of TGD clients. Puckett et al. (2023) found that only 67.67% of the time participants attempted to discuss the impact of minority stress of TGD lives did the clinician respond with reflection or intervention and in this there is no clear indication of what percentage of intervention was satisfactory. Clinicians who acknowledged the realities and complexities of intersectional identities were highly valued and increased participants experience of feeling understood.

2.5.4 Allyship needs validation by our community.

Services made efforts to advertise their allyship on their websites and visibly in their offices, displaying pride flags and explicitly welcoming LGBT+ and TGD clients and having pronouns and preferred name options on intake paperwork. Some participants reported awareness of tokenistic allyship and preferred organisations and practitioners that had a more active engagement in activism, local third sector organisations or could demonstrate more concrete examples of allyship. Word of mouth recommendations from TGD community members were named as some of the most reliable indications of affirmative practice. TGD people seeking care shared stories of asking social networks and online forums to ‘check’ if services were really affirming as advertised.

Participants valued LGBT therapists sharing their identities and especially having TGD clinicians share their lived experience, as it eased caution and enabled a freer flowing exploration through shared language and understanding. Self-disclosure still had to be done mindfully and cohesively to support the client’s story, as opposed to feeling the therapist was prescribing their own

experience onto the clients, or a disclosure that took over and mistuned to the moment. Participants desired being able to ‘get right into’ discussions of gender once safety was established rather than having to slow down and educate and default to the therapist’s pace and gendered frame of reference.

There was a universal finding for assertive, clear affirmation of GI coupled with at least some understanding of TGD lived experiences. Empathy and unconditional positive regard are core skills and competencies across all therapeutic disciplines. When therapists ignore or do not notice themes of gender, it impacts the TGD person’s trust and confidence in the support provided. Puckett et al. (2023), who measured TGD peoples experiences of socio-political discussion and overall therapy satisfaction in relation to being TGD over 12 months, found that at some point TGD clients rated their therapists positively, despite other research suggesting largely negative experiences, TGD people prioritise other areas of their needs and do gain positive therapeutic effect some of the time.

2.6 Discussion

This literature review aimed to construct narratives centring around TGD participants’ therapeutic experiences and what enables rapport building and positive experience, seeking to understand therapeutic contexts and not just GAC pathways. However, all studies found came from countries with a pathologising model, meaning access to GAC understandably remained in the background. The meta-narratives encompass the sense of TGD people’s low expectations set in part by minority stress inflicted by global transphobic attitude, magnified for those holding multiple minoritised identities. Most affirmative practices when described feel like foundational skills any clinician of any MH discipline should be able to demonstrate. As psychological practices continue to develop away from a more medicalised practice and acknowledge the socio-cultural-political influences on mental wellbeing, it might be a newer area of importance to consider especially when working with someone from a socially stigmatised group.

Therapists’ ability to understand the overlapping nature of a participant’s intersectional identity and ability to engage in exploratory discussion of gender were highlighted as valuable. This awareness of minority stress impact, coupled with active curious and positive responses to the client’s exploration of gender expression in ways that help mitigate internally held cisheteronormative beliefs, are the core components of affirming approaches (Ellis et al. 2020).

Therapists with a ‘flexible’ non-prescriptive approach listened to the participant’s desire for goal-oriented work or a more exploratory approach. Regardless of where participants identified themselves on their personal transition, there was a desire to have affirming exploration of the changes transition brings with the nuance for good and bad without fear that doubts, or negativity

would be used against them to bar access to medical GAC. Binary narratives left non-binary participants having to ‘figure it out’ alone and edit themselves for access purposes.

Puckett et al.’s (2023) reflection on not knowing if clients stayed with the same provider for the duration of the study highlights a gap in the research about the process of ‘finding’ a therapist for those navigating private healthcare systems. The search strategy did not yield any studies on TGD feedback or experience of rapport building in NHS therapeutic settings. Several participants in other studies mention privilege and socio-economic standing in the ability to pick and choose their therapist. The studies were largely based in countries with subsidized health insurance plans or private healthcare which perhaps does not compare to the UK, where the NHS is the standard and private healthcare much more limited to only those that can afford it. Few papers explicitly explored how confident participants felt discussing gender with their clinicians and if this is something they felt they had to leave out or hide, to help understand more relationally how TGD people felt understood and contained therapeutically.

Affirming practices led to therapists being perceived as more knowledgeable, which may influence clients comfort level in discussing gender (Puckett et al., 2023). Compared to trans feminine participants, non-binary participants found providers to be less but overall, there was a high level of satisfaction with providers seen as moderately knowledgeable.

The authors hypothesized the high baseline rates of satisfaction that were relatively well maintained might come from participants seeing therapists for a range of MH diagnoses and seeking to maintaining wellbeing. Acosta (2024) similarly shared participants experience of ‘giving up before starting’ due to the expectation of transphobia. Puckett et al. wondered if participants ‘make do’ with not being able to fully explore gender and rate other areas satisfactorily. Carlile, Butteriss & Sansfaçon (2021) researched the experiences of TGD youth and their families in England who shared feelings of ‘luck’ when encountering a supportive clinician. Basic and standard care approaches categorised as lucky highlights the dire situation in NHS GAC, especially for TGD youth.

Pathologising models of gender affirming care that gatekeep access to identity validation and treatment granted only to those who ‘convince’ the cisgender run system continue to perpetuate TGD identities being seen through a binary medicalised lens. Gender becomes othered, when things are bad participants feel gender is ignored entirely, clumsily pushed into the role of educator or viciously attacked by professionals unable to manage their own bias who continue to be protected by the wider MH system.

Binary views in society are not limited to constructions of gender, rather than confront bias it is all too easy to simply say ‘I am not prejudiced because I am not a bad person, and I am not bad at my job’. The unanimous finding of the absence of acknowledgement of gender and the lack of affirmation being so integral to the experience of therapy further throws a spotlight on how harmful therapeutic spaces can be for TGD people.

However, this does not explain the hesitancy or absence of affirmation, which as a core part of empathy and non-judgement should theoretically come with ease to any competent MHP. Guidelines promoting trans inclusivity and socio-cultural affirmative practices have been developed and existed since 2009 (ACA, 2009). The BPS Practice guidelines (2017) on working with sexual and gender minorities clearly state the importance of understanding social stigmatisation and to not associate gender or sexuality with mental health disorders and specifically calls out the importance to be aware of the additional stressors faced by racially minoritised TGD people. However, TGD SUs continue to report persistent ignorance and discrimination when interacting with NHS services (LGBT Foundation, 2018).

Even amongst the fast shifting and changing social narratives around acceptance and prejudice of different social identity categories, therapeutic spaces are supposed to be a reprieve from social judgement and negative appraisal. Narratives in psychological circles frame clinicians more as fallible human beings, also capable of having lived experience of MH difficulties and practicing professionally compared to the more infallible powerful conceptualisations of medics.

Thériault & Gazzola (2007) wrote on therapist feelings of incompetence (FOI), a phenomenon originally thought to ease with experience but persists despite years in the profession. Knowledge and administration are part of the key sustaining sources in Thériault & Gazzola’s model alongside personal factors, process issues and areas of human fallibility. Mistrustful and wary clients were also sighted as adding to FOI, alongside feelings of responsibility and change within the therapeutic relationship. FOI could lead to actual incidents of incompetence and avoidance by therapists and negatively impact therapist wellbeing. Despite this, training for MHPs on TGD issues is scarce and frequently not taken up, especially in the NHS where CPD training is frequently e-learning or not mandatory if specifically focusing on GI. Research has also consistently shown that professionals do not have protected time to effectively manage e-learnings. Blended learning approaches (in-person learning, reflective spaces and e-learning) are also the most impactful (Clarke et al., 2005), requiring more time and resource the system is unable to allocate.

Previous research on clinicians’ experiences of providing care to TGD people has shown that the type of MHP that participates in transgender research agrees that adequate TGD education

is severely lacking at all stages of professional development, institutional barriers linked to normative bias are frequently cited as implementation barriers (van Heesewij et al., 2022). Treharne et al.
(2021) found teachers of training courses felt they lacked expertise but meaningful inclusion of TGD contributors to training programs is significantly lacking. There are no standardised or nationalised trainings or guidelines for supporting people given a gender dysphoria diagnosis. Only 20-25% of professionals had come across GAC based training in graduate or clinical training settings, despite over 65% of therapeutic professionals seeking the training following identifying a community need or working with a TGD individual (Stryker et al., 2022). With a lack of a unified national approach, UK GAC guidelines frequently contradict those laid out by international expert bodies such as World Professional Association for Transgender Healthcare (WPATH) (Boyd, Hackett and Bewley, 2022). Increasing access or developing training alongside a population like TGD people who are identified as a group with increasing need would seem like the bare minimum but available courses at education and clinical level remain minimal.

The papers highlight TGD SUs do not just label their experiences as ‘good and bad’, and clinicians engaging in un-affirming practices were not automatically labelled as unskilled and malicious although such individuals likely exist. Unsurprisingly, TGD people wanted consistency, compassion and willingness of their MHPs to attend to them as individuals. Multiple papers cite the preference for flexible integrative approaches and an ability to go with clients both through childhood and present-day adjustments associated with gender exploration. All studies highlight the importance of nuance. Ignorance and avoidance have a silencing effect, dampening rapport and repeating the other and isolating experiences TGD people face in their lives. When therapists fail to conceptualise the added intersectional experiences of TGD people holding multiple marginalised identities, so much of a TGD person's life is fundamentally misunderstood. They often ‘make-do’ and leave their gender aside or never have space to explore gender to meaningfully, instead trying and focus on diagnosis or associated distress, which they may or may not associate with dysphoria or identity concerns. This potentially leaves integral issues unexplored, extending distress and leading to repeated episodes with MH services.

Elder (2016) highlights the importance for professionals to make efforts to gain some understanding of the historical backdrop of harm that has been perpetrated against TGD and queer communities, especially for older participants who will have lived experiences of these. As harmful and actively anti-transgender policies and practices are on the rise globally, clinicians have a duty to understand that MH services are not altruistic places of healing but contribute to maintain systems of power by participating in judging what identities and behaviour constitute as normal and seeking

to coercively correct that which it deems dysfunctional. Stryker (2008) writes on the development of terminology within the queer community that developed a way of identifying that ran in contrast to the systems of power around them. Psychiatric and Psychological systems have continued to pathologise anything that fell outside of the ‘biological’ and social standards of gender presentation they defined as normative and acceptable. It is not hard to hypothesise that the bare minimum acknowledgment and validation of the existence of TGD identities could destabilise many of the oppressive and pathologising practices that benefit the current system.

2.7 Limitations & Implementation into this research -

BPS practice guides and guidance for working with gender diversity (2017,2024) clearly state that professionals need to understand socio-political discrimination and historical context of oppression from the psychological community. They remind psychologists of the intersectional experiences of TGD people and to not assume certain groups will not be trans. Psychologists should respect the gender presentation of those who are TGD even if it does not align with practitioner expectations and that TGD clients have a right to self-determination. However, this is frequently not experienced by many accessing UK MHS and the well-intended values sit at odds with a system that requires a diagnosis to have one’s identity respected. Only one of the review studies looking explicitly at what participants believed contributed to a good therapeutic relationship took place in the UK, but all shared experiences of the above values not being met.

I recall my own supervisor on one of my training placements telling a gender critical mother to a trans teenager following their psychology assessment that our service was neither gender affirming or gender critical. Afterwards when I asked if he could clarify what he meant by that statement, he was unable to answer other than not wanting to ‘encourage’ the wrong decision and that he did not feel he needed to take any stance as he was not the one making decisions about GAC. He had also told me that my ‘clear position’, when delivering an educational staff training on understanding GI and the impact of the Cass Review to our team, ‘should have given more space to the other side’ in case I caused colleagues discomfort. When I shared that this stance of ‘taking no position’ is more easily aligned to non-affirmation, he was reluctant to enter any discussion with me on communicating in curious and affirming ways with trans young people, later writing on my training feedback paperwork to the university that I had made discussions on gender ‘uncomfortable’. Existing whilst trans is inherently political, but trans identities are reduced to labels one can opt out of believing in and like in many healthcare settings, professionals are taught to not discuss political beliefs, maintaining professional entitlement to remain silent and opt out of thinking and learning about gender.

This lack of awareness results in unintentional invalidation and the perpetuation of more insidious acts of malice. Despite its prominence in the public consciousness, those not directly impacted can opt out of paying attention and understanding how meaningfully it will impact their clients’ lives (Price, Puckett & Mocarski, 2021). I had my own contact with a therapist, stating GI was a ‘modern’ phenomenon they were not familiar with, and I could not expect them to go away and read up on it. I would have to take the time to explain my experiences to her before becoming fixated that certain elements of my personal history were ‘causes’ for my understanding of my gender. Holding in mind my own multi-faceted identity as a trans non-binary, mental health service user and mental health professional, I struggled to come to terms with what it is about gender that professionals struggle so much to engage with. Questions that become intrusive or tactless or simply completely unasked, when sensitive but deeply personal questioning is such a core competency for any therapeutic profession. Gender appears to be one concept that even those who identify as allies find hard to conceptualise empathically and curiously. These findings drew me to seek to understand how mental health service users and mental health professionals come to conceptualise their gender and if individual contexts across personal and professional lifespans influence understanding. I aim to try and better bridge the gap between TGD people and MH services to improve TGD client’s experience of therapy no matter where they are in their personal gender transition. When considering the MHS lack of training has long been an issue, but why this might be or in which ways do MHP struggle to understand and engage with gender remain unclear.

Stephens (2018) bravely and honestly raised his own cisgender confusion and was able to work through his initial reticence built from experiences in a cisgender world when he initially struggled to understand the language of his non-binary and genderqueer participants, reflecting on how this might cause rapport ruptures in less informed colleagues. I hope to try and investigate MHPs’ understanding of their own gender identity and its formation, as well as their understanding in relation to those they work with to help shift how gender is taught about in the staff training that this review highlights is so glaringly missing.

Chapter 3: Methodology

This section will consider the epistemological perspectives of the research and theoretical position. I will outline how these concepts underpinned the study design and explore the reflexive position of the lead researcher and how their lived experience as a TGD researcher and MHP and MH service user, informed the process of the research, this section will describe the study design and describe its participants.

3.1.8 Queer Methodology

Ghaziani & Brim (2019) argue that Queer Theory (QT) is unique in its drive to work against the systematic, positivist hypothesising and preferential treatment of generalisable data, common in the field. They propose a ‘Queer Methodology’ that emphasises interdisciplinary, imaginative collaboration, avoiding ‘hypothetico-deductivist’ ideological standpoints and instead moving towards a method that does not overdetermine but gently clarifies the processes of queer world making. They reject the basis of questions like whether queer people are ‘born this way’ as this implies that there is a biologically inherent way to ‘be gender’ and that biological markers for heterosexuality and homosexuality exist, leading to understandings of identity to be reduced to binary points, at best placed at either ends of a spectrum and at worse separate parallel impermeable boxes. Queerness is seen as a sedimentary formation, many layers each forming under the history and sociocultural influence that preceded it. Each layer gives some chain of coherency and influence to the next.

Table 6 Ghaziani & Baldassari’s Queer Methodology (2011)
1) Rejects unchanging categories
2) Rejects impermeable categories.
3) Rejects dualism and binaries, embraces multiplicity.
4) Queer methodologies seek to reject single-issue identity politics and inter group dispute that led to upholding concrete heteronormative ideals that twist queer spaces into ‘homonormative’ ones.

3.1.9 Categorisation & Pathologisation

Much of Western QT and lexicon comes out of North America from communities of People of Global Majority (PoGM), although much of the resulting pop culture frontlines the voices of White homonormative ideals. Activism and creativity, particularly from the Black Community, created what can often be taken for granted today as a Queer lexicon or ‘culture’. Understanding comes through creating shared conceptual understandings and categorising information. QT aims to subvert concrete and exclusionary ways of understanding, processes of sorting and categorising forms the baseline for understanding our social worlds.

Goria (2020) writes on the process of forming categories through spoken language. Over time linguistic theorists’ have outlined different types of categories; Taxonomic or common categories refer to ‘permeant’ or context independent language expressions like verbs or nouns. ‘Ad-hoc’ categories represent context-dependent constructs that orient to specific human activities and can be adapted to achieve communication goals (Mauri, 2017). Although ad-hoc categories are

constructed ‘spontaneously’, knowledge of other frames of reference are required for the category to be successfully communicated. Mauri uses the example ‘activities for a Sunday afternoon’, which could contain a range of diverse answers but shared linguistic meaning making might further rely on the relational history and dynamic between two speakers.

Theories of categorisation centre cognitive and discursive means of creation. Cognitive categorisation suggests that categorisation happens internally in our minds and discursive proposes that categorisation happens through linguistic communication. In isolation it is argued that neither is sufficient to explain how we come to understand categories, but both are required and contextually informed (Cartson, 2002).

Goria (2020) argues categories are constructed in real time through a range of linguistic resource. Context is highly important to how categories are formed. Barsalou (1983) investigated categories through experimentation and participants formed common and ad-hoc categories came to be through communication and coming to shared agreements in discussions together. However, Barsalou concludes that perceiving an entity does not activate all the ad-hoc categories that could associate with it. Cisheteronormative categorisation might lead to a masculine person to be categorised as ‘strong, stoic, capable of violence’ and this exists in opposition to a feminine ‘soft, emotional and care giver.’ Under cis-patriarchal narratives, the masculine and feminine exist as opposites and overlap is punished.

We as humans form the categories ourselves rather than categories existing as constructs, we discover and fit ourselves into. Some current categories might be more fixed than others, such as race and ethnicity, as such constructs have not always existed though historic systemic oppression and some distinct group traits have.

Sedgwick (1990) proposed an evolving model of QT taxonomy, rather than continuing the reign of reproducibility as gold methodological standard, Sedgwick invites us to adopt a model of,

“Making, unmaking and remaking of categorical meaning, which captures a more pragmatic validity of the evolution of language and terminology”.

Categorisation becomes unhelpful when we as a society, forget the cultural and temporal influences that give context and layers of meaning to how we come to label identities. Especially, as with GI that aspects of identity become socially pathologised. MHP’s conflate identity categories with diagnostic criteria and forgetting that psychiatric diagnoses also are formed with cultural contexts (Lane, 2020).

In times of increasing prejudice, some binary members of the trans community perceive social acceptance as a scarce resource that is dependent on assimilation, leading to increased policing of language use and gender expressions. Those who refuse to assimilate therefore face invalidation not only from the cisgender world and institutions, but also from some trans people who perpetrate cisnormative and pathologising standards and gatekeep GI validity. Debates around the role of identity as means of conforming versus those who see identity as means of transgressing norms can clash (Davis, 2009) rather than finding cohesion and acceptance in a true diversity of gender presentation.

In Western Mental Health Services (MHS), diagnostic categories centre our understanding of mental distress. The process of categorisation also assesses for level of risk and what type of service will offer help and what form treatment will take. Medical mental health diagnoses are conceptualised in the modern world as providing understanding and act as a gateway to accessing social care and can be used as a tool for self-understanding. Certain diagnoses have been commodified in the public consciousness and openly discussed and accepted in pop culture, whilst others remain stigmatised.

Lane (2019) writes on the varying responses of professionals when met with members of the public seeking certain diagnoses and a tendency to be more open to the ‘common’ and less stigmatised categories of diagnosis like anxiety, and sceptical responses given to diagnostic labels with a negative ‘moral’ or stigmatised characterisation like personality disorder. MHS are more aligned to the ‘seriously’ or severely unwell, whose testimony tends to be disregarded and although the worried well’s experience might be validated, they will be gatekept from significant resource like long term therapy. Strained resources also influence the development of a strict process of categorisation, causing professionals to become gatekeepers to MH support (Griffiths, 2001), in which TGD are deemed ‘too complex’ to help regardless of their MH experience. Some professionals contest the validity of TGD experiences, continuing to conflate GI with mental disorder despite the change in diagnostic classification. There is still an expectation of differential diagnosis to ‘rule out’ other influences on GI formation (Coleman et al., 2022).

Extensive discourse exists around the power of language and categorisation and its construction of binaries such as "us and them" or "patient and helper". The language and power of accessing care also have evolving terminology of "sick patient" to "service user" or "client." Antipsychiatry and critical psychology movements argue that diagnoses can be restrictive, reducing complex experiences to fixed categories. This can lead mental health professionals (MHPs) to dismiss individuals’ accounts if they don’t align with preconceived notions of a diagnosis, regardless of the person's actual testimony.

3.2 Autoethnography

Pearce (2020) writes on the power of autoethnographies when researching marginalised and oppressed communities the researcher is part of. She shares her experiences conducting transgender research in the UK and the lack of established support and expertise to meet the needs of TGD academics. Her work highlights the struggles of navigating neoliberal academic systems ill-equipped to support the pain encountered through autoethnographic work, proposing the collective action needed to better support the powerful stories that can be gathered by marginalised researchers.

As I began this research in 2022, I was slowly coming to terms with my own gender although I had been out in most areas of my life as non-binary for several years, which had enabled me to feel more myself. The more I connected to the research, I found community in which I saw myself reflected, just as my participants shared with me. I was able to squash the internal judgement of not being ‘trans enough’ (a simplification of a whole host of obstacles) and started my own medical transition. This permission I gave myself to grow, to apply testosterone gel every day and reshaping me into a self whose reflection felt increasingly recognisably me, has been the most liberating and euphoric experience of my life. Starting a process of self-acceptance I had previously not believed to be possible whilst bringing to the surface challenging feelings and experiences previously kept buried to survive a reality in which I could not clearly see a future for myself. I was acutely aware of my privilege in accessing this privately rather than waiting indefinitely on the NHS waiting list, especially with the looming shadow of the adult services review, threatening to block access to life-changing care for those unable to afford alternatives.

Accessing privately GAC pathways of seeking a gender incongruence diagnosis was still incredibly bruising and invasive as a non-binary person accessing hormone replacement therapy (HRT). Seeking top surgery was blocked by professionals citing a need for my identity to be validated by a second clinician because I was not seeking a binary transition, despite my diagnosis coming from a government-registered gender specialist. This requirement to ‘double check’ non-binary is not in line with WPATH Standards (Coleman et al., 2022). I found this representative of the UK’s attempt to maintain binary cis heteronormative gender expression.

I expected researching a topic close to my sense of self, seeking to support my own marginalised community, to take a toll. Alongside another key part of my identity, as a trainee to work to improve mental health services and therapeutic settings that continue to perpetrate harm against my community, was a motivating force to motivate through challenge. However, this awareness did not prepare me the emotional weight on the backdrop of surging transphobia in the UK and the shared experience of my TGD participants. The Cass report, politicians whittling away our existence to

bathroom and sports participation debates, particularly villainising trans women but creating legislation that forgets the existence of trans masculine people. Puberty blockers and young people’s GAC services shutdown and remodelled in worrying ways insisting upon autism assessments and leaving TGD people/youth waiting with unclear expectations on already decades long waiting lists.

Attending the Trans rights protest following the UK supreme court ruling on the categorisation of sex in the Equality Act 2010 (For Women Scotland Ltd vs The Scottish Ministers 2024) and the aftermath the mainstream media and government interpret the ruling to mean a unilateral judgement on what it meant to be a woman, and how my peers, colleagues and friends not in the community also responded. Readily believing that any ruling body has the right to define the meaning of a socially constructed experience, what and what isn’t womanhood. It reminded me how intertwined ‘biology’ is in mainstream conceptualisations of gender identity (GI) and how trans rights, and gender equity are still associated with a loss of resource or ‘safety’ for cis people. Although much of the initial response to the ruling have since been rolled back on, I found it hard to hold on to hope about how the ramifications of this ruling will ripple through the public consciousness and in the mind of the mental health system.

The perspective of my multifaceted identity (researcher, trainee clinical psychologist service user and TGD person) enhanced and hindered the process of this research. It created safety for my TGD participants with a fluency and fluidity of language and shared experience. I wonder if I was able to explore some topics in more depth to really draw out the meanings and factors that influenced their experiences of MHS, that I understood implicitly from my own lived experience. As an openly TGD researcher, I wonder if for the mainly cis staff group if there was a pressure to ‘not say the wrong thing’ which emerged in the theme of “The pressure to get it right”, avoiding misattuned gender assumptions. When formulating my interview questions, I did not want interviews to feel like exam conditions testing professional knowledge or replicate ideas from existing staff trainings that imply one can become completely competent in an identity or culture that is not your own.

With any research exploring marginalised groups and prejudice, I wondered how safe my participants would feel in sharing views they might perceive as unacceptable to me. When proposing my thesis, I was initially met with pushback from two prospective supervisors who told me that gender was ‘too complicated’ a topic and other instances of uncertainty, especially when asking staff to consider their own gender. The cisheteronormative narrative of gender is both entirely concrete, inherent and unquestionably true and complex, confusing and dangerous to discuss. Since this research’s beginning, my own relationship to my identity as a TGD person, MHP and a researcher has evolved and changed, my hope for outcomes of this research was to

inform training and change for MHS but I wonder if existing within the many bellied beast of academia and the NHS if I shifted and presented my questions as consumable to a cisheteronormative world, when my current self might have strove to be more radical and been able to tolerate risking more in an unsafe world.

Although this project is not a true autoethnography, throughout the interviews, the importance of the “folk like us” was noted between the TGD participants and I. A communal understanding through explicitly named sense of connection and the more unnamed ease of communication without having to pause to educate on the semantics or reality of their experiences. I openly stated my own journey as a trans MHP and where relevant my history as a service user of mental health services to overtly share my positionality with all the participants.

Co-production in healthcare research relates to the involvement of key stakeholders such as patients, service-users, and community members. Using the expertise of those who the research being undertook is about informs the process of the research itself and implementing any further work and findings discovered. The value of co-production in research is often undervalued, particularly in fields where professionals have traditionally been viewed as holding an authority of expertise in care and patient dynamics. As a result, co-production remains non-mandatory and frequently done tokenistically, especially in studies involving vulnerable and marginalised groups. Social power dynamics further shape participatory work: only those who feel safe are likely to engage, limiting diversity and representation. Traditional approaches to co-production tend to overlook the unequal power relations between professionals and contributors, often framing the relationship as equal without critically addressing the historical and systemic power structures embedded in the professional-client relationship, still implicit in healthcare research.

3.3 Study Design

Two rounds of online individual interviews were conducted, primarily via Microsoft Teams, with two held on Zoom at participants’ request. Interviews lasted between 45–70 minutes. The first group included eight participants who had accessed NHS mental health services within the past five years; some had also used private therapy. The second group comprised seven NHS mental health professionals. After each interview round, emerging themes were shared with participants to involve them in the research process and check alignment with their experiences. Service user (SU) participants were asked what questions they would pose to professionals. Their responses informed questions on whether staff consider gender in clients’ presenting issues and how mental health professionals (MHPs) perceive the field’s understanding of TGD experiences.

3.3.1 Interview schedule development

Three topic areas were selected for the interviews. The first area was different for the staff and SUs, discussing experience either accessing MHS or working in them and how they felt gender was discussed in those settings. Both groups were then asked about their own gender identity and finally about their thoughts more specifically about how mental health services interact with TGD people and what, if any improvements and changes participants thought might help improve how MHS support and interact with TGD people.

The schedules were developed with trans theory and social constructive lens thinking about participants felt internal sense of their gender and how their socio-cultural experiences influenced them and how others interacted with them and their influence on gender. Current research on TGD experiences of MHS were also kept in mind when developing the schedule. Questions were developed with the Research Supervisor and through peer research group discussion. After the participant round themes around what MHS could do to improved was developed into an expansive question in addition to the question around improvements to service provision for TGD SUs.

3.3.2 Reflexive Thematic Analysis

This research employed Reflexive Thematic Analysis (RTA) to analyse data. Widely used in healthcare research, RTA identifies patterns across participants' narratives while valuing the researcher’s lived experience in interpreting the data (Braun & Clarke, 2024). RTA involves familiarisation with the data, coding, generating initial themes, reviewing and refining themes, and finalising theme definitions before analysis write-up. It is not a rigid formula; reflexivity occurs throughout the process, requiring critical reflection on the researcher’s role and positioning (Braun & Clarke, 2022). This aligns with reflective clinical psychology practice, where awareness of personal experience informs effective therapeutic work.

RTA supports both summarising and meaning making, enabling exploration of shared experiences while considering the social context of those meanings. Current narratives around gender identity and mental health often rely on positivist, categorical frameworks, where mental health services (MHS) gatekeep trans and gender-diverse (TGD) individuals’ access to gender-affirming care. Just as gender is seen as diverse in this study, TGD experiences are not homogenous. RTA enabled theme development that reflected both surface-level (semantic) and deeper (latent) meanings, shaped by the pragmatic aim of informing staff training on gender identity and supporting gender-diverse clients.

Transcripts were read, annotated, and re-read to develop codes within and across transcripts, using Microsoft Word's highlight and comment functions. Broader themes were identified and refined into

subthemes. After both interview rounds, themes were reviewed with the research supervisor, then revised for clarity and coherence. Although delays in the research process may have affected participant engagement, themes were shared for participant checking. Feedback was received from three service users and two staff members.

Coding was done from a primarily deductive perspective, holding in mind the research aims and epistemological positioning of the lead researcher. In particular, influence of Minority Stress Theory for TGD people and its influence on their sense of self and how it feels to exist within minoritised identities and access MHS. Transgender studies influenced the approach to coding by considering narrative stories of gender and the journey many participants took when navigating their personal and social sense of GI.

3.3.3 Recruitment

Eight participants in the service user (SU) group were recruited through online advertisement and poster campaign. Details of the sample can be seen in Table 7.

One challenge at this stage was a high volume of bot responses and participants completing the demographic form to meet the criteria, seeking the £20 Amazon voucher compensation, however, did not engage fully in the interview program. Following this experience, recruitment was primarily done through a poster campaign across Essex at local LGBTQIA+ organisations.

Table 7 Participants who are accessing or have accessed Mental Health Services in <5Years.

Participant Pseudonym	Age group	Gender identity (as described by participants)	Ethnicity	Sexual Orientation
Milo	21-25	Trans masculine/non-binary	White British	Lesbian
Charly	55-60	Trans woman	White British	Bisexual
Claire	31-35	Binary Trans woman	White British	Heterosexual
Dan	31-35	Trans Man	White British	Queer

Lina	31-35	Cis woman	Arab	Bisexual
Maxie	18-21	Cis female	White British	Pansexual
Malachite	26-30	Agender/trans masculine/non-binary	White British	Queer/Asexual
Teddy	31-35	Non-binary/gender queer	White British	Queer

Seven Mental Health Professional participants were recruited through purposive snowball sampling and sharing the recruitment poster through the lead researcher's professional networks Sexual orientation is described in displayed participant demographics as it demonstrates a lens of shared intersectional identity that facilitated differing internal reflections on gender and how gender was externally appraised through the lens of sexual orientation by others.

Cisgender participants were recruited alongside TGD participants with the aim of improving MHPs understanding of gender in mind. TGD are frequently othered and pathologised in research. The lead researcher sought to demonstrate to staff that all people have experience of their gender identity, and it is a lens which will influence their experience of both receiving and providing MH support. As well as how their own relationship to gender will influence their perception of gender, hoping to provide clear examples to inform future training to help staff further their understanding of gender.

3.4 Round 1 Participants (People who are currently accessing or have accessed Mental Health Services in the past <5years)

In response to participant theme checking, one participant felt a quote they identified as their own would better belong in a different theme and following discussion this was agreed. The other two participants both felt the themes accurately reflected their experience.

3.4.1 Round 2 Mental Health Professionals (currently working in the NHS)

The youngest participant fell with the 26-30 range and the eldest the 45-50 range. Two participants were currently training on Clinical Psychology courses, and one was an Advanced level Systemic Family Therapy trainee: the other participants were employed in different roles in NHS teams (see Table 8). Direct experience working with TGD clients was not part of the inclusion criteria for recruitment; experience is listed here to provide some context and level of understanding to situation discussions in the interviews. All staff had some form of clinical contact with TGD people in their professional experience.

Table 8

Participant Pseudonym	Age group	Gender identity (as described by participants)	Ethnicity	Sexual orientation	Profession	Previous experience working with TGD
Sue	45-50	Cis woman	White British	Heterosexual	Trainee family therapist/Nurse Practitioner	Some direct therapeutic work in family therapy clinic.
Louis	26-30	Non-binary	White British	Queer/pansexual	Trainee Clinical Psychologist	Direct exp of working with GD clients 1:1, mainly in CAMHS*
Heather	45-50	Cis woman	White British	Other: feels indefinable	Health & wellbeing support worker	Some exp in intervention work
Aylin	26-30	Cis woman	Turkish	Bisexual	Psychological Wellbeing Practitioner (PWP)	Only in a manualised assessment context.
Viraj	26-30	Cis man	Bangladeshi	Heterosexual	Clinical Associate Psychologist (CAP)	Direct exp of working with GD clients (group setting)
George	31-35	Cis man	White British	Gay	Trainee clinical psychologist	Direct exp of working with GD clients 1:1 in community & inpatient settings.
Kian	35-40	Cis man	Mixed White British/ Black Caribbean	Heterosexual	Family Therapist	Direct experience in family therapy clinic

Two participants responded to theme checking and stated that they found themes evocative and reflective of their experiences.

3.5 Ethical Considerations

All participants were sent support resources alongside the participant information sheet and consent form, to ensure these were available upon initial contact with the researcher. Participants were informed of their right to withdraw, to decline to answer any question they were not comfortable with and to bring the interview to an early close if needed. A distress protocol was developed to mitigate any risk that might arise when discussing challenging and distressing topics. All participants were sent support resources before the interviews began and reminded of them at the end of the interview. Participants were prompted to contact the lead researcher (LR) if they had any further questions. The distress protocol stated that participants currently accessing MHS would be asked about current safety plans, support networks and prompted to reach out to relevant clinicians or crisis services if relevant or needed. Participants were reminded at the beginning of the interview that they could request a break during the interview and ask questions or seek clarification on any questions.

The interview schedule itself was developed to cover the research aims but to start with broad and open language that would narrow down in response to the individual, to allow for a diversity of experiences and understandings, aiming to try and not make participants feel put on the spot or uncomfortable around the sensitive subject matter.

Ethical approval was sought through the University of Essex and the NHS Research Ethics Committee. See relevant ethical approval documentation and examples of forms and documentation used in the research in Appendix 2.

Chapter 4: Findings

Minor changes have been made to quotations taken from the interview transcripts to further anonymise them and improve readability through the removal of repeated words.

4.1 Service user Themes

	Table 9			
Bridging Theme	**Meet me with curiosity so I am safe to explore my gender**			
Theme	Searching for gendered belonging	“Is your gender, gender-y enough?”	Diverse identities breach stereotyped tick-	Obstacles on the path to identity affirmation

			boxes	
Subtheme	*Finding my folk: the search for language*	*Binary norms create gender. rights and gender wrongs.*	*The blurred identity of a helper seeking help.*	*Being seen as who I am*
Subtheme	*Unmasking gender authenticity*	*Queering Questioning*		*“Why can’t I like pink & climb trees?”*

Eight participants in total, six identified as TGD, two were cisgender women. Two participants were in ongoing therapy sessions, five had historically accessed mental health services (MHS) and received therapy and one participant accessed services via crisis and diagnostic assessment for Autism and ADHD but opted out of therapy sessions. All participants had accessed support through the NHS and four had additional experiences in private, third sector and employer provided MH support. Two participants were currently working as mental health professionals (MHPs) in the NHS, and one had previously been an NHS MHP.

One objective of this research was to influence staff training on gender identity and supporting gender diverse clients, codes were generated with the pragmatic validity of this in mind, and so some themes take more of a semantic form reflecting participant stories of how they experienced the interplay between gender and their mental health. The research also sought to understand how Mental Health Professionals (MHPs) understand gender on a conceptual level and if they believe this interacts with accessing MHS. Therefore, some themes have been articulated in a deeper and latent sense.

4.2 Safe to question, curious to understand.

As the first round of interviews were analysed, an overarching story that binds together each theme is of identity formation. All TGD participants named an internal felt sense of difference although gender was not always identified as core to this feeling. Stories were shared around how societal gender norms and expectations influenced their sense of self and how gender difference was

perceived to be unacceptable through messaging from family and peers, this created an environment where repression or rejection of this internal sense of difference felt safer than exploring it.

“I remember my parents saying all the time; Why can't you be more feminine?” (Dan)

Participants struggled to find role models and language that connected with their internal authentic self, when gendered expectations were subverted either socially or in media it was often met with criticism from people in the participants’ lives. These experiences often acted as barriers to participants feeling able to make sense of their own identities.

“People say just appeared. It was kind of oh, yeah. But there was Boy George is for everyone of a kind of thing. But it was so different that culture didn't exist around it. The language didn't exist around it, certainly not where I live and certainly not the people I knew” (Charly).

The historic context of suppression of queer identities and having very few examples to relate to (Koch-Rein et al., 2020). Charly shared her more rural upbringing and how Boy George was seen as an exception to the rule, but other gender transgressions were not acceptable or accessible in her community, making it hard to imagine a world in which her own gender expression fit.

“Especially trans women. Are stigmatized by society...It's been difficult body wise, it’s one of the main reasons it’s taking so long for me to admit that to myself” (Claire).

Trans feminine people face the brunt of public transphobia alongside patriarchal beauty standards. Ideas of beauty and attractiveness influence how individuals navigate the world and are appraised by society. Attaining beauty can bring power, increased survival, legitimacy and is reworked into a form of resistance (Vartabedian & Figueroa, 2025), particularly for TGD people. Participants who had been associated with, or currently identified with femininity, described pressures felt around how their physical bodies were perceived and policed. Claire reflected on her fears of being accepted and of her own safety when presenting as herself, but the potential to not be accepted by others. Although there are broader societal conversations evolving around ‘body positivity’ and acknowledging the harmful nature of harshly upheld feminine beauty standards across the gender binary, a Trans femininee person’s social status and acceptance is frequently based against her ability to conform to cisnormative standards of ‘feminine beauty’ (Monteiro & Poulakis, 2019). Critique of the feminine form is still widely accepted and used as a tool to attack those who

do not fit the prescribed standards, and TGD people who might transgress these norms altogether often face public scrutiny.

Cisgender participants described their personal journeys of identifying with their femininity, despite internal and external challenges, there was a sense of safety to question and explore within the boundaries of what it meant to be a woman, compared to TGD experiences of transforming the boundaries of gender.

“I have had times where I've been like, am I. Am I not? just purely because I was what everyone would call at the time, a tomboy? But no, I do identify as cis female.” (Maxie)

Maxie describes a process of questioning her identity, particularly around not always conforming to typical standards of femininity and how this was questioned by others despite her own internal sense of cis femininity.

“I guess, cultural in the sense of I'm the only girl and the youngest. So, there's been a lot of growing up expectations of being an Arabic girl (…) being generous and caring are other themes from my culture that also connect me to my gender” (Lina)

Just as TGD identities are not homogeneous neither are the experiences of ciswomen, Lina shared positive traits of generosity and compassion associated with femininity in her culture as well as restrictive and patriarchal tropes. The study did not recruit any cisgender men; past research has suggested gender identity exploration is cross culturally more harshly restricted for cisgender men.

Participants shared how acceptance of a trans identity can be a life changing and joyful moment but is only the start of finding acceptance in the wider world and accessing care and reflected on what it might have been like to have lived in a more accepting world or more open and curious MHPs to provide safety if their environment did not.

“I didn't really to bring about didn't bring it up myself (gender)…. do wonder if I. Might have...Started properly acknowledging it myself...If people had been bringing it up a bit, if it's, if it had occurred to them and I part of me wonders if some of them had done privately but not felt able to” (Claire).

The continuing and increasing social backlash around queerness and gender diversity increased feelings of fear and uncertainty (Connolly et al., 2025). Participants often felt they needed

to withhold that element of their identity, and when themes of gender were shared, participants were met with prejudice or ignorance. I deeply resonated with the multiple barriers to connecting with the gender norms placed on me societally, particularly within my own non-binary identity and the additional restrictions placed upon non-binary folk to receive additional care and professionals meeting my gender with ignorance, doubt, repeating my experiences of coming out and trying to come to terms with my own identity.

“Some services that just have no training towards that and it is pretty much just put up to the people that work there to just search in their spare time (Maxie)

As a trainee mental health nurse Maxie reflects on the lack of continuity between different teams and available training on TGD and meaning that ignorance and more actively critical or prejudice responses to gender do not have the opportunity to be educated and nurtured into a more compassionate curiosity.

“You can be as homophobic as you want as transphobic, whatever. But there aren't going to be consequences (Teddy)

Teddy shared their experience that the systemic issues are deeply entrenched and even when raising a complaint both as a service user and a MHP, the follow through process and learning outcomes remains opaque and lacking in meaningful results.

4.3 Searching for gender belonging.

Regardless how they identified their gender, all participants described some process of ‘coming to terms’ with their gender identity. Trans and Gender Diverse (TGD) interviewees described an inner sense of difference from their peers and families. While this was not always explicitly labelled as a gender identity difference at the time, there was an inherent sense of feeling othered throughout schooling or navigating social spaces. Teddy reflects on the development of their identity across the lifespan and although a sense of difference was clearly present, the lack of representation within their social world and their awareness of how others might be perceiving them inhibited a sense of belonging.

“.. like no sense of belonging in any of those spaces. There was rarely any queer kind of input”. (Teddy).

Participants identifying as masculine or non-binary described a gender expression that was more acceptable as a young child that was then rejected as they approached puberty.

“I start going through puberty…And there's that switch…. why, why was I treated like one of the lads? And then, now…suddenly, I'm not being treated like one of the lads.” (Milo)

The attempts by cisheteronormative people to keep TGD identities in the shadows, reducing their visibility, does not influence the reality of TGD people existing in the world.

“We’d just come out at the end of the AIDS epidemic as well. So, the idea of being non cis non het was just anathema to almost everybody I knew.” (Charly)

Charly reflected on the impact of the AIDs crisis and the conflation by wider society with any kind of LGBTQ+ identity as something deviant or inherently sexual. Many participants touched on already holding an internalised sense of difference and then witnessing the non-acceptance or having queer labels hurled at them as insults. For some participants these experiences caused them to suppress and hide their sense of their gender and increased feelings of not having a place in the world around them, even when seeking MH support for fear of further rejection.

The two cis female participants recounted coming to terms with ‘femininity’ and sociocultural pressures of what it meant to find a sense of belonging through adopting and subverting labels they claimed or were prescribed to them, like ‘tomboy’ or ‘dyke’.

“And he was like, just the way you dress, you're a bit Dyke-y”. (Lina)

Both ultimately found strength and meaning but named finding their own space within their gender and in using terms like ‘tomboy’ positively, moving through the negative social pressures to conform to a standard that did not align with their own felt sense of femininity and finding a sense that connected them to their gender in a way that was affirming , finding confidence in how they navigate the world. There was a sense of the historic and hard fought for feminist movement to expand the category of ‘woman’ in cis women’s sense of self, which was held alongside their identity as queer women.

4.3.1 Finding the language of my folk.

The TGD participants described finding language through meeting other TGD peers either online or around them and representation through media and literature. Finding the language inspired

profound moments of realisation or opened the door to a more gradual journey to affirming their Gender Identity (GI). Previously the lack of belonging or reflection of their gendered experience in the world around them increased feelings of isolation and being able to identify gender as the source of distress or difference. As TGD participants sought to make sense of their identities alongside their cis peers and families, this building felt sense of difference frequently caused anxiety. When acting authentically in ways that aligned to their gender, often this would be negatively appraised by others.

“I never felt any like, a sense of gender …. My family started teasing me ‘are you a tomboy’ I would say No. ‘Or are you a girly girl’. And I'd say ‘no’, and they said ‘Well, you have to be one or the other’. And I kept saying no. But it became obvious that there was a correct answer. And the correct answer was girl.” (Malachite)

Some linked their distress directly to gender and others named knowing their gender difference was a key part of their identity but did not relate to ‘gender dysphoria’ as a concept. Those who felt confident in the stage of their transition felt anxious about their concerns being located within their transition.

“I knew I wasn't a woman, but I didn't really have the language.” (Teddy).

Mostly participants felt they could discuss a range of issues to their MHP without their GI being located as the root cause but frequently had to educate professionals on their identity and felt limited by language used by mental health services.

“And it wasn't until I realised what that issue was that all of a sudden, all the tools made sense” (Charly).

Participants shared lacking safe spaces to express themselves during childhood. All participants shared experiences of feeling pressure to conform within prescribed gender norms from a young age and often felt limited by normative gender expectations before they had the language to categorise their own gender. The marginalisation of TGD identities and conflation with sexual orientation and sexualised behaviour has meant prevailing conservative narratives limit young people's access to queer knowledge (Mizlock & Hopwood, 2016). Upholding that binary masculinity and femininity are the only way to be leaves those TGD and cis youth that do not fit the current definitions of ‘normative’ with persistence feelings of discomfort and uncertainty.

Gendered categories were not felt to be universally bad. Labels help provide meaning and a way to construct a sense of self and find community. Categorisation became oppressive when perceived ‘failure’ to fit neatly within box assigned to them was rigidly upheld by corrective, coercive responses intended to enforce the gendered expectations held by those in the participants lives.

“They had ideas of what they wanted their children to be. And my brother fit it perfectly. And I just didn't”. Dan

Two participants identified as cis women; they described how femininity could feel limiting and something not always congruent to perform. Both described journeys well into adulthood and some periods of gender questioning, before feeling secure and confident enough to assert more personal definitions of femininity.

“Maybe this, maybe I shouldn't be this, but also society… Just putting pressures on. Oh, you need to figure out everything. You can't just not have a label. You need to figure out what you want to be like.” (Maxie)

The cis women acknowledged that femininity allowed a freedom of self-expression and variation which was associated with confidence with age, belonging to a ‘newer’ generation and finding space within certain subcultures subverting certain norms in ways that benefitted them.

I noticed an expectation in myself when asking participants to use more descriptive and detailed terms when describing their gender, due to my own experience in finding meaning through language and reconciling with elements of my own life and experiences of societal structures and how they inform my sense of self, like internalised misogyny. Participants shared how hard it was to put into words what their gender meant to them. I reflected on my own experience of struggle, and the comparison of more binary aligned trans spaces which I did not always relate to, then discovering the terminology of ‘genderqueer’ folk.

An assumed, but also mutual shared understanding multitude of varying presentations between myself and the participants, might have led to taking less time clarify to feel understood, but needing more words and convey meaning to cis peers, despite not necessarily having concluded about a shared terminology. Some TGD participants would refer to me, in my role as interviewer in an ‘us’ in reference to the shared experience of TGD people. On reflection I would have liked to spend more time thinking about the experience of what language or communications helped participants feel understood in MH settings. However, at no point did this difference in language used cause me to question or doubt the testimony of my participants, my own lived experience and

struggle to accept myself and find language that fit me, privileged me to accept the diversity of ways TGD participants expressed themselves.

Participants reflected on how rare it is to be invited to reflect on gender, despite the shared stories of how gender norms might have been enforced by others in their lives, lack of non-normative language or even language to explore variation within the gender binary, limited the participants opportunities to explore their gender with curiosity and acceptance.

4.3.2 Unmasking gender authenticity

Participants shared varying experiences of a felt sense of difference during early life experiences. Some could identify an innate sense of knowing they wanted their gender to be different. There was a running thread connecting all participants of an incongruence between how they authentically felt and how others perceived their gender presentation. Not keeping in line to how gender was perceived by others was met with negative social outcomes, participants did not feel able to make free choice outside of the prescribed normative categories.

The standards often felt unclear and what the ‘gender rules’ were until they were broken, which often felt uncertain. Some participants, particularly those labelled as masculine felt there was more freedom in early life, with many participants describing gender restrictions increased sharply with the onset of puberty.

“When I was little. I was a little bit more girly in that, because it was kind of forced on me a little bit…and then, when I started like growing up and having my own brain, I'd go. I'm not wearing that dress” (Milo)

Some participants could clearly identify things like ‘girly-ness’ or a struggle to connect to more traditional masculine activities and traits, those with identities outside of the binary identified more a global discomfort that was not yet explicitly or entirely attributed to gender.

“I'd wish upon a star that tomorrow I wake up and be a boy day after day.” (Dan)

Caregivers and peers were the first enforcers of gender rules. Experiences were shared of trying to conform or ‘play the game’ in attempts to seek acceptance, often hoping to discover connection to their assigned gender. Malachite hoped puberty would be the ‘trigger’ to help connect them to femininity,

“I was deep in denial. I still was pushing it down and basically not thinking about it and like not thinking about it and like, just assuming all the sudden like, growing up, still didn't really feel like anything, and I didn't get everyone's excitement on a lot of things on being girls. So, when we learnt about periods and stuff I was like, oh, once I get my period, I start developing then that that will kick it. That will fix it. I'll start feeling like everyone else. And then I didn't. I ended up feeling worse.” (Malachite).

I resonated with their feeling of hopelessness, as increasing comments on my body and stories I was told about puberty and what was expected of me and my appearance as a woman. My ‘tomboy’ traits that had always been coupled with bribes to wear skirts and dresses, were becoming increasingly noted. Adults and peers policed my appearance, bullying my non-conformity and shaming failed attempts at femininity.

“I was bullied relentlessly from the day I went to school. And it only got worse when I went to college... But at that time, I wasn't behaving like a boy.” (Charly).

Puberty and the pressures of schooling to conform and achieve a clear path to adulthood and relentless social checking from peers were present across the participants experiences. Bullying was seen as unavoidable and profound feelings of isolation and loneliness were common.

“If I hadn't been raised in a society that shamed any kind of self-acceptance out for me, yeah, I probably wouldn't have ever really considered myself as a man…. And deep down I had admitted it, but obviously consciously I kind of had to go along with it” (Claire).

Patriarchal gender norms enable systems of power and privilege to function as they are, policing gender expression and punishing perceived deviance inhibits internal self-actualisation and acceptance. Loneliness and social isolation are significantly associated with worsening MH symptoms and are frequently observed at higher rates in queer populations compared to cisheteronormative ones (Benson et al., 2023). Despite participants experience of explicit or implicit negative feedback around their gender presentation, the gendered social rules and roles that ‘cis society’ proposes are biologically inherent never felt clear or comprehensible. This sense of uncertainty inhibited participants ability to feel safe in themselves, both with internal curiosity as described by Claire above. Participants also felt uncertain about bringing their full authentic selves to interactions with MHPs, experiences of prejudice in their personal lives and directly from MHS

meant TGD needed to self-monitor and cautiously approach therapeutic interactions to protect themselves from transphobia.

“…. I'm just talking about other things in my life, and kind of leaving gender out of it (....) not having to justify that feeling and explaining the why it felt bad” (Milo).

Milo reflected on after being faced with having to educate his therapist on some basic TGD concepts in a way that they experienced as having to justify his gender dysphoria and GI, he would feel better off focusing on his general MH and wellbeing even when gender dysphoria might have played a part his distress.

Five of eight participants identified as neurodiverse, TGD and experiences of neurodiversity have previously been shown to occur at higher rates than their cisgender counterparts (Cooper et al., 2022). Some participants had traits identified or full diagnostic recognition of neurodiversity during schooling, but most identified as neurodivergent as adults.

Many neurodiverse people describe a conscious and subconscious process of ‘masking’ developed to defend against rejection and harm in a neurotypical world (Hake, 2025). Some masks provide a sense of safety in navigating a typical words and others feel more burdensome, all require a lot of energy to maintain. Participants experienced being labelled as different leading to social rejection. TGD people holding multiple marginalised identities face increased instances of oppression. Participants internalised that behaving in ways that subverted gender norms was unacceptable and developed ‘gendered masks’ to fit in, frequently, inhibiting their ability to authentically embody their sense of self and their gender.

When participants shared their neurodiverse and TGD identity to professional's, MHS cast aspersions on neurodiverse people’s ability to truly know themselves, regardless of their capacity and often did not take the time to listen and respect conversations around gender, blocking TGD people’s right to tell others how they would like to be and present to the world. Affirmative staff experiences were often located to individuals, not as part of a culture of acceptance in the service.

“I corrected the doctor about me being trans. And, you know, when you tend to be trans and neurodiverse... They're like, oh, well, because you're neurodiverse you can't know you're trans (Malachite).

Both neurodivergent and neurotypical participants described needing to hide their authentic sense of themselves when presenting to MHS. Feeling understood and supported gets blocked around issues of identity, with participants sharing professionals naming their own lack of knowledge around TGD folk and of working with neurodiversity, increasing misunderstandings and harmful assumptions when these identities intersected.

“But then it also gets stuck. And it's either my transness or my neurodiversity”. (Milo)

Participants felt their issues were not fully explored or unpacked by professionals, even when taking great effort to explain themselves, professionals would become ‘stuck’ on gender and neurodiversity. Leading participants to feel invalidated or misunderstood. Participants in line with research on experiences of autism and gender dysphoria felt they had to work very hard to understand themselves and sense of self in a world designed for neurotypical people, only to be met with invalidation and disbelief when trying to share their authentic sense of self to professionals.

Most participant's shared experiences of cognitive behavioural therapy (CBT) and struggling to feel they could bring their full selves during the intervention. CBT has been critiqued for its potential to be invalidating to those with marginalised identities, especially when labelling experiences as ‘cognitive bias' when participants shared experiences of transphobia.

“You know, asking me to like, change how I perceive, you know, the world right, which is just like deluding myself. Why would I?” (Dan)

Milo and Lina both requested to not receive CBT, Milo was told he would have to wait longer, and Lina suspected her thought that behavioural activation focused approach would not be beneficial for her was only honoured due to disclosing she was an MHP. Participants did not feel MHS were able to give them care that was truly catered to their needs.
Most participants reported experiences of bullying that impact their MH, bullying was attributed to their gender presentation and how they presented to the world, often increased by peers picking on behaviours linked to neurodiversity.

“I knew that I probably was not safe at school because of how much harassment she was getting (fellow trans student) and bullying and stuff. So, I was getting bullied anyway, because I was perceived as being weird, which I assume was neurodivergent” (Teddy).

TGD people faced social pressure one multiple fronts to meet standards around appearance, mannerisms and social behaviour, the need to exist in a way that was accepted but felt aligned with the internal sense of self (Merit, 2025). To live authentically is denied and supressing gendered feelings was a shared experience across the group. Social norms around gender roles and stereotypical behaviours strongly influenced how people around participants responded to their needs, both regarding neurodiversity and gender. Participants faced rigidity on multiple fronts to meet standards around appearance, mannerisms and social behaviour. Others often did not accept their needs because it did not fall in line with gendered stereotypes. Even when seeking help, participants would be met with stubborn expectations to present a certain way. There was an overall sense that to receive care, some authenticity had to be masked.

“Admitting to myself accepted to myself I was trans. I did think to myself, about descriptions of masking and do some very similar to. So, it's kind of like...Me Learning to supress hand flapping and public kind of thing was very similar to me learning to not uh that my wrists go limp in public as well, or even privately” (Claire)

For neurodiverse and TGD participants much of their embodied experience was policed. TGD people also learnt different strategies to both mask behaviours labelled as not aligned to the gender assigned to them, suppressing a more authentic self. Then learning strategies that felt more affirmation to ‘pass’ as their chosen gender.

4.4“Is your gender gender-y enough?”

This theme explores how external narratives around gender, and social interactions clash with how TGD present themselves in the context of interacting with mental health services and especially if participants were considering seeking referral for GAC. TGD and other marginalised communities should be able to expect to be met with the ‘do no harm’ and non-judgemental, unconditional positive regard, promised by MHS. However, TGD have learnt to be cautious and expect at the minimum to be met with ignorance and at worse violence.

TGD people face pressure to align to more binary expression to be ‘believed’ or accepted for a referral (Seelman et al. 2017). Participants feared gatekeepers who decided whether their gender met obscure standards of being ‘good enough’ to get by. This theme also explores in more depth how the enforcement of gendered expectations blocks authentic connection and increases negative perceptions of self for the participants.

Although this research focuses on experiences of access to MHS in the context of therapeutic support, gender affirming care whether by in the NHS or private sector, and the difficulty in accessing this was still a backdrop to the context for many of the conversations around accessing support. Participants described stories shared within the TGD community of the limitations resulting from the experienced ‘binary transitions’ bias which was another barrier to being able to be their authentic selves in MH spaces.

“I know {Redacted GIC} are not great with non-binary people and because you want to have top and bottom surgery. I really suggest that you go in there and say I'm a man. And leave nonbinary at the door and pick it up on your way out and he did, and he got through the system faster because if you're nonbinary you need three appointments before you can do anything rather than two” (Dan).

This story very much matches on to my own, when marginalised groups are pushed to the sidelines of society, labels become concrete and fiercely upheld clans in which membership is policed, from my queer sexuality to my non-binary gender was never quite ‘enough’ for any LGBTQIA+ space I tried to find community in. A therapist I was working with stated that nonbinary was something modern she was not familiar with. However, after several occasions of misgendering me, and my request for her to look up the terminology surrounding TGD identities, as important to me to not be seen as a cisgender woman, she stated that it was unreasonable expectation for her to read up on ‘such a big topic’ despite my request being only to use language that made me feel comfortable,

This bias is further perpetuated in the rest of the world, lack of visibility upholds the notion that non-binary identities are not valid, participants shared stories of the doubt and prejudice from people around them and within the TGD community itself that the only valid transition is a binary one.

“Especially ‘cause When I say I'm transmasculine, if I'm interacting with guy professional, I'm saying “hey, I'm the same as you” while looking very much not the same as them, which I think caused more disconnect”. (Malachite)

Malachite's experience feeds into the notion that cis women are allowed a certain amount of experimentation within the socially acceptable perceptions of feminine. Whereas although afforded the privileges and power of patriarchy, perceptions of masculinity are more harshly upheld, leading to rejection by cis male MHPs who have not educated themselves or reflected on gender norms to reject trans-masculine people. This perpetuates prejudicial, invalidating narratives that frames trans

masculine people as simply ‘confused, unable to obtain any of the traits and subvert the powers associated with masculinity.

4.4.1 Binary norms create gender rights and gender wrongs.

Binary norms upheld by society bleed through to caring professions, leading to societal prejudices being repeated (Morton et al., 2022). This subtheme explores how participants perceived gender norms more explicitly, exploring how gendered expectations manifested in their social worlds. One aim of this research was to understand how MHS conceptualise gender, this subtheme explores the SU perspective, if participants felt they observed MHS consciously or unconsciously maintained gender norms in their interactions with them.

Almost all participants shared observations that feminine people do not receive social backlash for expressing emotion and accessing mental health support. However, this does not always result in feeling listened to or believed. Teddy and Maxie shared stories in their personal experience and as MHPs themselves around clinician bias and ‘feminine hysteria’ invalidating how feminine people express emotion and present to mental health services and the gendered bias in relation to certain diagnostic labels like personality disorder. Maxie shared accessing therapy throughout her childhood due to traumatic experiences, but upon reaching puberty her mood and distress were written off as ‘normal’ or hormonal, invalidating her experience and making it harder to access help. Several participants shared being aware of it being ‘harder’ for assigned masculine people to access therapy. They felt the social backlash being more explicit and harsher when masculine people show emotion in ways that don’t conform to standards of ‘maleness’.

“There can't be anything wrong with him because he has ticked all boxes that we, society have deemed need ticking for a good life. I think there's some whatever the opposite of misogyny...There's some misandry in healthcare services”. (Dan)

The possibility of gender expression outside of the binary label assigned to you becomes pathologised and punished (Heise et al., 2019). Suppression of expression outside of the gender binary creates feelings of isolation, as TGD people grow up and develop a sense of self, they internalise the message that something about them is intrinsically wrong or different. Norms are upheld and enforced often with little direct discussion about what exactly it means to be ‘male’ or ‘female’.

“My mother would try and put me in a dress, and I'd like, scream and cry and try and pull it off and she'd be like, just wear it for your granny for five minutes.” Dan

Labels appear to be as much for other people as they are for an individual, Maxie shared experiences growing up of feeling pressured to label gender and her sexuality when being able to exist in a more open space had always felt comfortable to her. Lina similarly shared.

“Why should you care if some of the ways I dress is a little bit, maybe more masculine? I have more masculine days, then days I'm more feminine?” (Lina)

Trans feminine participants faced significant opposition trying to step outside of the ‘masculine box’ assigned to them throughout their lives. Entering femininity is strictly and suspiciously gatekept. ‘Failing’ to keep to masculine norms, especially transgressions into displaying ‘feminine’ features as a male assigned person was met with harsh social critique and bullying.

“You know, I hate being a man and wished I could be something else, but that's just how things and for years I felt like, if everything wasn’t so negative against us (trans femme community) I probably would have been able to” (Claire).

Every TGD participant had experienced some form of stigmatised experience due to their GI when interacting with MHS, many arrived to MHS already having experienced stigma in other healthcare contexts. Teddy shared their experience of paramedics responding to their crisis call at a time before HRT and being perceived as feminine and experiencing misogyny and noticing shifts in how they are treated when assumed male and the privilege this has brought them. They reflected on how misogyny permeates MHS. MH institutions have been built through the lens of patriarchy and have the motivation to maintain its status quo built into its foundations.

“Oh, are you faking it, you trying to get attention? This thing of like? The narrative of attention seeking. The paramedic didn’t care why I was there; they were reading me as feminine or a woman. ….. And then I do think again, it's going back to these narratives of a silly woman can't control her emotions” (Teddy).

“I saw it a lot with like my friends who are identified as girls as well…We were just told to grow up so much faster than like the guys". (Maxie)

Gender norms were negatively enforced by many different places supposedly meant to provide support and care (Mesman & Groeneveld, 2018). Gender is rarely explicitly named around us, but is implicit in how behaviour is reinforced, praised, redirected and punished, especially during

childhood (Mesman & Groeneveld, Maxie reflected on her experiences at school and how teachers responded to her and her peers. Feminine people are both framed as less able to control their emotions but also to reach a level of maturity to become compliant and care giving to receive the pro-social benefits of feminine gender norms.

“If they work through their own biases, that they almost certainly hold passively and it’s not their fault, they have been raised in this society. But we should be able to expect that they have had to work through that themselves, as we've had to do” (Claire)

Participants described the significant amount of self-reflection and time spent to try and understand themselves and their GI and the risk they had exposed themselves to ‘come out’ and live authentically as themselves. Participants had often been questioning themselves and how they were perceived by others for much of their lives, even before coming to terms with their gender. Only to be met with doubt and questioning by professionals not even working in the context of GICs. To add insult to injury, doubt is often coupled with a lack of education or use of an evidence base to add clinical acumen to the doubting or prejudiced MHP inquiries.

4.4.2 Queering Questioning.

All TGD participants reported MHPs had very little understanding of TGD identities. Professionals generally had no frame of reference of what it meant to be a TGD person in the world and that they might experience minority stressors. Lack of knowledge was frequently coupled with the expectation that the TGD client educate the practitioner above and beyond what might be typically expected. Questions could become intrusive only satisfying MHPs’ interest, not collaborative with individual motivations for accessing MH support.

“I don't think she (nurse practitioner) really understood like the difficulties of living while trans. She didn't really ask me to, like, expand on anything…. Yeah. The questions were like politely given; I guess. But I really feel like she should have consulted some textbook instead of me.” (Dan)

Participants could acknowledge the expansive and evolving nature TGD terminology there was not an expectation for practitioners to know ‘everything’ but there was frequently a felt sense of discomfort in the MHPs when gender was discussed.

“And she said, if I get anything wrong, just let me know and I will change that. Which was good. I did have to sometimes have to stop and explain words, because obviously I talk on a lot of

other stuff, and I was talking about queer stuff. Which sometimes even people in the community don't know all the words” (Malachite).

TGD participants felt a vulnerability being open with professionals and how they were being perceived. The UK framework for GAC still requires a diagnostic label and pathway through MHS, even when not seeking GAC participants felt a sense of their experiences being conflated with mental distress.

“It boils down to most professionals really still pathologise us without necessarily realising it.” (Claire)

Curiosity was felt more often to have its origin in only gratifying the therapist rather than being mutually beneficial. Participants described MHPs asking questions that they had no reasonable or clinical rationale to ask. Participants did not report overt experiences of prejudice, but all encountered ignorance, administrative battles around use of titles, pronouns and chosen names and some microaggressions around their GI. Malachite reflected on their experiences in MH settings as well as their job working in a college, where colleagues similarly lacked the knowledge and curiosity to ask sensitive questions around TGD students, often positioning them as the expert rather than educating themselves.

“I don't want other trans people to go for it, so I'm happy to educate, but I would like the burden of having to educate people on ‘what not to say’ not always be put on me.” (Malachite) Dan recalled a therapist repeatedly asking to know his deadname despite having legally changed it some time ago and Claire shared a frustratingly common phenomena in the TGD of many people in their lives including professionals being perversely fascinated with their bodies.

“I think they were from ignorant rather than any real malicious intents, but it was quite uncomfortable… One that pops to mind is asking if I wanted any kind of…… surgery. You can probably figure out what kind of surgery she was enquiring after” (Claire).

Participants did not report overt experiences of prejudice, but all encountered ignorance, administrative battles around use of titles, pronouns and chosen names and some microaggressions around their GI. Milo shared an experience of his therapist perhaps authentically questioning the reaction to being deadnamed, highlights the importance of being aware of the impact of living in a transphobic world and having the validity of your identity regularly put under scrutiny. On the

surface, asking about a client’s emotional response to a question is a ‘normal’ part of building therapeutic rapport. But done without transparency or sensitivity can cause harm.

“He made a big thing of like. Oh, I'm sorry that I dead named you. And how did that make you feel? And all this? …. Some of some of his wording feel makes me feel like it's something… I've chosen.” (Milo)

Milo shared multiple examples of their deadname being used within this service despite having asked for it to be amended on the system on more than one occasion. TGD people who choose to change their names are frequently faced with obtuse administrative processes (like name changed at the GP does not translate to your CMHT). TGD feel at risk of being exposed by accident or malice when their deadname is used and having their identity being treated as a ‘choice’ to just change a name without any understanding of the transformative significance living with a new name can bring.

Some participants shared experiences of therapy before coming to terms with their gender and wondered if a sensitive clinician had thought to be curious about gender. This would have helped facilitate the journey towards finding the right language and overcoming their personal journeys of overcoming internalised transphobia and societal norms that had blocked their connection to a more authentic sense of self.

“If I had somebody who specialised in that in front of me back then...the last 10 years of my life would have been significantly different. They would have certainly been a lot calmer and more peaceful (Charly).”

This subtheme was dubbed ‘queering questioning’ as when asked, TGD participants all desired professionals to be better equipped with questions that facilitated gender exploration in ways that felt tailored to their personal context. Although many of the TGD participants had moved clinicians or changed to private therapy to feel supported, none of them reported only negative things about NHS clinicians. There was simply a desire for different questions to be asked. To queer questioning would be an invitation to ask questions outside of manualised approaches and to question the tendency to question the validity of TGD people's testimony of their gender identity.

4.5 Falling through the gaps” of a system full of cracks.

This theme covers the experience of navigating the mental health system and how GI might interact with this. Participants share experiences of long waits for care and of an awareness that in an already strained system the ‘non-normative’ needs of TGD are most likely to be missed.

““I think the mental health service relies on the gender identity clinics to deal with the mental health of trans people, which they just do not... They're designed so badly, and they function so poorly that they are not able to provide mental health support. I've never heard of any trans person actually having therapy.at a gender identity clinic.” (Dan)

There was a felt sense of ‘being a drain’ on a strained system and struggling to balance this alongside their own needs. In the painful wait for GAC, participants reported experiencing the feeling of their needs falling through the gaps, with the expectation ‘gender specialists’ were needed to support them with their wellbeing both linked when care is accessed it fails to fully understand and meet the full nuance and depth of their identity and lived experience. The responsibility to understand gender is othered and there is no felt sense of wider services wanting to improve their understanding.

There was a sense that MHS were not able to meet the needs of someone with multiple marginalised identities especially when therapists were frequently upheld white cis-heteronormative standard, professionals were forgiving naming the lack of education on cultural humbleness and gender throughout their own training but acknowledge its impact on therapeutic engagement and the need pick and choose what to educate a practitioner on, especially in the context of limited sessions in the NHS,

“I think sometimes because I haven't had a therapist who was from like, an ethnic minority background , every person I've had has been like white British, And so I feel like I have had maybe to explain certain things when it comes to culture oh, I feel like it just would have been too much if I had to explain things to do with gender as well.” (Lina).

4.6 Diverse Identities breach stereotyped tick boxes

MHS aim to provide care that meets people where they are at in terms of their identity and their individual needs, however for numerous reasons the services offered and the way MHPs are trained often creates a “one size fits most” approach leaving those with intersectional, marginalised identities with no choice but to engage with treatments not designed to meet their needs (Lowther-

Payne, 2023). Participants described experiences of feeling not listened to and misunderstood, leaving them feeling hopeless of receiving support with their MH. CBT was highlighted as ineffective, even when participants had previous unsuccessful experience of CBT, they described it being insisted upon or having to significantly longer for an alternative.

“CBT has really dogged on me, I mean apart from like a few very superficial things I’ve had very little benefit from it…. feels like it tells me there's something incorrect in me and outside of like a few superficial heuristic kind of things….it feels like being taught to lie to myself” (Claire)

TGD participants felt their transition was often highlighted by professionals, outside of relevant contexts. Not fitting the norm made them feel othered and viewed as something of ‘interest’ rather than a human person with unique needs like other SUs coming to get support. Participants felt the lack of knowledge around their needs that felt outside of accepted norms.

“Even if they had like a handout with the common things that we see in trans people, that they need help with their mental health…, Even if there were only five items like common factors that influence the distress of trans people it would be helpful” (Milo).

TGD identities and their expansive and multifaceted nature was understood as going against traditional models of help and support. Gender was often conflated with sexuality and themes were shared of them being framed as ‘specialist’ and participants mentioning being signposted to a local LGBTQIA+ charities for support, despite participants not feeling these themes were at the core of the issues they were seeking help for.

“Because we're breaching many stereotypes at once, and because of that, they find it difficult to know how to treat us”. (Dan)

4.6.1 The blurred identity of a helper seeking help.

Three of the participants also currently held or have held MHP roles and we considered how these ‘blurred lines’ of identity frame the experience of help seeking and feeling understood. They acknowledged how having their ‘identity’ of a professional could privilege them to having their views respected for care planning in a way they felt might not have happened for others.

“because of my career, I think I've maybe, I don't know if respect is the right word, but I think sometimes clinicians are probably a bit more able to be like, OK, so behavioural activation doesn't work” (Lina)

“When it comes to data or information regular people get a “needs to know only” as in they ask only questions ask questions they need to know to carry out the intervention. And in this case, they see Trans and they forget all of that it becomes “we'll just ask, because we want to” …. The Trans Broken Arm. Syndrome” (Teddy).

“Trans broken arm syndrome” refers to the idea that transgender people, particular those who seek medical pathways have their transition problematised when seeking medical care. For a trans masculine person even presenting with a broken arm, HCP might ask about testosterone levels or ask intrusive questions about their body. Dan shared a rare example of a clinician giving him an abdominal exam in A&E, providing care without questioning his gender which was a rare and valued experience, where previously upon finding out he is trans, clinicians frequently ask about his HRT despite there being no relation to his presenting symptoms.

As a former MHP, Teddy knew protocol and processes in detail and theorised the professional had felt entitled to disclose the information as ‘essential’, overruling Teddy’s consent and request to not share the information. This completely disregards the reality of transphobia within the system and frames the wider context of TGD epistemic injustice and not being granted autonomy over their own identities.

However, there was also a level of vulnerability in which parts of themselves were safe to bring to work particularly around a sense of non-acceptance about how visibly TGD and queer folk could be a be accepted as MHPs.

“We all bring ourselves to work. Some people can bring themselves more than others.” (Teddy).

4.7 Obstacles on the path to identity affirmation

This theme explores the experiences that affirmed participants’ gender identity. TGD research, especially in the current sociopolitical climate, can feel overwhelmingly negative and hope can feel hard to grasp. Expression of TGD identities becomes associated with pathology and struggle. This Theme investigates the radical joy and self-acceptance that participants felt when accepting their authentic selves and the external barriers that might fall in their path. Affirmation is an expansive term that refers to multidimensional experiences of finding affirmation. Accessing GAC is one path to affirmation (one with many obstacles in its path). Affirmation might also look like changing

appearance, engaging in pastimes that connected participants to their GI and showing up in social relationships in new ways.

Non binary and genderqueer identities are frequently met with invalidation even from within the trans community, binary gender identities are seen as more valid or ‘real’. Malachite felt they experienced a lot of invalidation of being agender. Internally giving themselves space to realise their GI and work on the evolving path of self-acceptance.

“The biggest way I knew was through my gender euphoria and just by simply realising. Yeah, I really don't feel like any gender” (Malachite).

That moment of self-acceptance was momentous, and participants frequently had arrived at this following signification periods of self-repression and external opposition. Self-acceptance also came internally and externally. TGD participants shared the experience of overcoming negative perspectives built up over a lifetime that they were able to start unlearning when they were able to affirm themselves.

“It's probably one of the first times I've actually been able to look at myself in the mirror and actually feel happy about where I'm at…Which is nice, because I've never had that feeling” (Teddy).

Charly shared a desire for more visibility to help break down the barriers in TGD individuals’ way. She recounts the lack of visibility in at her GP surgery and how off putting this might be for many needing to access MH support or GAC through the gateway of their GP.

“Even in Pride Month, there was nothing in this. I've been in the surgery twice this Pride Month. There's nothing in their news. Not even one little rainbow flag on the window”. (Charly)

Affirming acceptance allowed participants a sense of freedom and connection to aspects of gender expression that had previously felt oppressive. GAC allowed exploration of expansive definitions of gender unshackled from binary expectations.

“I always struggled with the femineity that people were pushing on me. But now I am taking T. I've gone a lot more into it, which is like a more fag aesthetic coming through now, which I love” (Teddy).

Feeling more confident navigating the world with the masculinizing afforded by T

(testosterone), Teddy felt more confident to experiment with the parts of femineity in their dress and mannerisms in ways that affirmed their gender queer identity.

4.7.1 Being seen as who I am.

Participants described moments where they recognised within themselves a connection to an authentic feeling of gender as well as important moments of social recognitions where strangers or loved ones affirmed their identity through social interaction and how meaningful this was in feeling this authentic self be recognised externally. This subtheme was extracted as participant experiences in their interpersonal worlds that affirmed them, hoping to help cisgender readers understand more of the TGD lived experience and help informs ways of helping MHPs understand a nuanced view of TGD people's lives.

“And my mum commented on it and said, ‘that’s a vegetable my son!’ and I was like. Yeah, that was the first time I was like, the first time that she referred to me in that way” (Dan).

Recognition and connection with a parent online, having a stranger correctly gender you in public, seemingly small moments that might be fraught with invalidation or affirmation. Milo describes the affirmation from training his voice to be lower.

“We went into a shop, and the employee was like ‘you alright man', when we left the shop, my best mate just turned around and said, ‘in that shop your voice dropped like quite a few decibels!’. I explained, Yeah, cause it kept him going, as he had assumed the correct gender” (Milo).

However, validation can be hard to find, as can spaces to feel safe alongside fellow TGD people. Finding peers and connection within the TGD community was especially important in enabling participants to both come out to themselves and feel supported as they started socially transitioning.

4.7.2 “Why can’t I like pink & climb trees?”

Hobbies, clothing and other day to day activities are frequently labelled as gendered by cisheteronormative gender norms (Mesman & Groeneveld, 2017). Participants described experiences of affirmation alongside experiences of their intuitive play or following their individual instincts being opposed by societal gender norms. Participants described affinity with activities labelled as not aligning with the gender assigned to them across their lifespan, participants recalled more freedom in early stages of childhood and opposition that increased with age. Moments of being accepted and allowed to present however felt right were precious.

“One of my first, earliest memories, I think I was five is getting my mum to paint my fingernails, I wanted to look like her (....) I was the somewhat stereotypical picture of being more comfortable hanging around with girls and preferring girls' toys. Then it obviously it was uncomfortable to be like that, but that was where I was comfortable” (Claire).

When the ‘shift’ in acceptance of gender play happened during participants mid to late childhood this could lead to increased feelings of self-consciousness and anxiety. Malachite ended up disconnecting from previously loved hobbies and activities and restricting their self-expression to avoid comment and judgement.

“I didn’t feel like a girly girl or a tomboy... I kept being asked which one I was. I love pink. I love climbing trees. I kept being told you can only be one. I pushed it down, rejected it. and eventually rejected anything that got me called a boy or a girl?” (Malachite)

The constant comment and expectation from the cisheteronormative world that others, particularly children, must think, feel and behave in the expected ways inhibits the natural process of any person's experimentation in self-expression that makes up identity formation. When the ‘White euro-centric, cis-heteronormative’ socio-cultural standard of gender presentation becomes accepted as ‘normal’, all participants felt restricted and criticised because of their gender. None of the participants were White cisgender heterosexual men, so this perspective was missing to understand both the perspective of those with privilege and the negative outcomes that are expected to maintain those restrictive standards of masculinity.

Engaging in traditionally gendered activities that aligned with individual GI could be affirming, NBGQ participants aligned with masculinity shared the difference and sense of ‘male privilege’ could be claimed that could feel very affirming in how they were perceived.

“I'm gonna play the traditional pub games like play pool, darts. And not being assumed that I'm going to be shit, cause, of my gender (...) they’ll play with me as an equal and say they let me win” (Milo).

Prior to understanding their GI, some TGD participants sought ways to conform and blend in to avoid ridicule. However, this often a sense of affinity or something that ‘made sense’ like being called unladylike or being told ‘you throw like a girl’.

“I was quite happy sewing. I learned that in the Navy, one of the things the Navy I could do a lot of and help other people and not be ridiculed for it because sewing was useful skill to have.”

Charly had recalled finding space within the often hypermasculine environment of the Navy to find socially acceptable ways to transgress social norms, the usually feminine past time of sewing that might have been ridiculed elsewhere. Gender norms were not fixed or as concrete, but often still harshly maintained. Participants often found niches, subcultures or ‘functions’ like Charly’s sewing skill to try and express themselves within or against social expectation.

4.7 Staff Themes

The following section explores the themes analysed from the current NHS Mental Health Professionals (demographic details found in table 8 in chapter 2). Questions surrounding the current state of MH care for TGD people were influenced by the themes from the service users.

Table 10 Themes for Mental Health Professionals		
Bridging theme: Safe to question, Curious to Understand.		
Main Theme	**“Questions we feel entitled to ask”**	**Shared experiences of otherness and empathising with trans & gender diverse experiences**
Subtheme:	“The pressure to get it right” - avoiding misattuned gender assumptions	“Power rests in masculinity decisions and the judgement... feminine people are the ones that will be doing the caring” Domineering narratives & accepting difference
		Staff reflections on Gender Identity, who gets to self-define and who gets gender prescribed?

4.8 Bridging theme: Safe to question, Curious to Understand

‘Safe to question, curious to understand’ overarchingly connects the themes of the MHPs, a complementary reflection to the SU group seeking safe space in which to both nurture an internal curiosity for their gender and be received with empathic curiosity. Staff reflected on their personal experiences of identity development and how existing structures and societal influences can inhibit the ability to explore GI safely and curiously in MH settings.

Almost every participant shared experience of ‘nontraditional’ gender role models and parental acceptance of difference and identity exploration, although this may have fluctuated over their childhoods or were set in a wider context of social prejudice and other adults and peers enforcing gender roles through bullying or other corrective social interactions.

“I would say my mum didn't fit traditional gender roles. She wasn't feminine... We didn't See putting on makeup and perfume and spending on clothes and she worked full time all her life.... But my dad, I would say, had. Stereotypical gender views.” -Sue

These experiences gave participants space to reflect on and make space for their own definition of their gender identity in ways that both aligned with and subverted ‘traditional’ gender norms. Community and peer connections were also crucial in nurturing a curiosity in understanding the experience and identity of others.

Formative messages around gendered expectations and societal shifts informed participants understanding of their own gender and their broader sense of gender norms. LGBTQ+ participants and those who had experienced being minoritised shared more frequent experiences of questioning their sense of gender and how the wider world perceived them.

“Coming from like a bit more of a Bohemian family household, I felt a little bit more privileged to make choices about what? Who do you feel more connected with? Whereas a lot of my friends may have had those feelings, but they were very much hedged in tradition and customs that were linked to spirituality” Kian.

The socio-political context for TGD people was named by several participants, alongside the sociopolitical factors that had influenced individual pathways into a career in mental health and making sense of personal values alongside that of the NHS.

“I think thinking a lot about fear, but more systemically, again thinking about what's going on globally in the world, but then also historically around gender, gender differences, LGBT. It feels like scary things because. It feels like it's. encroached on belief systems and values and all these really big and intimate ideas and coming in as an authority to say this is right, this is wrong” - Lou.

Safety to question your own relationship to gender and identity engenders curiosity about the gendered experience of others, staff also shared thoughts about how their professional orientations, particular team cultures and wider systemic factors might influence MHPs’ approaches to thinking about gender at work.

“It can be ignored in; in other professions I don't know. I think that when there is, I think it could just be added to like another list of. For example, if someone was nonbinary and they were experiencing X, Y and Z and this I'm very aware is my biased view towards the medical model, but it can just be seen as a diagnosis.” -George.

MHPs also referred to concepts such as ‘the social GRACES’, a commonly taught sociological model of identity for psychology and psychotherapy trainees (Burnham, 2018) that sparked their curiosity and increased confidence to name gender in their work.

“Our leaders and our supervisors of supervisors of supervisors are kind of coming from quite old and kind of stayed conversations around gender. So, I think if that's if that's the kind of. Heritage that exists in a place like a family therapy clinic and then we've got, you know, younger people, younger conversations and language that is more pertinent now. I think there is some slippage between those two kinds of spaces” - Kian.

Generational divides existed within professionals and their perception of the SUs they discussed, feeling that most young people were more open and connected to ‘newer’ language and terminology and elders being perceived as resistant or only connected to TGD issues if they had a personal connection outside of their working lives.

“Resistance comes mainly out of fear or uncertainty…. People are not sure how to have conversations around gender. Maybe they are not sure how that might play out clinically. Often, I hear people feel like there needs to be ‘specialist’ understandings of gender before being able to work with it.” -Lou

The professionals also perceived current socio-political attitudes to be increasingly influencing the wider MH system, both regarding largely societal awareness of concepts like trauma and in reflecting wider societal prejudicial beliefs. Participants largely showed an awareness of negative transphobic attitudes currently prevailing could contribute to normative gender perspectives.

Patriarchal gender norms perpetuate the need for assimilation and hegemonic standards, which prevail in mainstream narratives and become systemically entrenched (Horton, 2025). MHS have the power to conceptualise what is normative, non-normative gender expression are concretely accepted (Ellis et al., 2014). All participants felt that often only those that experience the minority stressor influence of patriarchal cisheteronormative take time to reflect on the role of gender in their own and their client’s lives.

“It hasn't been great being female, I think through now I've enjoyed being female. more recently probably. But yeah, I think it's positioned me perhaps in life that's given me less confidence. Less of a voice. And that's taken time to regain…. (the family therapy clinic) Gave me an experience of males as not always being overtly misogynistic and and that they listen to your opinions and that there's other ways of seeing the world. My view of their view.”- Sue

Sue reflected on how her status as a female professional evolved with age and experience. Her sense of safety and ability to express herself as a female professional were shaped by her experiences of an oppressive, sexist society across her life span. She noted how the nature of patriarchal gender norms, coupled with structural hierarchies within healthcare made it difficult to find safe environments to curiously express themes of gender. In her reflection she highlights how both societal gender norms and healthcare hierarchies are expressed and enforced in both implicit and explicit ways. The type of team and the culture of the workforce also had a profound impact on how sensitive discussions around gender and identity more broadly took place.

“As a gay man, noticing like male privilege and not being the typical kind of fit with the patriarchal society that we're in, so I feel really comfortable naming that when working with clients” – George.

George reflected on how he holds privilege as a white cis male professional, as well how he does not conform to traditional ideals of masculinity as a gay man. His personal experiences of being othered and labelled as feminine and the influence of the supportive relationships that validated his identity enabled him to develop a personal and professional curiosity around gender norms. His professional curiosity brought him to reflect on how gender is an important factor in how clients navigate the world, as well as the confidence to broach these conversations with clients of all gender identities.

4.8.1 “Questions we feel entitled to ask”.

As shared by SU participants, empathic questions about gender formulated in line with the experiences shared with professionals feel rare and most frequently gender is left out of the room entirely when accessing MHS. The themes informed a question to the professionals about their experience of asking questions about gender and if they had any reflections on discussions about TGD people amongst their teams.

> “What gets in the way, I think it is that that I do think we feel entitled to ask questions and don't check it out, anything else you know. And I think we should do”. -Sue

MHPs had gained confidence across their careers navigating challenging clinical situations, asking questions that might cause distress and navigating the resulting ruptures and repair. Issues of GI felt riskier to raise.

“Then there's this very reactive, very sort of shame and guilt led moment where someone says, oh, what have you done about race or what have you done about gender? And then there's this sort of like, oh, we need to have this sort of like. Very reactive space” – Kian

Discussions of identity can increase tension and a vigilance for the ‘right’ next step. Participants shared their experience of a wider socio-political setting of wider society and their colleagues’ and team's own contexts and the frequently unspoken differing beliefs that can lead to prejudicial interactions for TGD people.

“If you come up against the sort of clash of people who are saying you your experience is not real and then somebody saying no it is, then it's really tricky territory because, I would imagine NHS policy don't want to discriminate against staff whose belief is that this doesn't exist But there's some human in front of you saying this does exist.” -Heather

Participants observed some increase in conversations around other intersections of identity such as faith and race. These too required significant improvements in order to improve staff and client care. However, it remained challenging to narrow in on what about TGD issues caused continuing hesitation and avoidance.

“That kind of like lack of expertise and feeling like there's, you know, needing to have someone external with all of these years of experience..., but there has definitely been in the past working with clinicians where there has been someone that's presented with all sorts of difficulty and has been focused. been a bit” - Lou.

Conversely, participants observed colleagues could often frontline gender with gender nonconforming people even when this was not desired by the TGD person.

“The medical model kind of like pathologising model and more recently and more sort of like… a trend being linked to sort of being more trauma informed. And those and interestingly, I think things about gender diversity and racism. Are inherently about trauma and inherently linked to kind of Pathologising narratives” -Kian.

Pathologisation of TGD identities were raised by several participants, the fact that to access GAC, people are required to access a diagnosis has been deeply conflated with a pathological way of being compared to a ‘normative’ cis gender identity. Kian shared similarities of those suffering from traumas experienced by systemic racism where the racialised other is seen as pathological rather than acknowledging the socio-cultural nature of racism and trauma and the part the system plays in it. An inflexible categorisation of gender as normative not only invalidates the experiences of TGD SUs but many cisgender professionals fail to conceptualise a reality in which TGD experiences exist.

4.8.2“The pressure to get it right” - avoiding the misattuned gender assumptions in an under resourced system

All participants were currently employed by the NHS and four were currently seeking further training both through the NHS and individually to develop their careers. All shared their understanding of under resourced, ‘strained’ systems with high staff turnovers. All staff, but especially cisgender clinicians feared ‘making mistakes’ or falling into saying something harmful or offensive although examples of this were hard to define. Cisgender staff could identify a hesitancy in themselves and the settings they worked in around having conversations around TGD identities.

Comparisons were also made between community and inpatient settings, with great variability between teams around cultures of acceptance for themes of gender or diversity or changing administrative processes that otherwise ‘work’ to include pronouns and chosen names.

“Where I worked in the Community, I think there was a lot more kind of understanding about it. I definitely think that there were like some forms and things that we were using” -George.

Teams with high caseloads or an expected fast work pace were also theorised to have more challenges making space for training or making space for the complexity of more fluid concepts of gender against previously accepted ‘simple’ gender norms. There was a sense that moving beyond ‘not knowing’ or taking the risk to a ask a gendered question that could be poorly received might result in a loss of status. In training and team discussions, other factors and the narratives about the nature of certain work environments are prioritised.

“I think because of the overwhelming nature of where I am right now, it can be very easily passed because you're trying to quickly get all the important information because these people are at risk, clients So I think if there was a way to slow it down or find out before that happens, it might be beneficial.” - Viraj

Every participant mentioned a lack of training on TGD issues at all stages of their training and continuous professional development (CPD). When training was available it was likely to be raised by a colleague who identified within the LGBTQIA+ community, highlighting the onus being on queer professionals to have their communities kept in mind.

“One of the leaders is a gay woman and she's spread this training for us to join the trans allyship....I remember feeling really pissed me off because the manager of the service sort of could see I was in the middle of the LGBT+ trans ally training, but like pulled me out to talk about something and I felt it was a little bit like... I don't think this is important, so I'm going to talk to you about something.” - Heather

Finding time for non-mandatory trainings can be challenging, and training on gender identity is frequently ‘lumped’ together with LGBTQIA+ themes and specific sessions had to be sought out by participants in their own time. Heather shared an example of how non-mandatory trainings, especially those on identities, can be de-valued in the system.

“It's not just about like. didactic teaching, you know, like this is what you will learn about like, its conversation, that is kind of helping them flex muscles that they've never used before, or maybe flexing muscles that they've used in their personal life, that they haven't been invited to use clinically. Yeah, I just wonder about kind of like how we're inviting people to jostle together in a in a safe way”. – Kian

Kian highlights the importance of moving beyond conceptualisations of learning that are wholly based on the acquisition of information and absorbing knowledge, but about experientially

engaging with discomfort and being able to inhabit discussions around topics. Working to acknowledge that as clinicians our own gender and relationship to gender norms will naturally influence how we engage with the topic.

“Training staying all levels. Mandatory... Spaces to ask questions because most of the time the people that ask questions are the ones that are allies and curious and the ones that fear getting things wrong. That stops the conversation for those with less knowledge. So having space for any and all questions…that’s anonymous”. - Lou

The onus for making space for themes of gender falls on members of the community, Lou, George and Aylin identified as openly queer at work, and reflecting on their desire to represent and make space for TGD issues.

“I think in my new job there are more openly LGBT people, which helps but ... I am the LGBT+ champion in my service, so it kind of falls on me automatically so I end up being the person who talks more about gender or like what is available services support.” -Aylin

Aylin went on to share her concerns of lacking knowledge of the needs of TGD people as a cis professional and despite having personally sought additional training, as champion she was the only one to attend and share findings with the wider team. Being visibly queer in the workplace comes with its challenges and all three participants shared instances of non-acceptance from colleagues and patients. Lou shared advocating for TGD clients in team settings but noting resistance although this was not always overt.

“But there's definitely been again, like I said, whispering for, or things that are being said when I'm not in the room, or hearing from afar. - Lou

Most participants shared their doubts that any meaningful outcome would come from raising a complaint about encountering transphobia. Two participants had either personally raised a complaint or were close to a peer navigating a complaint about TGD prejudice and had not felt the outcome had led to opportunity or support for learning.

“The NHS, feeling quite under resourced and strapped staff as it is, and I think that there it feels as if there's certain things that are like crumble points that would be that people would be kind of reprimanded for like I can. I can imagine if that was like a racial comment that the making about something, I can imagine that would be dealt with a lot more.” (George)

Themes of identity were felt to be ranked into terms of ‘importance’ or relevance in the mind of MHS in which gender is at the bottom, discounting its relevance in the lives of both TGD and

cisgender SUs. This categorisation of identity as a distinct constructs fails to capture the complexity of clients and staff holding multiple intersectional identities.

“Or they're not aware that, for example, someone who's trans might go to a queer thing and face transphobia. I don't think they're quite aware of these kinds of things.” -Aylin

Viraj reflects on how as his team services a predominantly South Asian community, there is an assumption by the wider team that discussions of gender and queerness don’t need to happen due to ideas about the community and faith making this need unlikely. Working in a different team, Aylin shares her own push to provide good signposting for staff around Queer Muslims, which would likely have been missed without her own unique intersectional perspective.

“We can always blame time. We can always blame financial resources. But I generally do believe that there needs to be a better drive and a better push for it because so many people are being missed. So many things are being missed and you're not serving the demographic because that's what we are meant to be doing.” – Viraj

4.9 Shared experiences of otherness and empathising with gender diverse experiences.

The stigma associated with minority stress theory created a lens for empathic understanding for TGD people by participants with minoritised facets to their identity. This theme explores the generously shared experiences of feeling othered throughout their lives and how these brushed up against individual understandings of gender and how their gender was perceived by the wider world and instances of how their intersectional gendered identity interacted in the workplace.

“I'm a straight cisgender man and somehow, I feel like, you know... There's definitely a heartbeat in me around it because I feel like part of me has an experience in a different way. Where I inhabit something around, you know, being racialized in my practise, and that means I have a when you talk about our curiosity about harrowing experience, but somehow, it's blocked when we get to talk about gender, I feel a similar experience happens around race,” – Kian

“I find it's not just gender, but with other kind of minority stuff. I think that people can find it really difficult to sit with the idea of having privilege. So, I think that male colleagues that I've worked with before. I've had experiences of people. Getting quite defensive of the idea of being privileged in some way because obviously people from all walks of life will find there are challenges.” - George

Lou and Viraj both reflect on client expectations and service constrains when a request is made for a clinician of a specific gender.

“I identify as a South Asian man and. It's been positive most of the time where I feel there's been clients who have really appreciated me being open and honest about who I am, how I feel, my identity. But in other aspects it's been a bit of a roadblock where people don't feel so comfortable. Me identifying how I do and some part I put it to me being South Asian, but some part was just purely because I identified as a straight man” – Viraj.

Viraj shared an intervention of working with a cis woman who had experienced sexual violence, perpetrated by a man and when a female clinician was requested, one was not available without a significant waiting period. Ongoing open and tentative discussions around gender helped inform a successful intervention overall, which Viraj attributed to discussions about gender with peers and supervision which gave him the confidence to explore gender in ways he had not previously thought of.

Lou shared their own discomfort when they meet a client, who then requests a therapist of a different gender.

“They see me and ask for a non-male Therapist and obviously that's not how I try and be really challenging. To navigate and to, you know, almost highlight the pronouns and put them in really large texts just to see if that helps you know, seeing a client having sessions and then one day saying like well actually I'd like to present how I feel like... but then I almost feel like I'm into assuming that I'm one way and then I don't want to come in presenting as someone different from their perspective” - Lou

Lou also shared the conscious self-editing they sometimes feel the need to do, to not make colleagues and patients uncomfortable and managing their own bias and not “shoe-horning gender diversity into their work”. Similarly, the other queer staff participants shared their careful reflections about their personal perspectives and curiosities around gender and queerness. There was a joy in working with LGBTQ+ clients but an awareness of how frequently as the ‘out’ staff member all the LGBTQIA+ SUs will be put on their caseloads and how it protected cisheterosexual staff from developing experience.

4.9.1 “Power rests in, in masculinity decisions and the judgement... feminine people are the ones that will be doing the caring” - Domineering narratives & accepting difference.

This theme explores stories shared understandings of gender norms (GN), spoken and unspoken, and their influence over the participants’ own lives and conceptualisations of their GI and if they felt gender. All participants could name their sense of overarching GN and how these influenced assumptions and engagement in professional settings. Staff reflected on the repetition of traditional GN within MHS.

Many of the staff participants reflected on noticing that outside of certain professions like nursing or occupational therapy, the predominantly client facing roles were occupied by feminine people and leadership positions were occupied by predominantly white, cisgender men. SU participants similarly reported most of the therapeutic staff tended to be white feminine people.

O’Neil (2015) reported that despite shifting egalitarian attitudes relating to ‘working women’, prevailing attitudes in the UK still associate men as the ones who ‘should be in charge’ in workplaces. Their research suggests that cisgender white men do not question gender as to them it is invisible as a factor that influences their lives. Findings like this further cement notion that TGD people are devalued and deprioritised as those in leadership roles are blind both to their existence and importance.

Across the participants there was a shared sense of unfamiliarity in speaking explicitly and openly about their own gender and a sense of dissonance that the influence of GN could be named with ease, but personal reflections felt more novel and interesting.

“And even like you asking me about being a woman anyway it, kind of you know it, brings up things for people, doesn't it?” - Sue

Sue and Heather had reflected on the changing social capital that came with feminine gender norms and aging and how this influenced a sense of invisibility navigating social worlds but increased respect professionally and increased confidence in their sense of self or challenging different social dynamics at work that might not have felt possible as younger women. Patriarchal gender norms heavily influenced most participants development of their identity.

Apart from two clinicians based in a family therapy team who more frequently saw multiple people at once, all participants reflected on predominantly seeing feminine clients and working alongside feminine colleagues.

“Even now in the psychology team, I'm the only male and that's doesn't feel strange to me because that's So what I'm used to being all one of the only male members” –George.

There was a widely acknowledged concept shared amongst the participants that was conceptualised to be accepted by the wider cross-cultural system around them that; ‘talking about your feelings is feminine and masculine people should be stoic and suppress emotion’. This was noted despite the dissonant acknowledgement that men are still suffering and statistically suffer worse on gender binary MH outcomes.

“When I think about kind of like cisgendered stuff like males, females and their access to mental services, I think that it's been something that I've been aware of for a while that Cismen don't

access mental health services as often, but I can't think of any interventions that I've been in, like a community team or anything that's tried to address that... like, oh, great. OK. Men don’t talk. So at least we don't have. We'd have to deal with those referrals.” - George

There was a shared observation that generally across MH disciplines feminine people were on the frontlines and white masculine people were in leadership positions. Participants shared ideas around the ‘childcare’ tax and the pressure on masculine people to strive for the more financially lucrative positions to assume the expected role of ‘provider’ in relationship dynamics.

“Power rests in, in masculinity decisions and the judgement that calls on someone. Services do the caregiving, and feminine people are the ones that will be doing the caring” -Lou.

These overarching social constructs were thought to be widely accepted as universal and unlikely to be questioned without explicit thought that was hard to introduce unless baked into the foundations of a provision.

“I think unless things are explicitly meant... just as a sort of like first thought, that heteronormative structured spaces are like the default settings.” Kian

Cisgender participants shared a journey of finding space within the gender assigned to them, that although there was a comfort or strongly aligned connection to this not all concepts ‘fit’. This might have been expressed through appearance and dress or subverting notions of ‘power’ especially for those assigned male.

“I find it really difficult to describe now... But then it's always mixed in with all of these kinds of other, more harsh traits, which I don't quite agree with, like, well, men should be X because they are on top.... But I think that's why I feel quite conflicted. Because it Is trying to. Be strong but not be forceful” - Viraj.

There was a shared understanding amongst participants that although certain gender norms could be seen as ‘stereotype’ or not fitting with everyone, they were rarely questioned or named in clinical settings. Other factors like risk or diagnosis are prioritised and the intersectional influence of gender is rarely acknowledged.

“I don't think I've ever been in conversations that have spoken about Or at least, you know, gendered experiences around mental health or physical issues that are then thinking well. How do we engage gender diverse people either?” - Lou

Cis-heterosexual participants shared stories of considering themes of gender around parenthood or relationship dynamics. There was a sense that discussions that suggested flexing or breaching accepted gender norms (e.g. household division of labour) could lack depth and inviting

curiosity both for the therapist and client felt uncertain, despite the idea that gender clearly played a key role in these interactions. The lack of modelling and training creates a feeling of being deskilled, which becomes amplified around discussions of TGD issues.

“It's really tricky because I also don't want to be a kind of. It almost sounds like ‘I don't see colour’ by sort of dismissing somebody which is not my intention”. - Heather

Heather shared an experience working with a trans woman, who had previously mentioned her GAC care being managed by a GIC. Heather shared that she wanted to respect and treat the client like a woman and decided to not mention gender or the client's transition unless it was explicitly named. Heather shared her dilemma and reflections on whether this might have been affirming for the client, to be silently affirmed with space to simply discuss her healthcare needs or if not mentioning any potential experiences of transphobia or TGD concerns unintentionally silenced her. The fear of unintended harm remains strong, and the strength of normative gender narratives increases ‘ally’ clinicians’ fear of pathologising TGD identities.

The notion of ‘not seeing colour’ alludes to antiqued notions of treating everyone of a racialised identity as the same as each other with the naive assumption that, in any interaction, the complex factors caused by systemic racism can be put to one side in the name of ‘equality’. Although many trans people might find it incredibly affirming to be simply treated as their identity, there is no one-size fits all and without careful individualised exploration of gender, there are more chances for understanding to be lost.

“I think there's an anxiety about engaging in a conversation about gender and then that kind of like tripping into a conversation about someone's pathology.” – Kian

Kian shared a hesitancy that he felt could have shut down a more congruent exploration of a young transmasculine client’s identity, due to fears of conflating his gender identity to an experience of trauma. Several participants shared thoughts that the need for TGD people to be seen through MHS maintains narratives that TGD identities are pathological and other factors must be absent in order to ensure other factors are masking a ‘normative’ gender, there is little room for a ‘both and’ fluid conceptualisation of identity. To facilitate the beginning of more expansive conversations around GI between MHPs, how staff participants described their GI can be found in Appendix 4.

4.9.2 Staff reflections on Gender Identity, who gets to self-define and who gets gender prescribed?

Many of the professionals reflected on the many ways that gender is ignored or socio-cultural norms around gender and TGD identities are accepted as fact. Participants shared how TGD identities are often lumped together with LGB+ identities, further enabling those who meet the

cisheteronormative standard to other and disregard the role of gender. One of the research aims sought to capture a sense of how the MHPs understood gender as a concept and to understand if doing so encourages reflections about the role gender plays in all of our lives to increase curiosity and confidence around discussing it. This theme will share extracts of some of the professionals’ descriptions of their own gender.

“One pinnacle moment, swaying away from my identity of a man, but me being a Muslim man as well was quite difficult just growing up full stop. Like I remember when the 9/11 happened, like one of my teachers just grabbed me and compassionately saying. Son, I'm sorry, but I think your life will be different from here on out… And I think that also helps shape what myself, as a man should look like so that’s where the word power, protective comes from” (Viraj)

Being othered by domineering and oppressive narratives forced moments of reflection and for participants to find a language and a felt sense of their gender they could adapt for themselves within their understand of wider GN. Viraj additionally reflected on his career as a psychologist, a path sometimes viewed by others as not traditionally masculine and the importance of his identity in making space for himself. As well as the importance of having hobbies and interests that felt traditionally masculine to him, his interest in cars also helped him find ways to connect to male peers and clients through to more emotive discussion.

All but one of the professional participants identified as cisgender, which will be explored in later themes, but patriarchal norms and how cis-female participants navigated them influenced their own ability to connected to a comfortable sense of femininity.

“I'd say it's very strongly that I think I'm a woman and always have felt like that…you know, it's interesting because I'm getting older, I've really, I notice how. I'm treated very differently to have when I was a young woman” - Heather

As a ciswoman Heather felt confident in her identity but noticed various gains and losses with how femininity was appraised and valued by the social world around her. Other participants also to reflect on the varying degrees social experiences influence the gendered experience. Femininity and youth could bring others wanting to offer help and social capital. But was coupled unwanted and sometimes threatening attention. Age could bring more respect in some professional contexts but also brought an ‘invisibility’ and sense of being less socially interesting to others.

“I’ve really understood it to be well understood, my gender identity to be represent a representation or an expression of me. I'm not someone that fits well into so constructed boxes of

gender and nor do I want to, so. I think I found nonbinary a bit of a resting place where answers aren't necessarily needed, but that fits with me and my idea of me”. -Lou

Lou encapsulates the power of a label like nonbinary, as a term that inherently expansive in its definition, within the category many different experiences can exist at once. The label allows for comfort and for multiplicity. There are no restrictions or rules but a sense of positive ‘otherness’, expansiveness’ or ‘both/and’ place to expressive their GI. When traditional categories seek neat boxes with inclusion and exclusion criteria, the nonbinary or other identity labels that seek to transgress binary narratives can often be rejected. Lou’s resting place demonstrates the importance of understand individual relationships to language and how finding such language can be so beneficial for TGD people.

Chapter 5: Discussion

This section will provide an overview of the collated themes and analyse to what extent the research aims were met. This section will also explore whether these findings could be used to inform future training and service development for mental health professionals (MHPs) on understanding and supporting trans and gender diverse (TGD) people in Mental Health services (MHS).

This study sought to contribute to the exploration of how MHPs conceptualise gender identity in their clinical practice. Previous research has established a lack of education on TGD identities. This research wanted to understand if, how and to what extent MHPs consider the influence of gender when supporting the people they work with. Additionally, if they had worked with TGD people, considering if they considered their experiences and navigated conversations around gender. The research further centres the voices of TGD service users (SUs), seeking to explore TGD individuals' experiences of feeling their gender identity was adequately understood by MHPs when seeking help, either when accessing support for mental health concerns unrelated or related to their transition, or seeking access to GAC pathways.

5.1 Discovering diverse gender identities in an oppressively normative world.

The current socio-political landscape in the UK continues to intensify longstanding transphobic narratives in society, contributing to the marginalisation of the TGD community. MHPs and services have historically actively reinforced prejudicial, reductive narratives, framing TGD identities through the lens of trauma and other pathology and dismissed as manifestations of modernity. This perpetuates the epistemic injustices that stop TGD people from being recognised and living as their authentic selves, within clinical and institutional settings.

All participants, but particularly TGD people, could recall themes of gender throughout their lifespan and its influence on how they perceived their place in the world around them. These experiences shared were in line with research that lacking a safe and supportive environment in which you can see others like yourself enables the formation of a confident sense of self that positively influences wellbeing. To be able to flourish as yourself, affirmation is required. TGD people face constant multi-dimensional barriers to developing a positive sense of self-worth and an increased likelihood of negative self-belief (Wanless, 2016).

Freeman and Steward (2022) wrote on the epistemic injustice that arises from the erasure of TGD intersectional identities. Gender non-conformity and transitioning become categorised as ‘deviant’ or harmful to young people, and our stories are removed from the public eye and relegated to the shadows and ‘adult’ spaces, further conflating transness with sexual orientation and sexual preference. Epistemic injustice is particularly prevalent within institutions like the MH system. This erasure reduces even those who are self-proclaimed allies to TGD people stuck in feelings of incompetence.

All cisgender participants reflected on the relative novelty of thinking about gender and their identity, and how evocative it could be to consider its influence of their personal lives and professional work. Despite its novelty, all considered multiples lenses; culture, being a person of global majority and minority, the racialisation of gender and the experience of patriarchy and themes of age, sexualisation and parenthood for cisgender women. Combining into a broad picture, gender has an influence as a vector for minority stress, showing an existing capacity of the MHPs interviewed to view gender as a socially constructed phenomenon.

TGD participants felt an implicit discomfort before they found the language and experience of relating to TGD identities. Although many participants still struggled to describe their identity, having lacked role models growing up, many were also new to finding space in TGD communities or were new to finding social connections with fellow TGD peers. TGD participants shared the internal distress and self-doubt and external bullying and rejection that characterised much of their early life and experiences.

All participants struggled to reconcile their sense of self when they felt the expectation of gender norms from close relationships and wider social expectations in their lives. Whilst cisgender participants felt some level of implicit connection to their gender and feeling validated when aligned with gendered expectations, they shared experiences related to patriarchal gender-based violence and varying socio-cultural constructions of feminine people being at fault or devalued concerning sex and romantic interest. There was a desire for MHPs to have the capacity to

acknowledge the impact of gender norms, not just the oppressive nature of patriarchal sexism. To demonstrate and acknowledging the positive social benefits and sense of self-worth that can be drawn from connection to and being validated in their gender identity (Dorsen et al., 2021), combined with a nuanced perspective on the minority stressors TGD people face. Such understandings have been shown to enable richer therapeutic rapport and a deeper sense of collaboration in forming and achieving therapeutic goals (Pepping et al., 2025).

TGD people move through the world exposed to institutional and social norms that uphold gender norms within many other intersecting factors like race and class that create cisgenderism, that denies TGD people the right to define their own bodies and identities and delegitimises their distress (Riggs & Treharne, 2016). TGD staff and SUs reflected on their unique experiences meaning they had no choice but to consider their own biases and relationship to gender, which many felt MHPs had never needed to consider, maintaining the lack of knowledge on TGD needs. Professionals interviewed shared their awareness of the oppressive nature of gender norms and their impact on MH but remained uncertain of how to navigate these discussions.

5.2 Caring from within rigid normativity

MHPs frequently assume a gatekeeping role in access to gender-affirming care (GAC), adopting a paternalistic stance that positions them as arbiters of another’s identity. The process of needing to seek a diagnosis through which to validate their sense of identity has been shown to directly contribute to TGD minority whilst enabling clinicians to maintain paternalistic superiority, rather than holding a genuine therapeutic curiosity when engaging with gender identity. (Lorusso et al., 2025).

Normativity is broadly accepted as a construct that shifts and changes and is constructed differently cross-culturally and between generations within any given culture. However, norms can quickly be assigned moral value, and their variability and evolution over time become forgotten in the cultural consciousness (Heyes, 2023). As previously discussed, social norms and gender norms are not inherently harmful, but become restrictive, inhibiting empathy and curiosity when applied universally by cis-society and MHS as a singular way of being.

MHS have become systems that unquestionably uphold these systems of power that disregardTGD autonomy. To move toward open and curious gender-affirmative practice, professionals and the broader systems of care need to unpick the benevolent and harmful elements of gender norms carefully.

Some research has shown that questioning deeply held assumptions and attitudes can often lead to a worsening in wellbeing in those questioning them for the first time (Jones, Cahill & McDermott, 2023). Difficulties arise from staff struggling to reconcile with feelings of guilt at realising complicity with systems of oppression. Continued feelings of prejudice can lead people in majority identity groups to further adopt incurious and rejecting attitudes towards the minoritised. Ambivalence is also common in the face of the enormity of the issue. Discussions in institutions regarding those with minoritised identities become a surface-level discussion point rather than a mechanism for change.

Staff participants shared examples of topics like ‘trauma-informed’ now becoming commonplace in team workplace discussions and service provision, but in practice, there were many barriers from individual to service level not holding true to ‘trauma-informed’ values. Topics like gender diversity are not attributed as important or prevalent enough for concern. Staff felt a stagnancy comes from resistance amongst ‘elders’ in supervision and leadership roles, when the older generation define TGD identities as something ‘modern’ in ways that subversively lessens their validity.

This issue with leadership at the top was seen as a key factor in placing limitations on how education is conducted, and how critical concepts and debates are integrated into wider work systems. Woodhouse et al. (2021) investigated organisational culture regarding racialised inequality for healthcare staff in the UK. Hierarchy and strict distribution of power and devaluation of lower-band role voices maintain patterns of bullying and harassment. White staff in Woodhouse’s study reported feeling ‘excluded’ from racialised staff members’ social groups, without any insight on the wider ‘us and them’ narratives that might have created the necessity to build closer bonds with similar peers.

5.2.1 Diversely different team cultures

Conversations about gender happened more readily for those working in a family therapy context. Staff here felt that even when raised by clients themselves, conversations could feel stuck in rigid gender norm expectations that made conversations stilted, despite there clearly being a desire to explore how traditional gender roles were perceived to be a burden on interpersonal relationship dynamics being brought to therapy.

Participants cited vastly different experiences working team to team, with some working environments feeling significantly more hostile to TGD and LGBTQ+ people. Many reflected that it was having an LGBTQ+ person in a leadership position either in their direct team or within the local trust that enabled relevant training to be prioritised. Without community members

championing the way, TGD needs are unlikely to prioritised. When the team culture of acceptance is not present, queer staff participants did not feel safe being visible at work. This creates dissonance where responsibility to provide knowledge is allocated to the marginalised groups, but the environment is not always safe or receptive for learning to be provided.

5.2.2 Assumptions of respect versus assumptions of stereotype.

The two participant groups shared similar bridging themes centring around experiences of interpersonal interactions and wider social environments creating a sense that exploration outside of normative gender norms was unsafe and unacceptable. Participants felt others preferred when they could predict where they felt you should be in life and how you should act based on their gender presentation. Participants reflected on wanting to transgress paths that felt pre-determined, like becoming the compassionate cisgender male psychologist, who can be powerful without being domineering, strong but also in a caring profession. However, such actions were often questioned and for many, confidence to continue pushing norms came with age, professional experience and occupying pockets of space in their lives that gave a buffer of safety to continue transgressing norms.

Cisgender participants were included in the research to attempt to unpick the nature of cissupremacy and understand if MHPs consider the influence of gender as an intersectional component of identity and mental health. Staff discussed how gender was rarely discussed in their team meetings or amongst colleagues. Staff participants felt the system so concretely accepts gender as normative that gender is rarely considered as a factor to anyone's wellbeing despite strongly held stories in the system already like ‘men don’t talk, therefore suffer more’ and ‘women carry the burden of caring’. One staff member wondered in an already burnt-out system, perhaps it is beneficial that men rarely engage in community-based talking therapy as it keeps referral numbers down.

Staff reflected that the ‘normative-ness’ of gender roles are held so concretely that curious thinking and questioning rarely takes place and is just accepted. This is upheld in research on gender norms and gender ideology. Despite broad strokes of advancements in feminism and the softening of traditional gender roles, there are rising themes of violence and isolation for young men and the ‘male loneliness epidemic’ and longstanding statistics of higher rates of suicide amongst men (Walsh et al., 2021). The nature of masculinity is not questioned and accepted as it is, often the only discussions socially that arise is the burden on feminine people to care for masculine people’s needs rather than addressing the social barriers to make space for shifting narratives for masculine people to find ways to feel safer to express themselves. So, when TGD people transgress these norms altogether, or seek to assume the privileges or perceived power shifts of binary gender

transitions, these rigidly held assumptions are unable to bend and grow to allow curious questioning to facilitate the development of TGD affirmative practice.

Power and privilege of cisgenderism is enshrined in the institution of the mental health system. Discriminatory ideologies influence people's experience of their bodies and whether health care professionals meet their needs; these ideologies force TGD people to compensate and attempt to blend in within cisgenderist ideologies to try and survive. Riggs et al. (2015) offer a model of minority stress that stressors impact people directly concerning how their identity is configured, and the impact of privilege and the ‘compression’ of oppression.

Riggs et al. highlight the importance of de-centring the individual’s resilience and acknowledging strengths and resources and pressures that are also socially and environmentally based and the importance of social change. For MHS to change they would need to acknowledge their role as agents of oppression whether intentional or not. Frost and Meyer (2023) also critique the original minority stress model for being overly deficit-focused on an individual’s capacity for resilience. Marginalised people struggling and accessing MH services, bringing themes of social deprivation and systemic oppression, can become problematised by professionals and labelled as non-compliant or ‘treatment resistant’.

O’Neil (2015) notes that associations with femininity and masculinity have softened in recent years with broad themes of more gender egalitarianism. However, withsocial beliefs that wider society ‘expects’ masculine people to perform traditional roles, questioning of gender roles can result in feeling destabilised and negative self-perception that orient negatively towards maintaining the traditions even at the cost of self-image. Gender role assumptions for masculinity remain more socially prevalent, with notions of emotional restriction and patterns of dominance impacting how men engage with others and MH care (Marasco, 2018)

5.2.2 Identities with Multiplicity

The participants shared their experiences of coming against transphobia and more subtle or subversive gendered assumptions that influenced their experience of feeling safe or understood. We reflected on how the experience of seeking support was impacted by being a helper and a help seeker. This was an experience I shared as a TGD MHP, and I reflected on how these identities blended and blurred during the research process. I observed that the SU participants who were also MHPs more readily spoke about the privilege their profession gave them when seeking care and feeling listened to. This was not mentioned by anyone in the professional group, their awareness of’ the system’, was frequently placed in passion for their work coupled with pragmatic cynicism.

Others were seen as resistant to change, and the likelihood of the money needed to improve the variety of variables faced by SUs with marginalised identities, seen as unlikely to be invested.

The TGD and LGBTQ+ staff participants reflected on being led by their clients, not wanting to insert gender into therapeutic discussions due to personal interest. They also reflected on team dynamics and championing and advocating for TGD clients, and how, although overt prejudice from staff was rarer than prejudicial SU interactions, they held a sense of whispers behind them and colleagues holding negative views on TGD themes. The reality of marginalised identity research is that results often preach to the choir of the converted. Although I do not think I achieved breaking the mould, this does not detract from the generous and thoughtful contributions of my participant group of community members and allies. Okoroji et al. (2023) highlight the problems that occur with lived experience research and only capturing those who feel safe and able to participate, which they refer to as ‘elite capture’. Reaching diverse samples that capture every part of a community and recruiting those who work in caring professions and hold prejudicial views in ways that structure learning and improve service user outcomes remains an area for development.

Across anti-racist, ‘lived experience’ co-production and other work with marginalised groups, the onus is frequently placed upon the shoulders of the marginalised person or group (Faulkner & Thompson, 2021). Pearce (2020) also highlights how academic institutes are ill-equipped to support researchers with lived experiences researching their own identities. Professionals aim to centre the voice of those they are seeking to help when conducting research without sufficiently trying to address or be transparent about the pre-existing power imbalances and systematic oppression that exists in the conversations they invite marginalised groups into. TGD SUs needing help themselves will continue to be positioned as the guinea pigs providing answers for future TGD siblings until MHPs feel motivated to educate themselves and are equipped with sufficient resources to do so. Responsibility is frequently outsourced to the lone champion roles, as described by some of the staff participants. ‘LGBT+ champions’ amongst other categories, act as single points of information in teams. Within a strained system, champions are often the only ones sent on training concerning their own identities to disseminate learning to a team who might be unwilling to listen. Cisgender people also need to understand the nature of cisgenderism themselves before seeking answers on the TGD experience from their TGD clients.

Professional orientation might influence openness and readiness to accept that gender is socially constructed. The family therapists who took part reflected on their training, orientation, and tolerance for ‘safe uncertainty’ in their work. Several of the psychologist participants referred to the ‘social GRACES’ model (Burnham & Nolte, 2019), which has significant research surrounding it as a tool for reflection when working with identity differences. Those who mentioned models did so

out of personal interest and with the help of specific team dynamics which were not present in all workplaces. Multiple staff participants highlighted the prevalence of the ‘medical’ model of understanding within their teams, which centres on biological factors and the responsibility of the individual to be the agent of change in their mental health.

Participants described the challenge of being given CBT as the one-size-fits-all treatment, even when they had prior negative experience of the approach. When sensitively done, CBT can effectively work with themes of prejudice and be practised in a way that acknowledges the systemic impact of marginalisation. Cenat, Haeny and Williams (2024) proposed guidelines for anti-racist CBT. Shali (2024) conducted a systematic review with CBT therapists on working with sexual and gender minority (SGM) people, highlighting that the nature of CBT and existing therapist training can perpetuate discriminatory narratives from wider society and leave therapists ill-equipped to integrate the needs of minoritised groups. However, training that centred awareness and cultural competence improved supporting SGM clients with addressing themes of minority stress.

Although all staff cited an overwhelming lack of training, therapeutic orientation and associated training may enable staff to be more receptive to gender expansive attitudes. Internationally, training continues to be raised as an issue (Mezzalira et al., 2025, Puckett et al. 2024, Delaney & McCann, 2020, Stephens, 2018) yet neither academic or clinical settings appear to be making the moves to fill this gap in a consistent and standardised way, often leaving lone ‘champion’ TGD & LGBTQ+ staff to centre the needs of TGD in localised ways.

5.2.3 Barriers to respect

Research used to inform policy is rarely informed by the voices of TGD stakeholders, continuing the erasure of the needs and priorities of TGD people compared to the cisgender dominant narrative. Representative examples include the exclusion of TGD advocates in consultation for the 2025 UK Supreme Court ruling on the definition of gender in the Equality Act 2010 and the Cass Report’s high risk of bias found by Noone et al. (2025). The Cass report also makes worrying generalisations about the need to screen for autism when assessing TGD youth. They correctly observe that there is a correlation between neurodivergence and gender incongruence across multiple neurodevelopmental conditions. Other research has highlighted these findings to draw clinicians’ attention to tailoring their communication and adapting assessment processes to meet the needs of autistic TGD people. Cass, however, makes no suggestions of why neurodiversity should be considered, only vaguely stating clinicians should explore ‘other reasons’ for the person’s distress. This dangerously leaves findings open to seeing gender incongruence as a differential diagnosis to rule out in the context of autism (Giordano, 2025).

With the review of adult NHS GAC looming, TGD participants and I worried about what further epistemic harm might be brought about and what care might be taken away from us. Neurodiverse people are often infantilised by the MH system. Even when an individual is judged to have capacity, professionals often take a paternalistic approach, believing they know best, disregarding the individual’s testimony of their lived experience (Wodzinski & Moskalewicz, 2023). When TGD and neurodiverse identities intersect, this often results in the person being denied the ability to know themselves and their gender, as can been seen in the Cass report’s vague and unsubstantiated recommendations to assess TGD youth for autism (Giordano, 2025).

This research does not seek to imply there is any kind of cause-and-effect relationship but takes a de-pathological approach to both gender and neurodivergent identities. TGD and neurodivergent groups have intersecting shared experiences. Neurodivergent children may experience an aversion to the categorisation placed upon them by social gender norms, and as they age, find themselves aligned to more fluid gender expressions not aligned by the dominant social scripts. TGD and Neurodiverse groups also share the experience of wider society and healthcare system viewing their identities as ‘disordered’. Autistic people also have to tolerate societal notions that neurodivergence is something to be cured, or that they are best received socially when complying with normative standards as much as possible, no matter the cost to the individual. For neurodiverse and TGD groups, the strength of an acceptance and strength-based model has been empowering, especially for those living in the intersections (Bornstein, 2022).

Really, anyone who receives a sickness label receives a level of testimonial injustice within the power dynamic of care provider and care receiver. The professional gatekeeper may or may not provide access to onward care and the diagnostic labels that validate individual experience in the eyes of the wider care system. Despite their commitment to provide care and support, many MHPs still hold stigma towards people with MH disorders (Sreeram, Cross & Towsin, 2022). Negative beliefs may serve a function for the professional and how they carry out their work with individuals, however, stigma acts as a barrier torecovery for the people they care for (Luigi et al., 2020). Future research should consider the intersecting nature of MH stigma and identity characteristics like gender identity.

Greener and Moth (2022) interviewed participants who identified as having long term psychological difficulties. They found participants reported insecurity in how their everyday interactions would be perceived by state agents and members of the public for fear of their distress being invalidated. They also described the challenges to have their distress recognised and not be minimised or delegitimised by the welfare system, anexperience very much mirrored by TGD participants navigating the world, both in coming to terms with their GI and seeking GAC,

whererecognition of identity is through documentation by governing bodies and having MH distress recognised. Scrambler (2018) writes on austerity and the weaponisation of stigma, particularly in relation to disability benefit reform. In the current climate for state funded systems, resistance and the ability to make change on a macro-level has been made incredibly difficult to achieve.

UK neoliberal politics and the benefit system construct value in an individual’s ability to work, framing suffering in a moral order (Friedli & Stream, 2015). Those not deemed distressed ‘enough’ are framed as immoral, seeking support they do not deserve. Epistemic injustice of systems of power are able to dictate an individual’s reality to them, as well as the system's certainty and power to dictate some diagnoses as more valid than others.

5.2.4 The Bare Minimum.

SU participants accessing the NHS felt the strain of long waiting lists and social narratives of the NHS being under-resourced; there was an expectation that queer needs and narratives would fall through the holes made by the lack of resources. Many who were able felt they had been better off seeking a private therapist and being able to select one who advertised themselves as TGD friendly or shared their personal identity. Prior research has also highlighted participants valuing shared minoritised identity in terms of other characteristics like sexual orientation, as there was a felt sense of similar shared experience (Puckett et al., 2022). TGD people still make up a tiny fraction of the UK and seeing a surge in TGD representation in the NHS staff is unlikely, so other improvements will need to be made. Most of the UK will seek MH support through the NHS, and in times of economic uncertainty, accessing private therapy or even third sector LGBTQ+ therapy will remain a privilege for those able to afford it. Visible allyship, campaigns like posters and lanyards should be backed up by visibly practising pro-LGBTQ+ values, with evidence to substantiate them outside of tokenism, like connection to third sector organisations (Benson, 2013; Puckett et al., 2023; Stephens, 2018)

The field of TGD research is an evolving one, and TGD people make up a small percentage of the UK population; practitioners should be given the grace to develop their competence and skill. However, TGD service users must battle cumbersome administrative processes to have their chosen names and pronouns respected. Having preferred pronouns respected becomes a debate, with some clinicians refusing to do so, following harmful and dehumanising narratives that doing so ‘colludes’ with a pathological conceptualisation of GI. When clinicians refuse to respect the basics of how a person would like to be referred to, it unsurprisingly has a detrimental effect on engagement with healthcare as a whole. Benson et al. (2023) writes recommendations for clinicians and implores avoiding assumptions based on personal and unresearched beliefs and aiming to avoid the nature of forced binary expectations on people seeking help (Benson et al., 2023).

Affirmative practice has been shown in multiple studies to be positive related to therapeutic outcomes and improved therapeutic alliance (Acosta, 2024; Elder, 2016; Delaney & McCann, 2020; Puckett et al., 2023;Bettergarcia & Israel, 2018; Pepping, Cronin & Davis, 2025). Affirmative practice remains a contested concept, with TGD people demonised into ‘affirmation-demanding-monstrous complaining’ clients who disregard professional opinion. Such arguments are fed by Cass and other gender criticals, further sensationalised by the press (Horton, 2024) who shout that affirmative practice comprises of simply giving anyone who asks a fast pass to surgical intervention.

The Cass report suggests a ‘gender explorative’ approach as the alternative to affirmation. Although the name sounds benevolent, in their own words the exploration is based on the false statement that ‘most’ TGD youth change their mind, and clinicians must make sure that individuals are not really their gender assigned at birth. When clinicians do not recognise the validity of TGD identities, exploration lacks genuine curiosity and is conversion in disguise (Horton, 2024). When surveyed on affirmative practice, clinicians respond with defensiveness and conflating affirmation with ‘identity politics’ and being made to follow ‘politically correct ideologies’ (Mollitt, 2022). Many participants had come up against active hostility or resistance to accepting TGD identities in and out of work settings. Simply being open is not enough for a competent and supportive space for TGD clients. Lack of prejudice or hostility is only enough for a superficial engagement with themes of gender identity, clients valued therapists who were community members, already educated or transparently communicated their personal efforts to seek training or seek reading to educate themselves when working with gender diverse clients (Rosati et al., 2022). The act of not being transphobic is not a radical act and asserting the lack of prejudicial views does not necessarily mean clinicians have been supported to or taken the time to reflect on their own passive gender bias (McCullough, Dispenza & Parker, 2017).

5.3 Breaking down barriers to curiosity.

This research did not ask explicitly about the concept of pathologisation, though TGD participants all had experiences of TGD identities having a negative association, whether it was their very existence being refuted or framed as something negative and unwanted. For many this caused internalised stigma which increased their distress and lengthened periods of repression or questioning. Staff report uncertainty and confusion around how to support TGD people, especially those seeking MH support in tandem to or in relation to accessing GAC. Uncertainty is maintained through GAC requiring a mental health diagnosis given by mental health professionals (Benson, Allenm Axoitis & Metcalfe, 2023).

TGD SUs and MHPs unanimously agreed that there was a lack of understanding of what it meant to live and exist as a TGD person. For professionals to better meet the needs of TGD SUs, a shift is needed away from pathologising narratives and differential diagnoses to respecting differing paths of identity formation. Ethical debates are ongoing and circular within the medical community; other MH disciplines may not engage, seeing the diagnosis as the realm of psychiatry only without comprehending that for many TGD individuals, the diagnosis holds the only pass to the gates of life saving treatment. Cross-cultural and societal change needs to happen outside of the MH system. Bettcher (2015) addresses the reductive and limiting nature of the widely known ‘born in the wrong body’ story and how it holds back diverse gender expression and keeps social attention on the physicality and biology of TGD people.

Noble (2021) writes on the ethical dilemma the discussion poses and investigates the argument that the diagnosis of Gender dysphoria is in place to lessen regret rates and protect ‘vulnerable’ groups. They highlight that as a diagnosis, gender dysphoria has very little validity and HRT and gender affirming surgeries have incredibly low regret rates compared to other medical interventions. The existence of the diagnosis itself perpetuates its association as something that is ‘wrong’ with a person. Toiveonen & Dobson (2017) extract some of the core ethical concerns around GAC: the overriding of informed, free consent that exists for all other elective surgical procedures, respecting the dignity and rights of an individual and their sense of self and disregarding the self-knowledge of TGD people. Toiveonen & Dobson argue these issues remain justified by the wider system through narratives of protection of ‘vulnerable’ groups and minimising harm and risk.

MHPs lack basic awareness of TGD experiences as the ‘knowledge’ is siloed into the few and far between GICs and not seen as relevant to a non-specialist clinician’s curriculum, despite TGD people being widely known to experience higher levels of MH difficulty than their cis counterparts.

Clinicians experience heightened discomfort when faced with areas that invoke feelings of being ‘deskilled’ and topics that are labelled as political in nature (Mollitt, 2022). In the UK politically contentious topics become associated with deviance and disruption, it becomes socially ‘improper’ and inappropriate to discuss in ‘civil professional’ settings (Cammaerts, 2022). The unknown becomes a hegemonic “woke” villain in which TGD identities become othered beyond the point of curious empathy and motivation to meaningfully learn about.

Participants perceived that complaints about discrimination towards marginalised identities were placed in a moral hierarchy. Socially Established concepts like faith and ethnicity were seen to be ‘more valid’ and participants cited experience of colleagues saying anti-TGD rhetoric based on

‘personal belief’ that was seen to be validated by the wider system. However, with any issue of discrimination, no matter the characteristic, following the system’s complaints procedure was seen as something that rarely resulted in meaningful and lasting change. Frequently, this leftthe person raising the issue feeling vulnerable.

5.3.1 Training & education

It is well established that better and more education is needed on TGD identities (Mulqueen, 2025; Puckett et al., 2022; Puckett et al. 2023; Delaney & McCann, 2022; Stephens, 2018; Mizlock & Lundquist, 2009). SU participants were empathic toward professionals who they perceived as demonstrating a genuine curiosity and willingness to learn, though there was still an overwhelming lack of knowledge of TGD experiences. The professionals unanimously cited a scarcity of TGD training. What training they had experienced was either sought out independently or organised by senior staff who were members of the LGBTQ+ community.

Mezzalira et al.’s (2025) literature review of TGD experiences of psychotherapy highlighted similar themes to that of the literature review in chapter 1 investigating general psychological services. Clinicians need to be aware of the diversity of reasons TGD people access therapy. For staff to develop nuanced understanding of TGD experiences of accessing medical transition, future training should give staff an overview of medical GAC pathways. This should highlight the criticism and critical reform of the whole concept of GAC, and the alternative non-pathologising models like:
‘self-determination’ that exist and function internationally. Benestad (2010) wrote on how diagnostic requirements reinforce societal narratives of shame and restrict diverse gender presentations. Benestad proposed clinicians need to familiarise themselves with multiple gender categories.

Many experienced the well reported phenomenon of clients positioning them as educators, helping the professional to learn about TGD concepts and terminology (Stephens, 2018; Delaney & McCann, 2020; Mizlock & Lundquist, 2016) which was found to be unhelpful and as though the therapists were using clients for their own personal development rather than centring their needs. TGD clients being given the entire burden of educating professionals is a repeated phenomenon in gender identity research (Mulqueen, 2025; Puckett et al., 2022,; Puckett et al. 2023; Delaney & McCann, 2022; Stephens, 2018; Mizlock & Lundquist, 2009).

Unconscious bias training and cultural competency training have very little evidence in effectively reducing discrimination and research continues to neglect its impact on marginalised staff wellbeing in any depth (Woodhouse, 2021; Hatch et al., 2021).

Training needs to compassionately challenge MHPs to step outside of normative paradigms they understand as ‘normal’ (Hendricks & Testa, 2012). Training needs to engage MHPs in their attitudes towards gender essentialist beliefs and alignment to traditional gender ideology to effectively challenge negative attitudes toward TGD people. Mental health stigma in combination with the stigma produced by the pathologisation of TGD identities also needs to be examined (Jones et al., 2023). Schiralli et al. (2022) found cisgender men frequently hold the highest explicit and implicit beliefs on measures of stereotyped attitudes towards gender. Jones et al.’s work also highlights that cisgender men are more likely to have a sense of self-worth based in upholding traditional gender roles which significantly predicts anti-TGD attitudes. Participants observed primarily cisgender men remaining in leadership positions.

Gender based discrimination has been frequently found across healthcare professions. Hennein et al.’s (2023) participants reported an old boy’s club, excluding women from certain roles, in certain disciplines especially within medicine. Cisgender men in this study reported feeling frustration and white men perceived disadvantages to them in disciplines where women were preferred as clinicians or they felt racialised minorities were given the roles by equity programs. A lack of respect was also observed by men in ‘feminine’ professions like nursing. Understanding the pervasiveness of gender stereotypes and how they uniquely present in MH settings will be important in developing future training. Enabling teaching materials to help MHPs have space to explore gender identity and understand how it presents both to service user and between colleagues within the hierarchical MH system.

Masculinity and how it is constructed, both in those accessing MH services and how professionals understand supporting men and their own masculine identity, were raised by participants. Future training needs to address this in ways which do not alienate participants but allow exploration of discomfort and negative stereotypes, particularly in the face of increasing social discourse around male violence and longstanding research that cismale staff tend to hold more prejudicial views than other groups (Fisher et al., 2017), Female-identified practitioners have often had to overcome gender stereotypes in order to work in different healthcare professions which might influence their likelihood to hold more gender affirming beliefs (Speechly et al., 2024).

Models like Dere’s (2025) informed curiosity, which encourages reflection on personal cultural beliefs and values, can enable staff to develop their own hypothesis to question their relationship to social norms. It may help develop the skills and language around non-judgemental ways to ask questions for personal learning and develop strategies to challenge colleagues safely.

Schmidt et al. (2024) suggest a models of cultural humility, which builds up cultural competency focusing less on cultural information and knowledge. It centres the clinician’s way of being, developing awareness in which the self is positioned in your own intersecting identities and is reflected on in relation to the work. It may be integrated with models like trans-affirmative narrative exposure which offers strategies to manage the experiences created by minority stressors. Hours of education to content concerning identities and support needs alone has been evidence to not be enough to improve practitioner competence meeting TGD issues and shifting transphobic attitudes (Stroumsa et al., 2019).

Petty-John, Tseng and Blow (2020) highlight the importance of clinicians reflecting on the client’s intersecting identity and if they relate to the presenting problem before assuming. This reflection should include therapist reflection on their own identities and how they intersect with the client’s. They write on how constant self-assessment is unsustainable in the system therapists work in, however it is important for MHPs to question themselves around relational dynamics and social oppression between them and the people they work with especially when working with clients with different and marginalised identities. Their findings suggest the careful integration of discussion on relevant socio-political issues personal to the individual’s identity to attempt to open discussions around minority stress and living with marginalised identities. Puckett et al. (2023) agree that when personalised and sensitively done, demonstrating awareness of the impact of socio-political climate on wellbeing can be facilitative of trust and rapport building.

Teaching spaces need to address safety in learning environments to promote open discussion and reduce defensive reactions to tackling bias. The most important issue is lasting change. Pennington et al. (2022) looked at unconscious racial bias training for NHS senior staff had not released how their attitudes might trickle down to those they managed. However, long term follow up was not done to see if the short-term attitude change amounted to long term behavioural change. Training including ‘top-ups’ and follow ups are often not seen as financially viable or viable in terms of time as a team resource in the strained system of the NHS. They also found racial bias in the qualitative feedback from their training showing that some participants had not shifted in attitude and continued to use their position of authority to perpetuate racial bias. Those in leadership positions need to put in the work to create cultures facilitating open and honest discussions about prejudice and bias at all levels of the workforce.

Participants similarly suggested that singular training sessions rarely felt enough to develop personal sense of skilfulness, unless working in a setting with constant contact with TGD people. Staff and SU participants wondered if trainings should have ‘top up’ content to tackling knowledge attrition, including follow up sessions to create discursive safe environments to discuss learnings

and challenges experienced since the training. Although similarly to Pennington et al., MHP participants wondered about the reality of trainings with a repeated reflective space being perceived as being efficient and financially viable by those in senior leadership positions.

Gender affirmative exploration becomes something scary and avoided by MHP. Opposed in the Cass Report (2024) framed with watchful waiting gender exploration proposed as ‘the sensible alternative’. This frames cisgender as the norm professionals should wait and see if gender questioning children return too, rather than allowing for the expression of a TGD be seen as something acceptable. This creates a narrative amongst MHS that a TGD is a negative outcome and to be protected against. Affirmative approaches would not mean all children were given puberty blockers but rather the attitude to which social, medical gender transition are approached (Ashley, 2019). Rather than fearing discussing gender MHP would navigate expansive explorations about GI with openness and ease.

Freire’s (1998) work around educators addressing the learners fear of their own incompetence feels particularly pertinent to the narrative of ‘not wanting to make a mistake.’ This is not a new theme in the understanding of MHPs’ attitudes toward supporting TGD people (Canvin, Twist & Solomons, 2022). However, this position does not always motivate clinicians to further learning to resolve feeling de-skilled. Salpietro, Ausloos and Clark (2019) suggest that programmes teach gender as a factor in the socio-political landscape of clients’ lives, especially in the context of TGD experiences, and should be considered a core competency of counselling training. By recognising gender this way, professional and educational resource could be better organised to improve the system for TGD SUs.

The flaws in models of unconscious bias training and becoming culturally competent are long established (Tervalon & Murray-Garcia, 1998). More effort needs to be put into the impact of training on patient outcomes and orienting MHPs to making training-to-practice links when working with people with differing identities (Vella, White & Livingston, 2022).

SU hopes and thoughts for future training and improvement to mental health services can be found in Appendix 5.

5.3.2 Conclusion

For TGD participants, the norms set by the cisheteronormative standard are never comfortable and despite the pro-social benefits promised to cisgender participant, many of them still experienced social rejection and feelings of critique despite still aligning with the gender assigned to them. Cisgender participants demonstrated the importance of how everyone of us will benefit from more flexible attitudes towards GI, through their stories of personalising their own sense of gender

against more restrictive and socio-cultural gender norms. Domineering White Cisheteronormative narratives erase gender diversity from mainstream frames of reference which is reflected in the system’s lack of training and awareness.

From the point of registering for support, TGD people are excluded, questioned and invalidated. Even being given the respect of a preferred name is twisted into a point of debate. SUs continues to desire the bare therapeutic minimum of unconditional positive regard and empathy for their experiences whilst professionals feel too cautious to practice affirmation.

For understanding to translate from theory to practice, staff need to receive training that enables them to navigate their own personal experience of gender. This should deconstruct the nature of gender norms, and the benefits and harms they construct in our lives. Participants shared they did not expect encyclopaedic awareness but a sense of ‘the basics’ and that understanding of the struggles caused by a transphobic world were key. TGD participants’ desire was for their identities to be respected and for professionals to witness the freedom living authentically in their gender identity had brought. Being TGD would not always be the core of their problems and to it was important to feel safe that clinicians were not questioning the validity of their identities. Choice of words is powerful, implications of identity being a choice and fascinations with trans bodies made TGD clients feel vigilant, arriving in a space meant to be safe preparing to be met with invalidation for the identities they have already worked hard to come to terms with. TGD people need curious empathy from MHPs and an offer of collaborative support to navigate minority stressors and nurture their wellbeing.

5.4 Implications

- Training at university to continuous professional development needs materials at minimum co-produced by TGD people and ideally delivered by TGD professionals or lived experience TGD ambassadors.

- Training should situate the importance of the ‘bare minimum’, respect for chosen names and pronouns, awareness of minority stressors and understanding the harmful history of pathologising TGD identities and how these might be perpetuated within the current GAC and mental health system.

- Clinicians need to be provided with reflective learning spaces that enable them to safely question gender norms in relation to cis-supremacy narratives and gender ideology in their own lives and the lives of TGD people.

- Educators and trainers need to address the barriers created by ‘the fear of getting it wrong’, in workplaces and in learning institutions that might block MHPs from engaging with learning material and translating learning into practice.

5.5 Limitations

I had intent to carry out a focus group with a small number of volunteers from each participant group to share the themes from thematic analysis. I hoped to give TGD SUs the chance to have open discussion with professionals about their experiences and start a space of co-production with lived experience of TGD at its heart with the staff members to use discussions following reflections on the themes, to further develop ideas of how future training should be delivered and how findings might be best disseminated. I hope to attempt this at some point in the future.

Online recruitment was challenging. Poster campaigns advertising Amazon Vouchers for SU participant times were met with multiple bot replies and several participants who read the patient information sheet and correctly filled out demographic forms for inclusion attended the interviews but refused to be on camera for the video call, unable to answer questions like ‘what has history with mental health services been like”. In peer discussions across DClinPsy programmes, I suspected these participants needed the vouchers and were serial participants regardless of meeting study criteria. Future work perhaps needs to be more rigorous at participant screening and adapt how compensation is advertised.

Recruitment was adapted to just being through personal and professional networks in the second round which limited sample diversity in terms of ethnicity and age. The current socio-political climate may make TGD people cautious of engaging with research, especially projects associated with the NHS. Participants were primarily psychological and psychotherapeutic staff, future work needs to include mental health nurses, psychiatrists and other professionals TGD people might meet in the process of seeking mental health support.

Research is beginning to develop multiple frameworks of gender diverse development and affirmative treatment protocols. Ideally, future research needs to focus on a multi-disciplinary framework that can provide a ‘bare minimum’ of gender expansive and affirmative understandings that provides simple accessible frameworks to support professionals to initiate team-based gender discussions. In an under resourced, hostile environment, the revolution to education and training programs feels a long way off. To break the cycle of epistemic injustice and ignorance, staff should

be supported to learn together and not rely wholly on TGD clients and colleagues. Risks need to be taken to explicitly explore passive, benevolent and prejudicial attitudes that act as barriers to affirmative TGD practice.

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Appendix 1 -Glossary of acronyms used.

(This is not an exhaustive list of gender identities or terminologies. Categories and definitions of identity are personal and evolve and change alongside socio-cultural changes and settings)

TGD = trans and gender diverse

NBGQ= non-binary and genderqueer

GI = gender identity

MHS= mental health services

MHPs = mental health professionals

MH= mental health

Deadname = a term used by some people referring to the name TGD were given at birth.

Transgender= to not identify as the gender assigned to you at birth.

Trans feminine/trans femme = an inclusive term to refer to those who identify with both a ‘binary’ definition of femininity and womanhood and those who identify with a more fluid form of femme.

Trans masculine/trans masc = an inclusive term to refer to those who identify with both a binary definition of masculinity and manhood and those who feel more fluid in their masculinity

Non-binary = non-binary is not a ‘third gender category’, typically non-binary people don’t identify wholly with either masculinity or femininity but somewhere on a spectrum that can be inclusive of both, be interchangeably aligned with one or the other or exist in opposition to gender categories. Some non-binary people identify as transgender, and some do not.

Genderqueer = can be conceptualised as coming under the non-binary umbrella but may involve a further sense of transgressing from concepts of gender or of holding a sense of gender identity at all.

Agender = not identifying with or aligning to any gender, might be defined as feeling no sense of connection to gender.

Appendix 2: Ethics documentation

The LR has since legally changed their name, so there will be inconsistencies with the name listed on some documentation.

2a REC approval

HSC Business Services Organisation

INVESTORS IN PEOPLE® We invest in people Silver

Health and Social Care Research Ethics Committee B (HSC REC B)

26 January 2024

Ms Rebecca Broughton
52 Victoria Chase
London
CO1 1WN

Dear Ms Broughton

Study title:	**Understanding diverse gender identities and exploration of gender diverse individuals feeling understood in mental health settings. (working title)**
REC reference:	**23/NI/0151**
Protocol number:	**not applicable**
IRAS project ID:	**329010**

Thank you for your letter of 19 January 2024, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair and Lead reviewer.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Office for Research Ethics Committees Northern Ireland (ORECNI)
Lissue Industrial Estate West, 5 Rathdown Walk, LISBURN, BT28 2RF
Tel: (028) 95 361400 General Email: info.orecni@hscni.net

2a.1 University of Essex Ethics approval

Ethics ETH2324-0859: Mx River Broughton

Date Created	11 Feb 2024
Date Submitted	11 Feb 2024
Date of last resubmission	06 Mar 2024
Academic Staff	Mx River Broughton
Category	Postgraduate Research Student
Supervisor	Dr John Day
Project	Understanding diverse gender identities and exploration of gender diverse individuals feeling understood in mental health settings. (working title)
Faculty	Science and Health
Department	Health and Social Care
Current status	Approved

Ethics application

Project overview

Title of project
Understanding diverse gender identities and exploration of gender diverse individuals feeling understood in mental health settings. (working title)

Do you object to the title of your project being published?
No

Applicant(s)
Mx River Broughton

Supervisor(s)
Dr John Day

Proposed start date of research
18 Mar 2024

Expected end date
03 Mar 2025

Will this project be externally funded?
No

Will the research involve human participants?
Yes

Will the research use previously collected or generated personal data?
No

Will the research involve the use of animals?
No

Will any of the research take place outside the UK?
No

External approval

Which external organisation is providing approval for the project?
HRA NHS REC

Please provide details of the approval(s) required.
NHS REC pannel approved for qualitative research with potentially vulnerable population (adults who are accessing or have accessed mental health services in the past 5 years)

Has the required external approval already been obtained?
Yes

If yes, please attach evidence of approval.
If no, is external approval being sought?

External approval ID
IRAS ID: 329010

Risk and risk management

Risk Assessment documents
Are there any potential risks (e.g. physical, psychological, social, legal or economic) to participants or subjects associated with the proposed research?
Yes

If yes, please provide full details and explain what risk management procedures will be put in place to minimise the risks.
The interviews will ask particpants to consider their history with their mental health and their gender identity which may be distressing in nature. Particpants will be given a range of support resources prior to the interview starting and reminded of their right to withdraw and directed to the support resources at the end of the interview. Please also see attached the distress protocol developed for the project.

Are there any potential risks (e.g. physical, psychological, social, legal or economic) to the researchers working on the proposed research?
Yes

If yes, please provide full details and explain what risk management procedures will be put in place to minimise the risks.
see above.

Are there any potential reputational risks to the University as a consequence of undertaking the proposed research?
No

If yes, please provide full details and explain what risk management procedures will be put in place to minimise the risks.

Are there any other ethical issues that have not been addressed which you would wish to

2b Service User Recruitment Poster

How is gender identity understood in Mental Health Services?

Everybody has a gender, so everybody has a gender identity. I want to speak Gender diverse* people and cisgender* people about how they understand their gender. I am looking to explore if gender identity might have influenced your experience of accessing mental health services.

Who can be involved: I would like to speak to anyone over 18-65+. Living and working in the UK who is currently accessing mental health services or has accessed them in the past 5 years.

I would like to speak to people from a wide range of sexual orientations, ethnic, cultural, faith. neurodiverse and generational identities.

What is involved: You will be invited to a 60minute Microsoft teams interview.

There will also be an **optional** chance to participate in a focus group with Mental Health Staff who will have undergone the same interview thinking about how Services understand gender identity.
(All participants will be anonymised data will be stored securely and confidentially.)

University of Essex

To participate please contact :
River Broughton
(pronouns they/them)
Email
rb22589@essex.ac.uk
IRAS ID: 329010.

Definitions *

Gender Diverse = an umbrella term including transgender, non-binary, genderqueer, agender, amongst other identities

Cisgender= identifying as the same gender assigned to you at birth

2c Staff recruitment poster

How is gender identity understood in Mental Health Services?

Everybody has a gender, so everybody has a gender identity. I want to speak Gender diverse* & cisgender* people about how they understand their gender. You **do not** need any experience of working in a Gender Service. The only requirement is to be open to discussing if gender might impact how people engage with Mental Health Services and if you think your own gender, might impact how you work.

Who can be involved: I would like to speak to anyone over 18+. Living and working in the UK who is currently working as a Mental Health Professional in any capacity.
I would like to speak to people from a wide range of sexual orientations, ethnic, cultural, faith. neurodiverse and generational identities.

What is involved: You will be invited to a 60minute MicrosoftTteams interview.

There will also be an **optional** chance to participate in a focus group with Mental Health Service Users who will have undergone the same interview thinking about how Services understand gender identity.
(All participants will be anonymised data will be stored securely and confidentially.)

To participate please contact :
River Broughton
(pronouns they/them)
Email
rb22589@essex.ac.uk

University of Essex

IRAS ID: 329010

Definitions *

Gender Diverse = an umbrella term including transgender, non-binary, genderqueer, agender, amongst other identities

Cisgender= identifying as the same gender assigned to you at birth

2d Example Consent form

University of Essex

Version 2, Dated: 22.12.2023

IRAS ID: 329010 Centre Number: Study Number: Participant Pseudonym for this trial:

CONSENT FORM

Title of Project: **Understanding diverse gender identities and exploration of gender diverse individuals feeling understood in mental health settings.**

	Please initial box
1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw without giving any reason, and without penalty. Before and during the interview. I understand that any data collected up to the point of my withdrawal will be removed before and during the interview. After the interview is complete their will be deadline of 4 weeks after The anonymised transcript of the recording will have be integrated into the study data set and cannot be removed. However, before the deadline I can withdraw without giving any reason and without penalty.	☐
3. I understand that the information collected may be used to support other research in the future, and may be shared anonymously with other researchers.	☐
4. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained.	☐
5. I understand that my fully anonymised data will be used for the purposes of data collection and analysis as part of their professional doctorate in Clinical Psychology. It may also be used in an article to be published in an academic journal.	☐
6. I agree to take part in the above study	☐

Name of Researcher: **River Broughton**

Date Signature Name: Date: Signature:

Researcher seeking consent: Signature: Date:

2e Example Participant Information Sheet

IRAS ID: 329010 version 2 Dated 19.01.24 (MHP version)

Participant Information Sheet

Project Title: Understanding diverse gender identities and exploration of gender diverse individuals feeling understood in mental health settings.

Introduction

Before you decide to take part in the current research study, it is important for you to understand, why the research is taking place and what it will involve. Please take some time to carefully read the following information.

Who is conducting this study?

The Chief Investigator is River Broughton Trainee Clinical Psychologist, Essex University. The researcher is conducting this study as part of their professional doctorate in Clinical Psychology. A qualified Supervisor is overseeing the research.

Academic Supervisor: Dr John Day, Lecturer in the School of Health and Social Care (Clinical Psychology), Department of Psychology, Essex University.

What is the purpose of this study?

The study hopes to understand how gender identity might influence a person's experience of accessing mental health services and if they have felt supported when discussing their gender. The study hopes to understand how Mental Health Professional's might define and make sense of 'gender' and supporting people who might wish to discuss their gender identity. The study is also interested in how professionals make sense of their own gender and if this has any impact on their work.

The study would like to speak to Gender Diverse (GD) and cisgender people. To understand gender identity as a whole and you experience or understanding with working with Gender Diverse people. With the view to opening discussions, understanding, and potentially developing educational and training materials for mental health staff.

Definitions
Gender Diverse (GD): GD a non-exhaustive list including identities like; transgender, non-binary, agender, genderqueer amongst other terms.

Cisgender: Identifying as the same gender as the one assigned to you at birth.

Why have I been asked to participate?

You are a mental health practitioner currently practicing in the NHS and open to discussing gender and gender identity and how this might shape how service users experience of accessing services and engaging in therapeutic interventions. As well as how you understand your own gender and if gender identity as a concept might impact your work and how people might engage with the interventions you provide.

Taking part in this study is voluntary and you do not have to participate if you do not wish to. If you decide to take part, **you can withdraw before 4 weeks after your completed interview**. After this point your transcript will have been integrated into the study and cannot be withdrawn

You do not have to answer any questions that you do not wish to. You can also request a break during the interview if you need one.

How do I withdraw from the study?

If you wish to withdraw from the study before your interview or before 4weeks afterwards, please contact the main researcher, River Broughton, by email (rb22589@essex.ac.uk) within four weeks of taking part.

What will happen to me if I take part?

To participate, you will be asked to take part in one interview recorded via Microsoft Teams (for purpose of transcription) lasting around 1 - 1½ hours in a comfortable setting, which could be your own home. The interview will involve talking to the main researcher (River Broughton). Everyone will be asked the same questions, with follow up questions varying depending on your individual experience. Before the interview takes place, you will be sent a document of the themes covered in the interview and a list of supportive resources should you need them after participating.

If you consent, you may be contacted later to ask if you would like to participate in a further focus group involving service users who have gone through the same interview. The group will involve cisgender and gender diverse staff and service users discussing what themes the research has generated and what if anything might be used to improve how Mental Health service users support people talking about gender and gender identity.

Confidentiality

Please note participation within this study is completely voluntary and anonymous, your employer will not be informed of your decision to participate within this study.

If you say anything that caused me to feel concerned for your safety, I will signpost you towards options for further support. In some cases, I might need break anonymity and confidentiality to discuss this with my research supervisor or relevant support services. I will always work to keep you informed throughout this process.

What are the possible advantages of taking part?

There are no direct benefits for you in taking part in this research. Hopefully findings from this research project will be used to contribute to the current understanding of gender identity and meeting the varying needs of gender diverse and cisgender people in the context of accessing mental health support. This could guide the development of recommendations and educational material for supporting health care professionals and their work with gender diverse people and understanding the role gender for anyone accessing mental health services.

What are the potential risks of taking part?

The study will involve answering questions of a sensitive or potentially distressing nature. If you find any of the questions particularly difficult or intrusive, you do not have to answer them. You will be reminded, that you can ask to stop, take breaks, reschedule the interview, or withdraw if you need too.

There will be a space for debrief at the end of the interview and you will also be given information on relevant sources of support. There are no special precautions that you need to take before, during or after taking part in the study.

What can I do if I feel like I need additional help?

Following participation in the study, if you feel like you need further support, we advise you to seek support from the Participant resources pack.

Other sources of support include the staff wellbeing support service based within your local NHS trust, the Samaritans helpline (telephone: 116 123) who will be able to listen to your concerns.

If you wish to formally report bullying behaviours, we advise you to seek further support by following your local NHS trust protocols and internal whistleblowing procedures or contacting trade unions for impartial representation if required. Freedom to Speak Up Guardians may also be able to provide further advice and support if they are appointed within your local NHS trusts. Support may also be found in Trust LGBTQIA+ networks if you feel safe to reach out to them for support.

What will happen to the information collected about me?

Your research data will be used for the purposes of data collection and analysis. In all cases, your information will be stored on a secure password protected University of Essex sever which is compliant with current data protection regulations (Data Protection Act, 2018; General Data Protection Regulations, 2018). Your data will be stored securely for a period of three years, if questions are raised about the research findings that require consultation with the anonymised data collected from the study.

If you would like further information on HRA UK GDPR transparency

https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/dataprotection-and-information-governance/gdpr-guidance/templates/template-wording-for-genericinformation-document/

Anonymity.

All data that is collected will be anonymous to ensure that you cannot be identified from any information. During completion of the interview, you will be asked to provide a pseudonym name to enable the researcher to identify and remove your data should you wish to withdraw from the study following completion. Your pseudonym name will be stored securely and separately from your research data in a password protected ‘link document’, which will enable your pseudonym name to be linked to your data.

In the interests of transparent and open research practices, some research publications request that researchers share their anonymised research data (such as interview transcripts) when publishing their findings. So, they can assess the quality of the research. If the research is published in a scientific journal, your data may be used to summarise the findings of the research, however your data will be always fully anonymised. Information such as names of people or organisations may be redacted to further protect your anonymity.

The research team is aware that even if data is technically anonymous, there is a chance some parts of the information may be rendered identifiable in combination with other contextual pieces of information within this project.

How do I find out about the results of the study?

We are very grateful to you for taking part in this study and we welcome your interest in our research findings. The research will be written up as a doctoral thesis, and it is hoped that the research will also be published in a professional journal. From April 2025 onwards, you are welcome to contact the researcher using the contact details below to find out about the results of the study.

What if I am unhappy or if there is a problem?

‘If you have any concerns about any aspect of the study or have a complaint, in the first instance please contact the principal investigator of the project; River Broughton using the contact details below.

River Broughton: rb22589@essex.ac.uk

If you feel that you cannot approach the principal investigator or are unsatisfied with their response, please contact the departmental Director of Research in the department responsible for this project:

Dr. John Day (email john.day@essex.ac.uk).

If you are still not satisfied, please contact the University's Research Integrity Manager:

Dr Mantalena Sotiriadou (e-mail ms21994@essex.ac.uk).

River Broughton in the first instance and Dr John Day can also be contacted during office hours, if you have any further questions about participation.

Who is organising and funding the research?

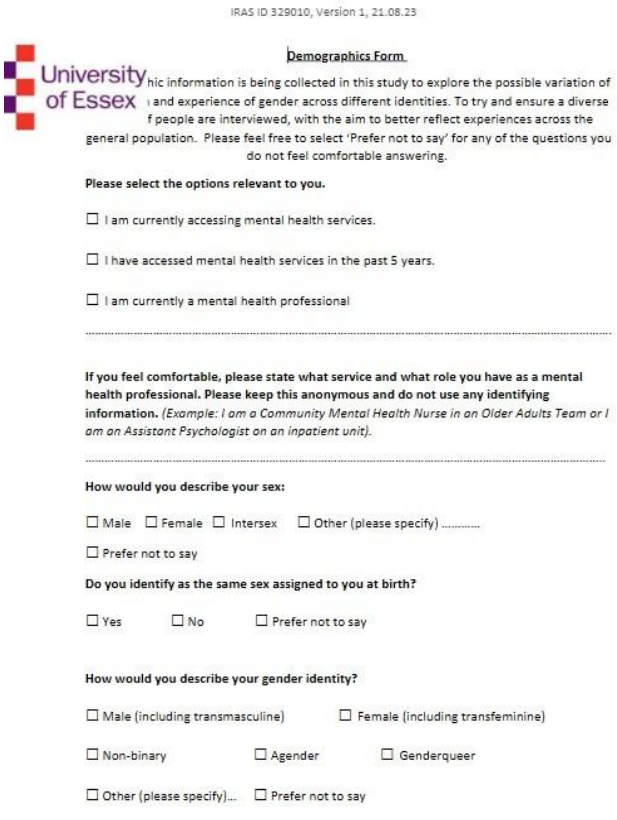
The research is being carried out by a doctoral student at University of Essex. The research is sponsored by the University of Essex. The research forms part of the academic requirements of the doctorate in Clinical Psychology programme and it is not funded.

The research project has been given a favourable ethical opinion by an NHS Research Ethics Committee. (Committee name tbc). ERAMS reference ERAMS to be applied for once REC approval is secured).

Ok, so what happens now?

If you wish to take part in the research, please contact the main researcher via email River Broughton on rb22589@essex.ac.uk t to provide your consent to taking part in the study. **2f**

2f Example Demographics form



IRAS ID 329010, Version 1, 21.08.23

University of Essex

Demographics Form

hic information is being collected in this study to explore the possible variation of and experience of gender across different identities. To try and ensure a diverse f people are interviewed, with the aim to better reflect experiences across the general population. Please feel free to select 'Prefer not to say' for any of the questions you do not feel comfortable answering.

Please select the options relevant to you.

☐ I am currently accessing mental health services.

☐ I have accessed mental health services in the past 5 years.

☐ I am currently a mental health professional

.....

If you feel comfortable, please state what service and what role you have as a mental health professional. Please keep this anonymous and do not use any identifying information. *(Example: I am a Community Mental Health Nurse in an Older Adults Team or I am an Assistant Psychologist on an inpatient unit).*

.....

How would you describe your sex:

☐ Male ☐ Female ☐ Intersex ☐ Other (please specify) .....

☐ Prefer not to say

Do you identify as the same sex assigned to you at birth?

☐ Yes ☐ No ☐ Prefer not to say

How would you describe your gender identity?

☐ Male (including transmasculine) ☐ Female (including transfeminine)

☐ Non-binary ☐ Agender ☐ Genderqueer

☐ Other (please specify)... ☐ Prefer not to say

IRAS ID 329010, Version 1, 21.08.23

How would you describe your sexual orientation?

☐ Homosexual (Gay) ☐ Bisexual ☐ Pansexual ☐ Queer ☐ Asexual ☐ Lesbian

☐ Heterosexual (straight) ☐ Other (please specify)..... ☐ Prefer not to say

How would you describe your ethnicity?

☐ White British/English, Welsh, Scottish, Northern Irish ☐ Irish ☐ Gypsy/Irish Traveller ☐ Roma ☐ White European ☐ Mixed White Background

☐ Other White Background (please specify).....

☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese

☐ Other Asian Background (please specify).... ☐Mixed Asian & British

☐ Mixed Asian & Other Background .....

☐Caribbean ☐African ☐ Mixed Black African & British ☐ Mixed Black Caribbean & British ☐ Mixed African & Caribbean ☐ Mixed Black & Other background ☐ Other Black background (please specify).....

☐ Any Other Mixed Ethic Background (please specify) .....

☐ Other Ethnic Background (please specify) .....

☐ Prefer not to say

Please select the option that best represents your Religious/Faith/Spiritual identity.

☐ Christianity ☐ Islam ☐ Jewish ☐ Hinduism ☐ Buddhism ☐ Sikh ☐ Agnostic ☐Atheist ☐ No religion ☐ Spiritual ☐ Other (please specify)..... ☐ Prefer not to say

Please select your age

☐ 18-21 ☐21-25 ☐26-30 ☐31-35 ☐35-40 ☐41-45 ☐45-50 ☐51-55 ☐55-60 ☐61-65 ☐ 65-70 ☐70+ ☐ Prefer not to say

2g Example Interview Schedule

IRAS ID 329010, Version 2, 29.01.24 MHP version

Interview Schedule for Interviews for Mental Health Professionals

Interview topic guide,

I will confirm with the participant if they have received the signposting support materials and share the support document in the chat of the Microsoft teams calls.

The following topics will be covered throughout the interview.

Topics: Mental Health, Gender, gender and mental health services.

Mental health

How would you describe your mental health history and

your relationship with mental health services?

-Holistic perspective of individual’s experience

- if gender played a role of understanding the intersection of gender, gender identity and mental health difficulties and accessing support does not come up organically I will ask more directive questions,
- Did professionals treat you different because of you gender?
- Ability to explore mental health/gender or have mental health seen as separate to gender.

Gender

- How would you describe your gender identity – what does this mean to you?
  - What aspects of your childhood have informed your gender identity as it is now? (pastimes, events & experiences and if not coming up what pastimes inform your gender identity now as an adult)
  - Has your gender developed in a continuous way over time or have there been events or experiences that have opposed or rejected how it is currently?

Gender & MH services:

- Ability to explore mental health/gender or have mental health seen as separate to gender.

What are your thoughts about how mental health services understand gender?

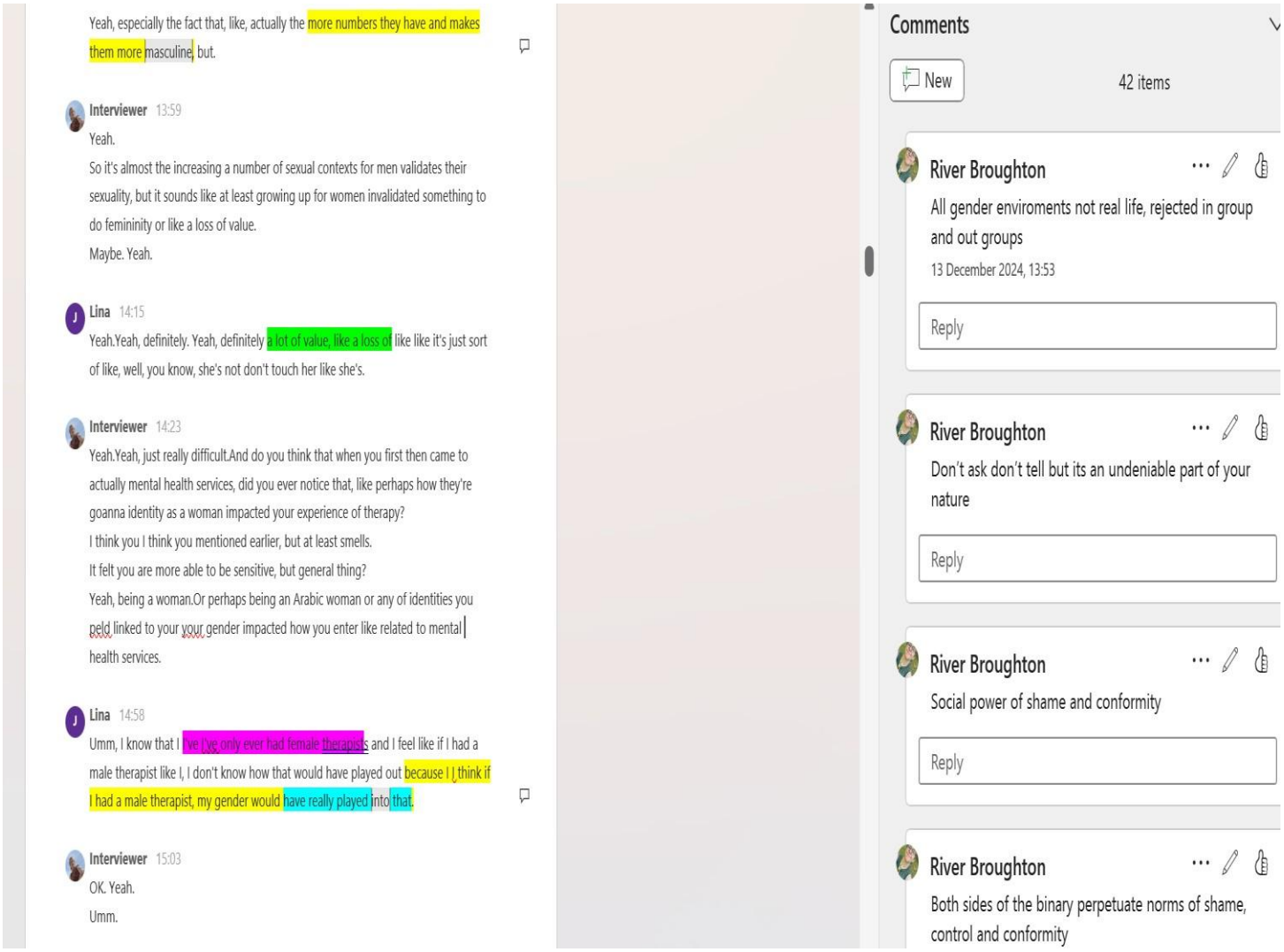
Question themes generated by SU’s (Themes of wanting to understand staff awareness of *how* questions about gender are asked (the type of language or context they come up) and understanding the feeling of gender identity is a topic clinicians avoid.

Do you ask about gender identity in your work/how do you/did you feel exploring gender with your clients?

- What do you think might inhibit conversations about gender in your work/within your wider team?

Participants will also be informed that there might be voluntary opportunity to participate in a focus group with mental health staff discussing how gender identity is understood in mental health settings. They will be able to opt in by replying to the debrief email they will receive post interview and do not need to decide now. They will be informed that the staff will have undergone the similar interviews as them apart from the questions about accessing mental health services.

2f: Transcript coding extract



Yeah, especially the fact that, like, actually the more numbers they have and makes them more masculine, but.

Interviewer 13:59
Yeah.
So it's almost the increasing a number of sexual contexts for men validates their sexuality, but it sounds like at least growing up for women invalidated something to do femininity or like a loss of value.
Maybe. Yeah.

Lina 14:15
Yeah.Yeah, definitely. Yeah, definitely a lot of value, like a loss of like like it's just sort of like, well, you know, she's not don't touch her like she's.

Interviewer 14:23
Yeah.Yeah, just really difficult.And do you think that when you first then came to actually mental health services, did you ever notice that, like perhaps how they're goanna identity as a woman impacted your experience of therapy?
I think you I think you mentioned earlier, but at least smells.
It felt you are more able to be sensitive, but general thing?
Yeah, being a woman.Or perhaps being an Arabic woman or any of identities you peld linked to your your gender impacted how you enter like related to mental health services.

Lina 14:58
Umm, I know that I I've I've only ever had female therapists and I feel like if I had a male therapist like I, I don't know how that would have played out because I I think if I had a male therapist, my gender would have really played into that.

Interviewer 15:03
OK. Yeah.
Umm.

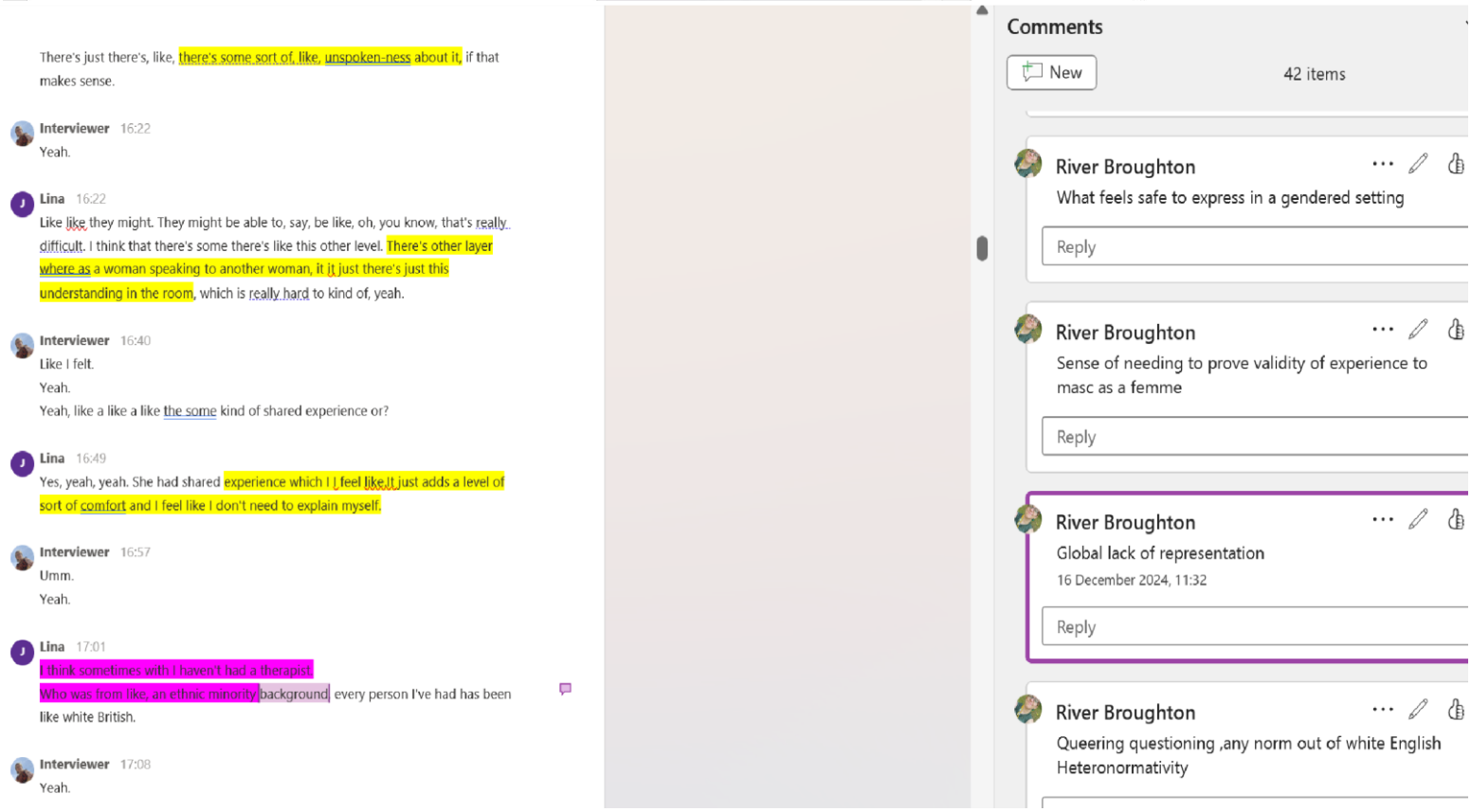
Comments
New
42 items

River Broughton
All gender enviroments not real life, rejected in group and out groups
13 December 2024, 13:53
Reply

River Broughton
Don't ask don't tell but its an undeniable part of your nature
Reply

River Broughton
Social power of shame and conformity
Reply

River Broughton
Both sides of the binary perpetuate norms of shame, control and conformity



There's just there's, like, there's some sort of, like, unspoken-ness about it, if that makes sense.

Interviewer 16:22
Yeah.

Lina 16:22
Like like they might. They might be able to, say, be like, oh, you know, that's really difficult. I think that there's some there's like this other level. There's other layer where as a woman speaking to another woman, it it just there's just this understanding in the room, which is really hard to kind of, yeah.

Interviewer 16:40
Like I felt.
Yeah.
Yeah, like a like a like the some kind of shared experience or?

Lina 16:49
Yes, yeah, yeah. She had shared experience which I I feel like,it just adds a level of sort of comfort and I feel like I don't need to explain myself.

Interviewer 16:57
Umm.
Yeah.

Lina 17:01
I think sometimes with I haven't had a therapist.
Who was from like, an ethnic minority background every person I've had has been like white British.

Interviewer 17:08
Yeah.

Comments
New
42 items

River Broughton
What feels safe to express in a gendered setting
Reply

River Broughton
Sense of needing to prove validity of experience to masc as a femme
Reply

River Broughton
Global lack of representation
16 December 2024, 11:32
Reply

River Broughton
Queering questioning ,any norm out of white English Heteronormativity

Appendix 3: Summary of Papers Reviewed.

The mental health experience of transgender and gender diverse Colombians

Acosta (2024), a grey literature PhD in psychology using Reflexive Thematic Analysis (RTA), exploring the perceptions and experiences of TGD people accessing MH services in Colombia. 40 people participated in semi-structured interviews. A predominantly urban, university educated and employed Three had no healthcare plan; others were either ‘contributors’ (paycheque-deducted) or on government-subsidised plans due to protected class status.

Acosta adopted a social constructivist epistemology drawing on minority stress and health belief theories. They identified an overarching theme; as ‘Cistem’: mental health systems were not made to include TTGD populations.

Three main themes and ranging subthemes:

Experiences which: 6 subthemes, 1.1.1-1.1.2 addressing structural barriers and the need perform to the standards of the system, 1.2-1.2.2 addressing the ignorance and policing perpetrated by MHP and 1.3 accessing help only comes at crisis.

Perceptions: 3 subthemes addressing the hopelessness and fear of the harm that might be experienced when accessing help, lack of guidelines and enforcement of MHS on TGD people.

Addressing Needs: 5 subthemes, 3.1.1-3.3 covering the need to heal alone and self-manage, community connection and activism, autonomy in transition and surviving a hostile society.

Acosta Canchila (2024) concluded the administrative set up and training of clinicians does not account for the existence of TGD people. Which is reflected in the exclusionary narratives in wider society, even when adaptions are attempted these are still framed through binary perceptions of gender. MHP also lack understanding and education on supporting people experiencing marginalization and discrimination. Finding affirmative spaces requires knowledge and the ability to select treatment.

Experiences of Older Transgender and Gender Nonconforming Adults in Psychotherapy: A Qualitative Study

Elder (2016) undertook a TA investigation into psychotherapeutic experiences across the lifespan of the participants, investigating the historic context and influence on therapy and how psychotherapeutic services have progressed, with the understanding the needs of TGD people are often overlooked due to transphobia. Ten, one-hour interviews were gathered with each participant having a minimum of 1 psychotherapeutic experience, time in therapy ranged from 2-42 years across their life across a range of psychotherapeutic modalities.

Three Categories, 1: Experiences in therapy: Trans affirmative and healing and painful, negative, transphobic experiences. Positive changes to conduct off therapy.

Category 2, Life experiences; Transition, transition issues, unique older TGD experiences, Family of origin, Discrimination & abuse, Resiliency community and activism.

Category 3 Recommendations: For TGD seeking therapy, recommendations for providers.

Life experiences, including gender and transitioning, older TGD experiences, family of origin, discrimination, abuse, resiliency & activism and recommendations for TGD and trans affirmative therapy.

Although participants reflected on significant move away from ‘curing/conversion’ practices on TGD identities many had experienced and endured as abusive perpetrated by the system and MH and healthcare providers are more knowledgeable, this primarily marks a shift away from active prejudice rather than knowledge and understanding to help develop deeper empathic understanding of GI and older TGD experiences.

A Phenomenological exploration of transgender people’s experiences of mental health services in Ireland

Delaney & McCann (2020) undertook an exploration of personal experiences of TGD people navigating the Irish MHS, utilising Interpretive Phenomenological Analysis (IPA). IPA allows for an in-depth analysis of participants experience of the research phenomena which can lend itself to smaller sample sizes. Four participants were interviewed, lasting 45-60mins.

Themes: Affirmative Experiences; affirmation was framed as encouragement and validating understanding of trans experiences as opposed to pathologising TGD identities. Alongside proficient insight into the systemic and societal barriers faced by TGD people and the barriers to GAC.

Non-affirmative experiences: participants shared the discreditation of their own phenomenological experience of their identity. Non-affirmation was also characterized by discrimination and misinformation and attempts to dissuade someone from their individual experience of their GI.

Clinician relationship refers to stories of different professions encountered and developing rapports of trust and comfort. Clinician relationships were also characterized by inauthenticity and lacking in support.

Delaney & McCann (2020) specified the role of nurse managers in the Irish system to provide an organisational approach on a systemic level; policy, care practice and clinical environment to better improve care for Irish TGD people.

Requeering the Trans Binary: Gender Nonconforming Individuals’ Experiences in Counseling and Therapeutic Settings.

Stephens (2018) a grey literature PhD in counselling, following a queer theory informed hermeneutic phenomenological design, exploring TGD people, explicitly focusing on those who identified outside of binary gender categories. Nine participants were interviewed (45–60 minutes each), generating eight master themes:

Queer Identity Development: Participants reported challenging normative gender expectations throughout their lives, leaving them alone to try and make sense of their identities amid prevailing normative narratives. Many experienced increased anxieties around medical transition with only binary pathways feeling openly available. The researcher found terminology to be inconsistent, personal sense making was central and labels were used primarily for convivence. However, finding ‘non-binary’ language was an affirming experience for all participants identity formation.

Internal barriers: All participants shared experiences and predictive fears of mental health services repeating marginalisation and oppression experienced elsewhere in their lives.

Environmental & External Binary Pressures; Stories shared of non-binary gender expression being invalidated. There were varying reactions to the internalisation of hurt and othering from social interactions.

‘The works not done yet’: Participants valued non-prescriptive therapeutic space with collaboration on being goal focused or allowing for a more open exploration. Having space to freely explore GI alongside other life challenges felt validating. Participants also highlighted the importance for TGD community connection outside of therapy.

Therapist reactions to Transgender Identity Exploration: Effects on the Therapeutic Relationship in an Analogue Study.

Bettergarcia and Israel (2018) used an analogue experimental design to examine TGD participants’ responses to three mock therapy video conditions: affirming, non-binary affirming, and non-affirming. Participants (N = 409) were grouped by medical transition status (38% no desire, 34% interested, 19% in progress, 10% completed) and randomly assigned to conditions. The non-binary condition involved fluid gender exploration without assumptions of medical transition, while the

non-affirming condition featured pathologising language (e.g., “You’re really confused about your manhood”).

Participants completed the Counselor Rating Form–Short (CRF-S), Session Evaluation Questionnaire (SEQ), and Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS), though only CRF-S scores were used in the main MANOVA and ANOVA analyses. CRF-S subscales assessed Attractiveness, Expertness, and Trustworthiness using 7-point Likert scales.

Results supported the first hypothesis: participants rated both affirming conditions significantly more positively than the non-affirming condition across all variables, with medium to large effect sizes. No significant differences were found between the two affirming conditions. The second hypothesis that ratings would vary by transition status was not supported. Transition goals did not significantly influence preference between affirming conditions.

The findings highlight the harmful impact of non-affirming approaches, even when presented with warmth. Trust, empathy, and affirmation of TGD identities reaching beyond assumptions of medical transition are central to therapeutic effectiveness. Clinicians should remain informed on evolving gender-related guidelines and tailor affirming practices to individual client needs, supporting fluid, non-linear gender journeys.

Seeking Support: Transgender Client Experiences with Mental Health Services.

Benson (2013) conducted a feminist phenomenologically informed thematic analysis of seven TGD people and their perspectives of therapy. The following themes were developed; Purposes for seeking mental health services: Quality of life (QoL) and gender identity. QoL refers to factors such as wellbeing, relationships and emotional health. There was an assumption by services that all of these would be explicitly linked to GI, but this was not always the case. However, these issues are often better understood to co-occur alongside the impact of living in a transphobic world.

In the Gender Identity theme, participants were pursing transition and needing professional sign off for documentation like a name change or accessing medical treatments. Here MHS are not sought out as need but a requirement which causes frustration at needing your own identity legitimatised by an MHP.

The themes of Problems in practice, therapist reputation and trans affirmative practice are summarised in table 3.

Transgender and gender diverse clients’ experiences in therapy: Responses to sociopolitical events and helpful and unhelpful experiences.

Puckett et al. (2023) Thematically analysed qualitative survey data investigating TGD participants experience of discussions of GI and sociopolitical events. The cohort was part of a larger study by the authors on self-reported mental health (MH) diagnoses, service engagement, and perceptions of therapists (Puckett et al., 2022). Investigator-developed, open-ended questions, data points were collected monthly over twelve months. Of 107 participants, 17–32 responded monthly, yielding 297 data points on sociopolitical events, 658 on helpful, and 615 on unhelpful therapy experiences.

Sociopolitical context Themes included: facilitating coping by bearing witness; integrating identity, systems, context; and feeling disconnected or misunderstood. Referenced events included Trump’s presidency, Supreme Court rulings and Elliot Page’s coming out. Therapists who acknowledged the personal significance of such events were highly valued.

Themes on helpful and unhelpful therapy experiences are summarized in Table 3. Although therapists were rated highly at baseline, negative experiences were still common.

Puckett et al. (2023) theorise that even affirming therapists may lack nuance in understanding TGD identities and the fundamental importance of more GI education. Validation, empathy, and therapist confidence in discussing identity-related topics were essential. The authors underscore the need for therapist proactively understand on TGD-specific concerns and awareness of sociopolitical impacts when working with TGD populations. Identity discussions and acknowledgment of minority stressors can enable rupture and repair processes, fostering therapeutic trust. Sociopolitical events offer non-pathologising, exploratory pathways into starting gender-related themes. The authors proactively highlight a weakness of the study that they did not track if participants’ stayed with the same therapy provider and the struggle many TGD people report finding an affirming therapist, and whether or not high validation scores are skewed by ‘making do’ or having to choose to not explore gender.

Appendix 4 MHP reflections on connecting with and describing personal Gender Identity

Many participants shared that TGD is ‘lumped’ together with LGBTQIA+ identities, maintain the impression that only people outside the cisheteronormative have a gender identity. One of this research aims was to understand how MHP understood gender as a concept and to understand if doing so encourages reflections about the role gender plays in all of our lives to increase curiosity and confidence around discussing. This theme will share the stories and experiences of how the professionals related to their own sense of GI.

“Whatever my supervisor was interested in, I'll do it on that. It just so happened that my supervisor was really interested in gender identity. And my whole dissertation was on gender identity. And really entered it from an academic perspective. And then more that you read, the more that you understand things, the more you like. That's interesting. I feel like I'm reading about me. - Lou

“Having that experience of working with male family therapists ever since I started nurse training. Gave me an experience of males in a very different way. Gave me an experience of males as not always being overtly misogynistic and that they listen to your opinions and that there's other ways of seeing the world. My view of their view.”- Sue

“I think very mad thing. Is, is, is loving cars. Obviously I've got lots of them and I really enjoy that because it was a nice segue away from all of this my career away from choosing a wrong path because I really put my sunk and my teeth into It but it also is like I see what other men do and they do also have share very similar hobbies with me. -Viraj, it stems from and growing up and seeing all of the, I guess some part of the horror... Viraj

“I don't know about positive rather than comfortable maybe. Comfort accepted or implicit. What is the right word?” -Aylin (speaking about positive or affirming experiences of her GI)

“Like just become invisible, which has its advantages. But also, it's a bit of a loss actually that feeling of like my power as a young woman has gone.... if you needed directions or help with something, I just feel like it's much easier for a young woman to have that. Yeah, that I'd say that is how it felt like power. As in people will listen to what you have to say, not actually because of what you're saying, but the body that is coming out of”. - Heather

“That’s a big question, ……I for me, I've really understood it to be well understood, my gender identity to be represent a representation or an expression of me. I'm not. And someone that fits really well into so constructed boxes of gender and nor do I want to, so. I think I found nonbinary a bit of a rest of the place where answers aren't necessarily needed, but that fits with me and my idea of me”. -Lou

“I often fantasise, you know, like if I grew up in a place that was like. The spaces that I'm talked about before colonialism arrived in places like Jamaica. I think what kind of person I would have been?” – Kian

Appendix 5 Service User suggestions for future training

Better/More Training	Types of training	Admin & Systemic Processes
Education for admin staff on assuming titles or gender […] based on voice over the phone […] They should be educated in that as part of their training, so like AFAB and AMAB. (Milo, trans masculine, SU).	"Staff should have interactive seminars deconstructing societal norms and FAQs and social stories to help staff with gender identity and queerness. Staff need to better understand the umbrella of terminology […] the diversity of the trans experience. "(Malachite, 25-30, agender, SU).	Better processes […] with legal and chosen names. Better system for pronouns on the system. (Milo).
More could be done there and within the NHS, [..] I think t unless your team leader is going to say this is mandatory training […] only people with personal interest will seek it out. (Heather, 45-50, staff, ciswoman)	"It's not just about […] didactic teaching. […] I just wonder about […] how we're inviting people to jostle together in a in a safe way". (Kian, 35-40, cis man, Staff)	They did the investigation […] and unfortunately, they couldn't keep me updated […] [, she said we will try and implement training going forward. We've spoken to the psychiatrist […] but he's never acknowledged it. (Teddy, on psychiatrist disclosing their gender identity to GP despite being asked not to, and a desire for better complaints processes)
"I always put a little stick figure with arrows in my trainings […] showing the intersections of faith and identity and LGBT+ people facing islamophobia or a trans person facing transphobia even at a queer event" (Aylin, 3135, ciswoman, staff, on more intersectionality in training)		