Narratives of Mental Health Professionals Supporting Trans, Gender Diverse and Gender Questioning Adults

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Abstract

Trans, gender diverse and gender questioning people appear at a high risk of suffering from mental health difficulties, but often describe having negative experiences accessing both physical and mental healthcare in the UK. At the same time, health professionals have described feeling deskilled, and lacking confidence in their ability to support gender diverse people. There has been limited research exploring the experiences of mental health professionals who provide care for gender diverse people in mainstream mental health services, and even less in the UK. In this study, 7 mental health professionals from a range of disciplines took part in semi-structured narrative interviews via Skype, telephone, or in person. Accounts were analysed using Constructionist Narrative Analysis, to better understand the types of stories told, the positions taken by the participants, and the local, social and historical contexts of the narratives' construction. The clinicians' narratives were infused with wider societal narratives, which were drawn on and resisted in their stories. These included narratives of *feeling deskilled, standing up to higher powers, separating different parts of a person, risk from men,* and *transwomen as dangerous.* Implications for clinical practice have been suggested, such as providing open and non-judgmental space for discussion when training mental health professionals in gender diversity, and holding in mind the influence of powerful narratives when designing policies and making decisions about mental healthcare for gender diverse individuals.

Chapter 1. Introduction

Terminology

This project is about the narratives of mental health professionals who have provided care for trans, gender diverse, and gender questioning individuals. Thought and practice around gender diversity is continually evolving, ideas and positions frequently contested, and language has become a topic of debate in itself. It is therefore important to begin this dissertation by introducing the terminology I have used in relation to queer and trans identities.

Firstly, it is important to delineate 'sex' and 'gender'. The term 'sex' is generally understood as whether a person is biologically 'male' or 'female', and 'gender' describes how a person identifies socially (Barker & Scheele, 2019).

In this dissertation, I use the term 'queer' to describe people "outside of the heterosexual norm" or ideas which challenge "norms around gender and sexuality through different ways of thinking or acting" (Barker & Scheele, 2016, p. 7). The term 'trans' is often used as a shorthand for 'transgender', and as an umbrella term for people whose gender identity is different from their birth assignation, including those whose gender is "at odds with the labels 'man' or 'woman'" (Whittle, 2006, p. xi), whether or not they have had, or wish to have any physical interventions. As well as 'trans' being a term which refers to individuals and their identities, Pearce (2018) also describes discourses of "trans as movement", referring to collective, politicised, social movements, and the creativity, fluidity, and world-building of queer identity and experience (p. 9).

The term non-binary is also used as an umbrella term, to describe genders outside of the dominant, binary conceptualization of gender (Barker & Richards, 2015). Although non-binary gender identities are often understood as part of the trans umbrella, some non-binary people do not also identify as trans (Scottish Trans Alliance, 2016). 'Cisgender' (often shortened to 'cis') refers to people who live their life in line with the gender which was assigned to them at birth (Enke, 2012).

'Gender non-conforming' is a term often used to describe people whose gender presentation does not 'conform' to the presentation expected of the gender role assigned to them at birth. This description can also include people who identify with the gender they were assigned at birth, but do not follow the 'rules' of their gender role. The term 'gender questioning' often refers to someone who is in a process of questioning or exploring their gender. 'Gender diverse' is another umbrella term. Similar to the term 'trans', it includes anyone whose gender identity, role or expression is different from the gender they were assigned at birth. This umbrella terms tends to more comfortably include non-binary, non-conforming or gender questioning people who may not identify with the word 'trans'. Therefore, I have used the phrase 'gender diverse' throughout this dissertation to refer to trans, non-binary, non-conforming and gender questioning people. I will at times also use the terms 'trans' or 'trans identities', referring to trans and queer discourses and movements, as described by Pearce (2018).

Many articles included in the literature review use the acronym 'LGBT', to refer to lesbian, gay, bisexual and transgender people. This acronym has been shortened to 'LGB' when articles have only focused on sexual diversity, excluding gender diversity. Finally, I will use

single quotation marks to highlight a specific word as contested or as a construction (e.g. ‘competence’), and double quotation marks when directly quoting an author or participant.

The journey here

I also begin this dissertation by situating myself, the researcher, and how this research came to be. Wells (2011) describes how “the researcher inevitably shapes the investigation”, and the importance of researchers knowing themselves, “to enhance understanding of the phenomenon under study” (p. 119). In their description of constructionist narrative analysis, Esin et al. (2014) highlight the importance of examining how researchers are positioned in relation to their research. Thus, I have also included this here, to allow readers to consider for themselves how the contexts of the researcher have shaped the research. The section finishes with a brief introduction to my epistemological position, which is expanded in the Method section.

How the research came to me

When thinking about my journey here, the story could start from many different beginnings. The story could begin when I was 14, in Catholic secondary school, beginning to realise that my life would be very different from the one I expected, and was going to be unacceptable to many of those around me. Or it could begin when I was 11, when I learnt that being a ‘tomboy’ wasn’t allowed any more, and I had to change the way I looked if I wanted to go by unnoticed. The story could start when I was 22, living in a queer flat-share with a good friend, whose mental health team would not offer them psychology sessions, because they ‘didn’t know enough’ about their gender identity. Or it could start with the inspiring conversations I had with that same friend 3 years later, about their own research in the field of education, and the incredible work of Dr Ruth Pearce.

Mental health and queerness have been two strands of my personal and professional life story, since before I was born. The strands have met, diverted, intertwined and engulfed each other, shaping the people I have met, the relationships I have had, and the person I am now. So, it isn’t much of a surprise that I have been particularly interested in the places where mental health and queerness meet. As a queer person, I have met and loved people who hold, create, and dance with gender in so many different ways. And sadly, I have also heard their stories of struggle in a healthcare system which doesn’t always have space for them. As a mental health professional, I have met, worked with and admired colleagues in my places of work, who are committed to supporting whoever comes through the door. Yet, I have also seen them struggle with ‘knowing what to say’, or how to provide the best care for gender diverse clients. With a foot in both of these worlds, and hearing multiple stories of a wish for something better, this research came to me.

My position in relation to the research

As a mental health professional, I consider myself a member of the participant group included in this study. I can relate to shared experiences of working with limited resources, the shared language of mental health and illness, and the shared working culture. Through my experiences working in the public sector, I have taken an anti-austerity position, recognizing the pressure put on services due to a decade of government cuts. My position in relation to my participants (and other mental health professionals who haven’t participated) is that ‘people make the best choices they can, given the constraints of their situation’ (Jones &

Asen, 1999, p. 39). Thus, not internalising the 'blame' for any poor practice within individual workers, but within a dysfunctional system.

In proposing this research, I have positioned myself as a queer person with a concern for the care gender diverse people receive in mainstream mental health services. I position myself as an ally to gender diverse communities, and believe in inclusive and affirmative mental health care, which validates people's experiences, without judgment or discrimination.

More broadly, I conduct this research under the discipline of Clinical Psychology, which positions itself as a scientific discipline, using theory and evidence to inform practice. It is important to note that Clinical Psychology, and other mental health professions, have a dark and unethical history in relation to sexual and gender minorities (Clarke et al., 2010). Historical practices were pathologizing, attempting to diagnose and 'cure' what was considered 'deviant' from the heterosexual norm (Bayer, 1981), and many of these practices endure around the world. The scientific tradition has historically held a harsh separation between the 'researcher' and 'researched', 'doctor' and 'patient'. In contrast to this tradition, the institution from which I conduct this research appreciates qualitative research, recognising the need for post-structural approaches to understanding lived experiences, and the local and experience-near knowledges needed to help inform practice. In this research I try to bring my personal experiences of sexual and gender diversity to the work, and have sought service user consultation to aid me further.

When considering where the power lies in this research, as the researcher, I have the most power - I choose who participates, and how they are portrayed. My participants discussed their gender diverse clients, who have the least power in the research as their voices are not directly heard.

My positions as both a mental health professional and a queer person in relation to this research, create both strengths and barriers. I may be more attuned to the specific contexts, languages and references made by the participants when telling their stories. However, these positions can also create barriers to listening and analysing from an outsider or neutral position, therefore I have attempted to actively listen from these positions.

My epistemological position

In this research, I have taken a social constructionist position. Gergen (2011, p. 2) describes social construction, writing that "what we take to be the world importantly depends on how we approach it, and how we approach it depends on the social relationships of which we are part." Social constructionist ideas have contributed to understandings of both mental health, and queer experience. Barker and Scheele (2016) describe how queer theory examines power relations, and dominant understandings of sexual and gender identities, exposing how these ideas are constructed by their time and place, and how gender is performed (e.g. Butler, 1990). Similarly, Bentall (2004) and Foucault (1965) describe how dominant ideas about 'madness' have been shaped by historical events, policies, and institutions of the West[1], particularly rooted in "scientific foundationalism" (McNamee & Gergen, 1992, p. 1). Through taking this epistemological position, I posit that the contexts and dominant

[1] I use the contested terms 'West' or 'Western' to describe parts of the world dominated by 'white' people, as a result of the European diaspora which occurred through colonisation (Ryde, 2009).

discourses available to mental health professionals today, shape how we construct our understandings of mental health and gender diversity.

Situating the research

Current Context

Recent years in the UK have seen an increase in representation of gender diverse people in the media (Barker, 2017), increased legal protections for people identifying as trans, and a growing influence of trans people and trans ideas in the sphere of health (Pearce, 2018). At the time of writing, the Gender Recognition Act 2004 is being reformed, aiming to improve the processes of gaining legal gender recognition for gender diverse people. However, this increase in representation and legal protection has been met with stories of 'moral panic' in some sections of the media (Barker, 2017; Stone, 2018), questioning the rights, self-determination, and even the existence of gender diverse people.

Transphobia and homophobia are terms which describe prejudice or discrimination against sexual and gender minorities. Unfortunately, examples of transphobia are very common across the world, documented in popular media, research literature, and crime statistics. In June 2019, the BBC reported that transphobic hate crimes had risen by 81% (BBC, 2019), and every year, the Trans Day of Remembrance honours the lives of gender diverse people who had been murdered across the world (Transgender Europe, 2019). Mizock and Hopwood (2018) describe the economic challenges faced by gender diverse people, as a result of transphobia, and Pearce (2018, p. 54) provides several examples of how "anti-trans prejudice can have severe consequences for trans patients."

During the time this research was conducted, mainstream media in the UK has been particularly interested in the treatment offered to gender diverse young people. The national gender clinic for under 18s was criticised in many popular news outlets (e.g. Adams, December 2019; Donnelly, December 2019), and in March 2020 a judicial review began investigating consent procedures around young people receiving physical interventions (e.g. Doward, March 2020; Duffy, March 2020). In April 2020, women and equalities minister, Liz Truss announced that she will be "making sure that the under 18s are protected from decisions that they could make, that are irreversible in the future" (Truss, 2020). Thus, the UK appears to be in a place of uncertainty and discord in public understandings of gender diversity and trans identities, with particularly polarised and hostile public debates.

Essentialist vs Constructionist Models of Gender

Many of the debates around gender diversity (e.g. single-gender spaces, and self-determination) have grown out of differing paradigms for understanding gender. The debates can largely be understood as essentialist vs social constructionist paradigms. Arguments against granting gender diverse people in the UK equal rights and legal protection often come from an essentialist paradigm of gender. An essentialist view claims that there are "certain essential, biologically based or psychologically universal features of gender" (Hepburn, 2003, p. 107). This essential gender identity is usually dependent on the sex assigned to a person as birth, based on their visible physical characteristics (Serano, 2007). Arguments from a 'gender critical' perspective often draw on gender essentialist assumptions to exclude transwomen from women-only spaces. Similarly, arguments from religious groups may draw on this paradigm when arguing against granting further rights to gender diverse people,

arguing that God created human nature to be male or female, and this nature cannot change (Thatcher, 2011). Alternatively, some 'gender critical' activists (e.g. Transgender Trend, n.d.), argue that the 'born in the wrong body' narrative, constructs gender identity as a fixed and essential characteristic of the brain.

Constructionist models of gender identity offer an alternative to the essentialist paradigm. These models suggest that gender identities are better understood in terms of context, historical period, culture and social circumstances (e.g. Eliason & Schope, 2007). Butler (1990) would argue that gender is 'performed' through behaviour and expressions, rather than those behaviours and expressions being as a result of an inherent gender. These models are more likely to be drawn on by queer theorists or activists in campaigning for improving the rights and legal protections of gender diverse people.

More recently, the essentialist vs constructionist debate has distilled into what some describe as a gender critical (e.g. Brunskell-Evans & Moore, 2019) vs gender affirmative (e.g. Hidalgo et al., 2013) debate, in the way medical establishments should support young adults and children with diverse gender identities. Arguments from these opposing ideologies play out in the media, healthcare settings, communities, and in the experiences of gender diverse adults and children themselves (Pearce, 2018).

Decolonising Gender

Anthropological research looks to other cultures and societies for examples which support or conflict with Western 'universal' ideas of humanity, such as gender. Famously, Margaret Mead (1935) contributed to a feminist critique of patriarchy by writing about the Chambri societies in Papua New Guinea, whose male-female gender roles appeared to be the reverse of Western gender roles, challenging the essentialist and 'natural' ideas of gender roles in the West.

Decolonising scholars such as Lugones (2007) go much further in explicating the role of the West in constructing these 'universal' ideas of gender. In her dissection of heterosexualism and coloniality, Lugones describes how 'sexual dimorphism' (binary genders) was a Eurocentric, colonial model, imposed on indigenous communities "to serve global, Eurocentred, capitalist domination/exploitation" (p. 196). For example, she describes how, prior to colonisation, many Native American communities recognised homosexuality, more than two genders, and were matriarchal and egalitarian, as opposed to patriarchal and hierarchical. She writes how colonisation and "the inferiorization of anafemales[2]" meant that 'anafemales' were excluded from leadership roles, control of property, and other important economic domains (p. 197). In addition, Barker, Vincent & Twist (2018) describe examples of non-binary genders across time and around the world, arguing that the binary 'opposite sexes' idea of gender was popularised in the West as recently as the late 19th and early 20th century.

As the centralising powers of the West have rotated around the Church, the State and Science, so has the oppression of trans and queer identities: as sinful, as illegal, and as

[2] 'Anafemales' (abbreviation of anatomical females) is a term originally used by Oyěwùmí (1997) as a translation of the Yoruba word *obinrin*, which was originally translated to mean female/woman. Oyewumi writes that the Yoruba ideas of anamales (*obinrin*) and anafemales (*okunrin*) were "neither binarily opposed nor hierarchical" (p. 32-33). The prefixes *obin* and *okun* referred to differences in anatomy, hence the terms 'anafemales' and 'anamales'.

pathological. Unfortunately, gender diverse people around the world are still oppressed by each of these mechanisms of power. However, as this research focuses on mental health, I will discuss in more detail the pathologisation of gender diversity in the West.

Pathologisation of Gender Diversity

Early sexologists in the West considered anything outside of the heterosexual norm as pathology or illness, describing queer people as 'profoundly disturbed' or 'psychopathic' (Stryker & Whittle, 2006). This initial conceptualisation of queer identities as sexual pathology, was carried forward into the early iterations of the *Diagnostic Statistical Manual of Mental Disorders* (DSM). In DSM-I (APA, 1952), and early prints of DSM-II (1968) homosexuality was considered a sociopathic personality disturbance. However, following pressure from activist movements (Bayer, 1981), homosexuality was declassified as a mental illness in the sixth printing of the DSM-II (1974). 'Transsexualism' was included for the first time in DSM-III (1980) and continued in the DSM-III-R (1987). In the DSM-IV (1994), the term transsexualism was replaced by 'Gender Identity Disorder', which was used to describe people who did not identify with the gender they were assigned at birth, and did not appear to have an 'intersex condition[3]' until 2013.

In 2013, this diagnosis was updated to Gender Dysphoria (APA, 2013), referring to the distress associated with the incongruence between assigned sex and gender identity. The change moved away from describing gender diverse people as having 'disordered' genders, and enabled non-binary people to be included in this diagnosis. However, continuing to list 'Gender Dysphoria' in the DSM, still positions people who have dysphoria as having a 'mental disorder'. In May 2019, the World Health Organisation voted for the ICD-11 to go one step further, replacing the previously named 'Transsexualism' with 'Gender Incongruence', and removing it from the list of Mental Health disorders completely (Human Rights Watch, 2019). Instead 'Gender Incongruence' is listed under the Sexual Health chapter, thus no longer describing gender diverse people as having a mental health problem.

Castro-Peraza et al. (2019) argue that the depathologisation of gender diverse identities is a human rights issue. They propose that gender dysphoria should be removed from diagnostic classification, as homosexuality has been. They argue that the pathologisation of gender diversity contributes to human rights violations experienced by gender diverse people, due to the stigma associated with mental illness. These violations include attacks, forced medical treatments, and lack of gender recognition. However, Serano (2007) argues that care should be taken that gender diverse individuals would still be able to access the physical interventions they require from medical practitioners, before gender identity disorder (now gender dysphoria) is removed from the DSM.

Gender Diversity and Mental Health

Unfortunately, it is unsurprising given the contexts described above that gender diverse people in the UK experience significantly high levels of mental health difficulties. The Trans Mental Health Study (McNeil et al., 2012; n = 889), reported that 48% of trans people in Britain reported having attempted suicide at least once, and 84% had thought about it. 55% reported being diagnosed with depression at some point in their lives. In addition, the survey

[3] The term 'intersex' is used to specifically describe people whose anatomy or physiology differs from the conventional expectations of a male or female person (Barker & Scheele, 2019).

reported that 63% had experienced one or more negative interactions in general mental health services.

Similarly, in the USA, Reisner et al. (2015) reported that transgender youth, sampled from an urban community health centre, had significantly more mental health difficulties compared to cisgender matched controls. Crissman et al. (2019) painted a slightly more complicated picture in their population study, finding that overall transgender individuals self-reported poorer mental health compared to cisgender individuals. However, when looking at groups of minority genders, they reported that cisgender females, 'female-to-male' individuals, and 'gender non-conforming' individuals reported poorer mental health than 'male-to-female' individuals and cisgender males.

Gender diverse people may require support from mental health services as a result of questioning their gender (Ellis et al., 2015), or the minority stress (Meyer, 1995) they may experience as a result of moving through the world as a gender diverse person. Equally, gender diverse people may require mental healthcare for issues completely unrelated to their gender identity. The links between gender diversity and mental health have been further complicated by the historical requirement that, prior to 2013, trans people were initially assessed by mental health services before being referred to gender identity services (McNeil et al., 2012; Pearce, 2018).

Several studies have described the specific challenges experienced by people with non-binary identities, which may contribute to their experiences of mental health difficulties. Thorne et al. (2018) compared 'mental health symptomatology' between binary transgender and non-binary young people, and reported that the non-binary group experienced significantly more anxiety and depression, and lower self-esteem. The authors suggest this could be due to the additional barriers and discrimination faced by non-binary people, in a society which sees gender in a very binary way. Similarly, Vincent (2016) describes how discourses in both medical contexts and queer communities often work to delegitimise non-binary identities, and Crissman et al. (2019) suggest that non-binary individuals may experience poorer mental health because of the widespread assumption of gender binaries in healthcare research, provision, and institutions.

Garrison (2018) suggested additional challenges faced by non-binary people, by comparing the identity narratives produced by binary and non-binary trans individuals. Garrison argues that some non-binary individuals may feel they have to produce narratives which reflected dominant cultural accounts of trans experience, in order to affirm their identity as being 'trans enough'. This pressure is reflected in some non-binary people's accounts of having to present as binary trans to gender clinics in order to access the interventions they require (e.g. Vincent, 2016). However, Vega et al. (2019) argue that Garrison's sample was not representative of non-binary people, particularly those who do not also identify as trans, arguing that 'genderqueer people' are the ones most likely to be critical of dominant gender narratives and gender essentialism.

Gender diverse individuals' experiences of healthcare

Physical healthcare

The research literature demonstrates inadequacies across different physical healthcare contexts around the world, in providing care for gender diverse individuals. Roller et al.

(2015) interviewed 25 trans individuals to explore how they navigate the American Healthcare system, and Kosenko et al. (2013) analysed responses to an online survey of 152 American trans people's perceptions of stigma in physical healthcare contexts. Pearce (2018) on the other hand, analysed discourses online from forums around trans people's experiences of the healthcare system in the UK. Despite their geographical and methodological differences, all three studies suggest that there are significant difficulties and barriers faced by trans people attempting to receive adequate trans-related physical healthcare (e.g. prescription of hormones), and non-trans-specific physical healthcare (e.g. primary care).

Similarly, Lindroth (2016) reported that transgender people in Swedish sexual health-promoting settings experienced healthcare professionals as lacking appropriate knowledge and having expectations of binary gender and heteronormativity. The participants also experienced poor access to healthcare in sexual health settings. Studies have shown that these negative experiences have a knock-on effect on gender diverse people accessing healthcare in the future. For example, Samuels et al. (2018) reported that nearly half the trans people they surveyed avoided going to the emergency department when in need of acute care, commonly due to fear of discrimination, or previous negative experiences.

Several studies have explored the barriers faced by gender diverse people in accessing appropriate physical healthcare. In her systematic review of eight primary studies, Kcomt (2018) reported that "transgender populations experience profound rates of discrimination within the U.S. health-care system" (p. 201). Similarly, in their review of the literature, Safer et al. (2017) reported that discrimination in healthcare, health insurance policies, employment, and public policy, as well as healthcare professionals lacking awareness about transgender health, contributed to the barriers gender diverse people face in accessing appropriate healthcare. Following focus groups with trans individuals, Bauer et al. (2009) describe how the *erasure* of transgender people in both the policies and information available to the healthcare system, has resulted in gender diverse people being seen as anomalies, and hence given the responsibility of remedying the system's deficiencies.

Several studies have reported that gender diverse people with other marginalised intersecting identities (e.g. Bowleg, 2012) have even poorer experiences of healthcare. For example, in their study of trans people of colour in Chicago, Howard et al. (2019) reported that most of their participants believed they would have more positive experiences of healthcare if they were cisgender or white. Similarly, Shires and Jaffee (2015) reported that 'female-to-male' transgender individuals in the USA who were Native American, multiracial or had lower incomes were more likely to experience discrimination in a healthcare setting.

Mental Healthcare

There has been a smaller amount of research into gender diverse people's experiences of accessing mental health services. Bess and Stabb (2009) interviewed 7 trans people in America who had received a course of psychotherapy. They described having supportive and affirming relationships with their therapists, who supported them both during and after making decisions about physical interventions. However, this study selected participants who had used psychotherapy to explore their current gender identity, rather than for support or treatment for mental health problems. Several participants in this study mentioned that during previous experiences of therapy, unrelated to their gender identity (e.g. for depression or grief), their mention of gender identity issues had been ignored, or responded to negatively.

These negative experiences were echoed in the study by Ellis et al., (2015) who analysed survey data from 621 trans people about their experiences accessing mental health services in the UK, for reasons other than trans-related care. Around a third of the respondents reported being dissatisfied or very dissatisfied with the care they received. They reported experiences such as their clinician not being educated on trans issues, and their gender identity not being seen as genuine, but seen as a symptom of mental illness. Around a third of respondents reported having worries about accessing mental health services due to their trans history. Many reported worries that any difficulty they present with would be interpreted as due to them being trans. Similarly, trans people in Australia have also expressed dissatisfaction with the mental health care they have received (Riggs, Coleman, & Due, 2014).

Similar to in physical healthcare, research suggests that previous bad experiences, fear of treatment (e.g. "I didn't know what would happen to me"), and stigma also prevent gender diverse people seeking mental health services when they require them (e.g. Shipherd et al., 2010). In her study, Pearce (2018) describes the mistrust gender diverse people might have towards mental health providers, such as fearing that disclosure of mental health difficulties may negatively impact on their access to physical interventions. However, one person in Pearce's study was quoted saying that blanket statements about mental health professionals being untrustworthy could also be harmful. Although gender diverse people commonly have difficult experiences with mental health professionals, some also have positive and supportive experiences (e.g. Sallans, 2018). In addition, all the transgender participants in Benson's (2013) study expressed a belief that mental health services can be helpful if the clinicians are informed about transgender issues.

Clinicians' experiences of providing care

As many individuals and researchers have highlighted, there appear to be inadequacies in the interactions between healthcare providers and gender diverse people. Despite this, there is limited research exploring clinicians' experiences of supporting gender diverse individuals. Snelgrove et al., (2012) and Poteat et al., (2013) both interviewed clinicians (e.g. physicians, nurses, endocrinologists) to explore the barriers and stigma transgender patients in North America face when accessing healthcare services. All but one of the clinicians interviewed in these studies were physical healthcare providers. Clinicians in these studies spoke of feeling deskilled, and one participant was quoted as "not knowing where to go or who to talk to" (Snelgrove et al., 2012, p. 4).

A handful of studies have investigated the attitudes of mental health professionals towards gender diverse people. Kanamori et al. (2017) reported that counsellors in the USA tended to have positive attitudes towards transgender clients, and Riggs and Sion (2017) reported that cisgender male psychologists and psychology trainees in Australia expressed more negative attitudes towards transgender people than cisgender females. Ali et al. (2016) reported that psychiatrists and psychiatry residents in Canada expressed less negative attitudes towards transgender people than those expressed by the general population. However, these studies do not provide any information about clinicians' experiences or actions when providing mental healthcare, and are highly subject to social desirability bias. The final part of this chapter will systematically review research into mental health professionals' experiences of providing care for gender diverse individuals, and the kind of research methods employed in these investigations, identifying the gaps in the literature and the rationale for the current study.

Systematic Literature Review

Search strategy

A systematic literature review was conducted, aiming to answer the research question 'How do mental health professionals describe their experiences of providing care for gender diverse clients? Table 1 presents the terms used to search for literature in this area. The terms were separated into two concepts, Concept 1 relating to *Mental Health Professionals*, and Concept 2 relating to *Gender diversity*. The 'AND' function was used to combine search results for these two concepts.

Table 1.

Search Terms.

Concept 1: Mental Health Professionals	Concept 2: Gender diversity
"mental health professional*" OR psychologist* OR "social worker*" OR "psychiatric nurse*" OR psychiatrist* OR therapist* OR counsellor* OR counselor* OR "support worker*" OR "healthcare assistant*" OR "mental health nurs*" OR "mental health worker*" OR psychotherapist*	agender OR nonbinary OR "transgender persons" OR transgender OR transsexual OR "gender diverse" OR "gender non-conforming" OR "gender questioning" OR non-binary OR gender-expansive OR "gender dysphoria" OR "gender identity disorder" OR transwom* OR transman OR transmen

The *Mental Health Professionals* concept was searched for within the title of research papers only, to ensure that Mental Health Professionals were the subject of the research. When searching for this concept within the abstract or keywords, many thousands of articles were found where mental health service users were the subject of the research.

The *Gender Diversity* concept was searched for in the title, abstract, and keywords of research articles in order to capture any reference to working with gender diverse people.

These search terms were used to search PubMed, SCOPUS, psycARTICLES, and psychINFO. The search terms "mental health nurse*", counselor, "gender dysphoria" and "gender identity disorder" were added after initial searches using PubMed, and reviewing relevant papers. The search term "gender identity" was removed as it generated many irrelevant papers about gender differences between therapists. The search term psychotherapist* was added after further searches using SCOPUS. No further limitations were made to the searches regarding earliest date of publication.

On 3rd November 2019, the search demonstrated in Table 1 generated 17 results in PubMed, 143 results in SCOPUS, 15 results in psycARTICLES, and 264 results in psycINFO. Altogether this totalled 439 search results. After excluding duplicates (171), 268 results remained.

The titles of these 268 papers were screened for relevance. Irrelevant papers were screened out[4] if the papers focused on: children or young people only (64); physical health or physical interventions only (7); sexuality rather than gender (17); studied career counsellors (2); or the papers were not about gender diverse individuals at all (4). Papers were included at this stage if they referred to LGBT individuals in general. 92 papers were excluded after the titles were screened, leaving 176 papers for further screening.

The abstracts of these 176 papers were then screened for relevance. Again, papers were screened out for the exclusion reasons outlined above (49). Papers were also excluded at this stage if they were: a book, chapter, commentary or review which did not include primary research (66); were not available in English (8); focused on training only (6); did not study mental health professionals (4); were not about professionals' experiences of providing mental health care (3); a specific clinical example (1); a paper about differential diagnosis (1); doctoral dissertations unavailable to read (7); or related to the development of a self-report measure (1). Following the screening of abstracts, 146 papers were excluded, with 30 papers remaining to be examined further.

The full text of these 30 papers were read and screened for relevance. Papers were excluded from the systematic review if the research was: with supervisors rather than clinicians (1); about LGBT people in general, without specific findings related to gender diverse people[5] (7); focused on staff training (1); a commentary (1); not about mental health care (1); a specific clinical example (1); or not about professionals' experiences working with gender diverse clients (2). Six papers were excluded which only measured mental health professionals' self-reported attitudes towards gender diverse individuals, without reporting any other experiences, or actions related to their work.

Following this final screening, 20 papers were excluded, leaving 10 relevant papers to be reviewed. After an extensive citation and reference search of these 10 papers, one additional paper was found to be relevant to the review. This paper used the word 'clinician' to refer to mental health professionals, which had previously not been included in the searches. One more search was conducted in each of the databases using the word 'clinician' and the *Gender Diversity* concept, which identified one more paper relevant to the review. Therefore, the total number of papers included in the review was 12. See Figure 1 for a flowchart demonstrating the process described above.

[4] Some papers were screened out for more than one reason.
[5] Research which sampled LGBT people in general were only included in the review if they reported findings specific to working with gender diverse clients.

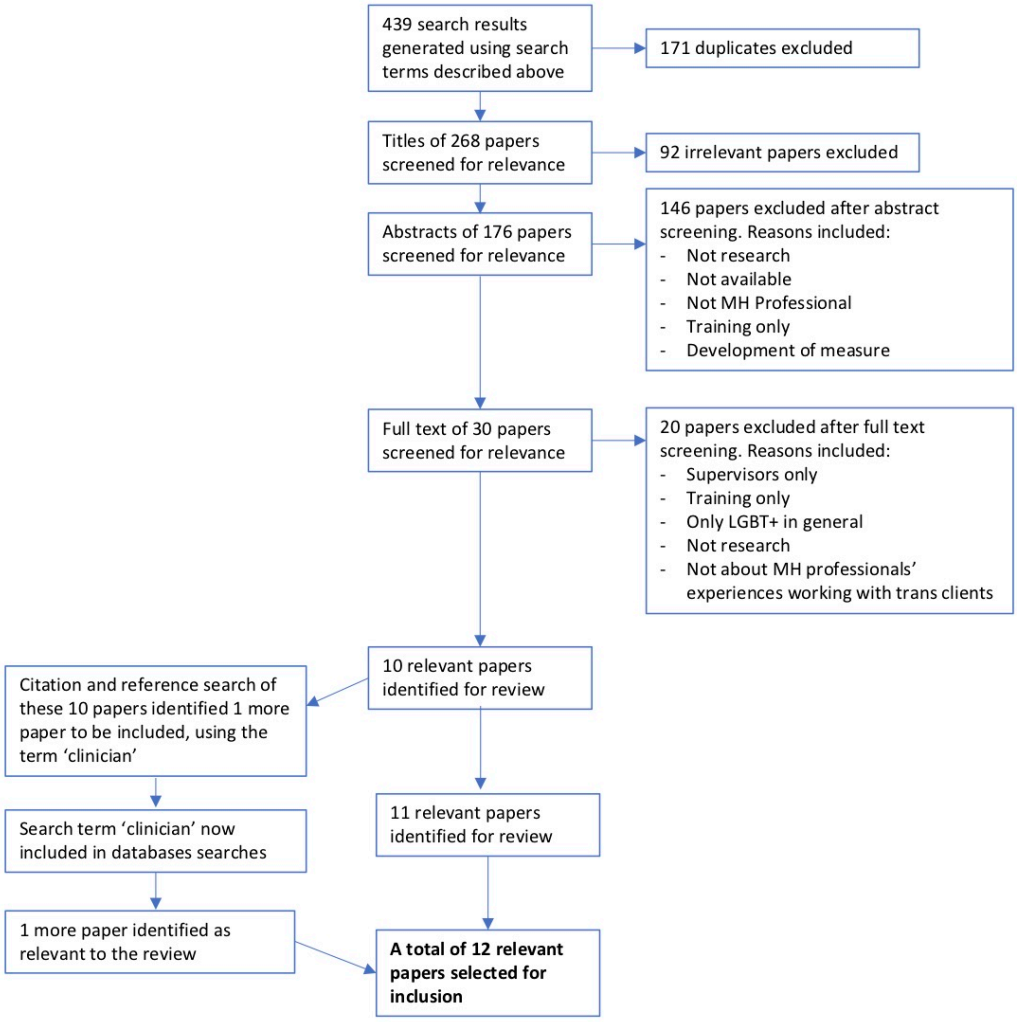

Figure 1. Steps of the Systematic Review.

Synthesis strategy

The papers selected were organised into three groups, determined by their methodology. The findings for each group were initially synthesised separately, and the quality of the methodologies used by the studies in each group were evaluated. The similarities and differences between the findings from different studies were explored. The findings across all the groups were then drawn together, and the research evidence as a whole was critiqued. This process maps on to processes of Narrative Synthesis for studies with heterogenous methodologies, described by Ryan (2013).

Systematic review findings

Table 2 summarises the 12 papers selected for inclusion in the systematic review. The 12 journal articles can be separated into three groups, those which used quantitative methods (e.g. novel and standardised self-report measures), those which used qualitative methods (e.g. semi-structured interviews, reflective journals), and those which used mixed methods (e.g. surveys with both open and closed questions). Each journal article was subject to a quality

check, following the criteria outlined by Elliott, Fischer, and Rennie (1999). The outcomes of these quality checks can be found in Appendix A. These quality guidelines were selected because the authors pull together criteria for both quantitative and qualitative research, both of which are necessary for the articles included in the present systematic review.

Table 2.
Article Summaries.

Authors (Year)	**Country**	**Title**	**Aim**	**Participants**	**LGBT/ Trans**	**Methodology**	**Results and Conclusions**	**Strengths and Limitations**
Johnson & Federman (2014)	USA	Training, Experience, and Attitudes of VA Psychologists Regarding LGBT Issues: Relation to Practice and Competence	To survey the attitudes, experience, and practices of clinical psychologists who work with LGBT veterans	384 veterans' health administration (VHA) clinical psychologists	LGBT	Quantitative. Online questionnaire, 52 'quantitative questions' on training, experience, practice, attitudes, competence, and need for training in LGBT issues. Correlations and factor analysis used.	Psychologists had minimal training in sexual orientation in gender identity, although most showed a desire for further training. One third felt competent treating transgender clients. Younger psychologists showed more positive attitudes and better competence. Training in graduate school had biggest impact on lifelong experiences and attitudes towards working with LGBT clients, therefore an important time to train.	Strengths: snapshot of current attitudes/competences, and ideas for positive change. Weaknesses: included data from psychologists who worked with very few, or no trans clients. More focused on sexuality. Limited generalisability. Quant analysis missed depth. Didn't ask participants about race/ethnicity/sexual orientation
Riggs and Bartholomaeus (2016a)	Australia	Australian mental health professionals' competencies for working with trans clients: a comparative study	To survey Mental health professionals' competency working with trans clients, and explore variables which could be correlated	304 counsellors, mental health nurses, psychiatrists, psychologists and social workers	Trans	Quantitative. Online questionnaire including: demographic questions; adapted version of the Counsellor Attitude Towards Transgender Scale (CATTS, Rehbein, 2012); and novel Confidence in Working with Trans Clients Measure (CWTCM). Factor analysis and ANOVA to interpret results	Greater experience working with trans clients predicted higher levels of comfort. Negative relationship between reported comfort and religiosity. Females and participants with more experience working with trans clients gave more accurate clinical answers. Psychiatrists demonstrated lowest level of clinical knowledge compared to other professionals	Strengths: Identifies particular groups who may benefits from additional training. Uses several self-report measures together, with adaptations relevant to Australian participants. Limitations: Majority female, all cisgender respondents.

Riggs and Bartholomaeus (2016b)	Australia	Australian mental health nurses and transgender clients: Attitudes and knowledge	To survey the experience, knowledge and attitudes of MH nurses in Australia towards trans people	96 Mental health nurses	Trans	Quantitative. Online questionnaire including: adapted version of Attitudes Towards Transgender Individuals Scale (ATTIS; Walch et al., 2012); adapted Counselor Attitude Toward Transgender Scale (CATTS); and demographic questions. Factor analysis and ANOVA used to interpret results	Most the participants had worked with trans clients, but only a minority had training. Training was linked to more positive attitudes and better clinical knowledge. Experience working with trans clients linked to better clinical knowledge. Reported religiosity linked to less positive attitudes. Female and older nurses showed better clinical knowledge	Strengths: Specifically identifies the need for more guidelines for Mental health nurses. Limitations: Majority female respondent'. Relatively small response rate. Paper raises questions about the applicability of these measures for use with Mental health nurses.
Dispenza & O'Hara (2016)	USA	Correlates of Transgender and Gender Nonconforming Counseling Competencies Among Psychologists and Mental Health Practitioners	To explore which identity related variables correlate with transgender/gender nonconforming counselling competencies	102 mental health professionals (counsellors, social workers and psychologists)	Trans	Quantitative. Participants recruited at a multicultural counselling conference. Paper questionnaire included demographic measure, Gender Identity Counselor Competency Scale (GICCS, adaptation of Bidell, 2005), and Social Desirability Scale. Multiple regression analysis to identify correlates	Sexual minority counsellors more likely to have affirming attitudes, required knowledge and competencies for working with trans clients. Ethnic/racial minority counsellors showed higher self-reported competency. 8 or more years of clinical experience linked to higher competence and skills. Makes suggestions about clinicians reflecting on their identity and privileges	Strengths: Thorough statistical analysis. Range of ethnicities, ages, experience, and some diversity in sexual orientation. Limitations: all participants from multicultural counselling conference, may have particular values/experiences which aren't generalisable. Majority female, all cisgender participants.

Israel et al. (2008)	USA	Therapists' Helpful and Unhelpful Situations with LGBT Clients: An Exploratory Study	To explore psychotherapists perceptions of helpful and unhelpful situations with LGBT clients	14 psychotherapists, 7 women, 6 men, one transman, range of sexualities	LGBT	Qualitative. Semi-structured interviews, recruited online through counselling/therapy/LGBT organisations. Asked about one situation where they thought they were particularly helpful / unhelpful to client. Ethnographic content analysis.	Therapeutic relationship, therapist response to client's gender identity, disapproval of client's lifestyle/gender expression, and client having other marginalised/discriminated identities influenced whether therapy was seen as helpful/unhelpful by therapist. Therapists may need additional training on working with transgender clients, LGBT people of colour, and those who have limited access to resources.	Strengths: Diverse sample in terms of gender, ethnicity, sexual orientation, location, education, field of practice. Weaknesses: Paper focuses on mostly LGB issues. Self-selecting sample may have more positive attitudes towards LGBT people
Salpietro, Ausloos and Clark (2019)	USA	Cisgender Professional counselors' experiences with trans* clients	to explore experiences, training, strengths and values of cis counsellors when working with trans* clients	12 cisgender professional counselors	Trans	Qualitative. Recruited through mailing lists, and purposive sampling to identify those with more experience. Demographic questionnaire, and individual semi-structured interviews. Transcendental phenomenological approach to explore essence of participants' lived experience.	Four overarching themes emerged - challenges in treatment (e.g. inadequacies of healthcare, superficial training), cisgender counsellor learning experiences (e.g. personal experiences, supervision), essential knowledge (e.g. gender competency), and counsellor skills (e.g. therapeutic alliance, advocacy). Suggest knowledge and understanding of working with gender should be considered a counselling competency.	Strengths: Specifies trans clients, not LGBT as a whole. In depth analysis of experiences and makes recommendations for improving the profession of counselling. Weaknesses: Majority of participants, and both main researches were white and cis. Most participants female.

Rutter et al. (2010)	USA	Couples Counseling for a Transgender-Lesbian Couple: Student Counselors' Comfort and Discomfort with Sexuality Counseling Topics	To explore themes and implications from two trainee counsellors' reflective journals when working with a queer couple	Two co-working student counsellors, providing couples therapy for a married queer couple (transman and lesbian)	LGBT	Qualitative. Participants given reflective journal assignments, with reflective questions to prompt their writing, during and after the course of therapy. Supervisors conducted a Constant Comparative Analysis on the reflections	Themes of not knowing where to go next in therapy emerged. Also, the trainees' hesitancy to discuss the couple's difficulties with sex and intimacy until much later in therapy. Makes suggestions for improved counselling training, and supervision to better support queer couples	Strengths: Goes into detail about the practice and reflections of two counselling trainees working with a queer couple, rather than reporting general attitudes. Limitations: Findings could be specific to just these two heterosexual, white, cis trainee counsellors
Lutz (2013)	USA	Assessing clinical competency among clinicians who work with transgender clients	Examine the preparedness, training, and types of work therapists do with transgender clients	6 therapists working with or advertising that they specialise in working with transgender patients	Trans	Qualitative. Therapists names searched for through therapist directory, searching for therapists who specifically mentioned working with transgender people. Interviewed about training they'd had and the kind of work they do. Phenomenological qualitative analysis.	The therapists demonstrated empathy for the transgender community, gave examples of how they educated themselves and remained informed. The clinicians had no formal training in working with transgender people. Suggests effective improvements to training, and ways to work with transgender clients	Strengths: Assesses competency in a richer and more nuanced way that questionnaires. Limitations: Assessing therapists' competency against a multicultural competency model (Sue & Sue, 2008), however participants' competency may be assessed differently using different frameworks.

O'Hara et al (2013)	USA	The Preparedness of Counselors in Training to Work with Transgender Clients: A Mixed Methods Investigation	To investigate the preparedness of counsellors in being able to support transgender clients	Phase 1: 87 counsellors in training from an urban university in the south-eastern United States Phase 2: 7 counsellors in training (same population)	Trans	Mixed Methods. Quant: Questionnaire of counselling competence (GICCS) and demographic data, including contact with trans people. ANOVA and correlational analysis. Qual: 2 focus groups to explore educational experiences useful for working with trans people. 'Basic qualitative research design'	Quant: The more personal and professional contact with trans issues, the more competent trainee counsellors considered themselves Qual: Themes emerged such as struggles with terminology related to trans issues, sources of knowledge coming from the media, uncertainties around how to work with trans clients, being a trainee, and topics which should be covered in training.	Strengths: Mixed methods allows for broad, rich and triangulated data. Makes recommendations to counselling profession. Limitations: Participants majority female, white and heterosexual. All participants from one university.
Dentato et al (2018)	USA	Preparing social workers for practice with LGBT populations affected by substance use: perceptions from students, alumni, and service providers	To investigate how well a drug and alcohol counselling module for social workers prepares social workers for working with LGBT clients.	63 social work students and alumni of a drug and alcohol counselling module, and service providers	LGBT	Mixed Methods. Online questionnaire on competency and preparedness for working with LGBT populations. Descriptive statistics. A small group also completed qualitative interviews. Emerson, Fretz and Shaw (1995) model of coding to analyse interviews	Most of the sample said their training did not prepare them well for working with trans clients. Although just under half still considered themselves competent. Majority of sample said trans topics were not handled well in classes. Study found a specific gap related to comfort, preparedness, and self-rated competence in working with trans clients compared to other LGBQ groups.	Strengths: Mixed methods approach. Makes recommendations for improving training. Limitations: Sample of students and alumni from one social work programme. Majority female, white, heterosexual. Limited results specifically linked to trans group. Very limited analysis of qual data.

Kawano et al (2018)	USA	Dance/Movement Therapists' Attitudes and Actions Regarding LGBTQI and Gender Nonconforming Communities	To investigate dance/movement therapists' knowledge, preparedness and practice when working with LGBT+ clients	361 dance/movement therapists	LGBT+	Mixed Methods. Online survey including demographics, attitudes and actions regarding LGBT+ clients, adapted specifically for dance/movement therapists. Mixture of quantitative and qualitative data gathered. Descriptive stats, and content analysis.	43% reported that client's gender identity did not influence their choice of intervention. 97% reported mirroring language of a person's gender identity. Several respondents described sharing a person's gender identity with their team to ensure correct use of pronouns. Suggest that therapists tend to have good intentions, although lack awareness of issues such as gender binary expectations, language use, and legal issues	Strengths: Mixed methods approach, combining quantitative and qualitative data. Limitations: 91% participants female. Results heavily dependent on self-report, questions were leading and could elicit social desirability. Could have more questions specific to trans issues.
Whitman and Han (2017)	USA	Clinician competencies: Strengths and limitations for work with transgender and gender non-conforming (TGNC) clients	To investigate training experience, terminology understanding and competency of mental health practitioners to work with trans clients	53 adult mental health providers including psychiatrists, psychiatry residents, clinical and counselling psychologists, doctoral students, and social workers	Trans	Mixed Methods. Online questionnaires: demographics; GICCS; knowledge assessment; social desirability scale; and three clinical vignettes. Researches, and participants, and independent observers provided competency ratings. Descriptive statistics, Qualitative data thematically analysed.	Participants rated themselves less comfortable and interested in working with clients with gender concerns. Clinicians in training scored significantly higher on vocabulary test than licensed clinicians. Problematic responses to vignettes included targeting the clients' gender identity for therapy, and imposing religious/spiritual orientation. Some clinicians endorsed high levels of comfort and competence working with trans clients, yet also endorsed problematic/stigmatising beliefs.	Strengths: Mixed methods and multi-dimensional measures of competency increased validity. Explicit recommendations for training for clinicians. Limitations: Low clinician response rate. Small sample size, and may be missing those less comfortable working with trans clients, or with more stigmatising beliefs. Qualitative analysis very limited

Group 1: Quantitative Research Articles

Four of the research articles reviewed used only quantitative methods to research mental health professionals' work with gender diverse adults (Dispenza & O'Hara, 2016; Johnson & Federman, 2014; Riggs and Bartholomaeus, 2016a, 2016b). All four studies involved mental health professionals completing questionnaires (either online or paper), which generated scores related to their self-reported attitudes, comfort and confidence working with gender diverse clients, as well as their clinical knowledge, assessed by the researchers. These scores were considered measures of the clinicians' 'competence'.

Riggs and Bartholomaeus (2016a; n=304) and Dispenza and O'Hara (2016, n=102) both sampled from a range of mental health professionals (e.g. counsellors, social workers). Whereas Riggs and Bartholomaeus (2016b; n=96) surveyed mental health nurses specifically, and Johnson and Federman (2014) surveyed 384 American Clinical Psychologists who provided psychological therapy to LGBT veterans. All the articles in this group were deemed good quality according to the guidelines shared by both quantitative and qualitative research (Appendix A).

Overall, these four studies reported that more 'competent' clinicians tended to be those that were generally more experienced (Dispenza & O'Hara, 2016), and those that were specifically more experienced working with gender diverse clients (Riggs and Bartholomaeus, 2016a; 2016b). Clinicians reported having minimal training in the area (Johnson & Federman, 2014; Riggs and Bartholomaeus, 2016b), however more training was linked to greater 'competency' (Riggs and Bartholomaeus, 2016b). Younger psychologists, sexual, ethnic and racial minorities, older nurses, and female clinicians tended to be more competent (Dispenza & O'Hara, 2016; Johnson & Federman, 2014; Riggs and Bartholomaeus, 2016a; 2016b), whereas psychiatrists, and those who reported themselves more religious, tended to be less 'competent' working with gender diverse clients (Riggs and Bartholomaeus, 2016a; 2016b). All authors in this group suggest that mental health professionals would benefit from further training to support gender diverse clients.

All four studies are strengthened by their relatively large sample sizes, however the majority of the samples were mostly white, female, and cisgender. All the participants in Dispenza and O'Hara's (2016) study had attended a multicultural counselling conference, therefore were likely to have particular values or experiences which may not be generalisable to all mental health professionals. The study by Johnson and Federman (2014) provides a useful snapshot of clinicians' attitudes, knowledge, practice and self-reported competence working with LGBT veterans at a particular point in American history, shortly after the 'Don't ask don't tell' bill was repealed. However, clinicians' attitudes, competences and experiences related to working with transgender clients may have changed since this time, as the Trump administration banned transgender individuals from serving in the military from 2019. The research mostly focused on attitudes and experiences working with LGB clients, rather than gender diverse clients, and no information was gathered regarding the participants' ethnicity.

All four studies in this group measured participants' attitudes towards gender diverse clients. Although research demonstrates the potential harm caused by clinicians who hold negative attitudes towards gender diverse clients (e.g. Nadal, Skolnik & Wong, 2012), the strength of the association between attitudes and behaviour is complex, and can be influenced by other factors such as context and time (e.g. Ajzen & Fishbein, 1977).

Johnson and Federman (2014) and Dispenza and O'Hara (2016) included measures of clinicians' self-reported competency, however the validity of these measurements is likely to be affected by social desirability, and the clinicians' desire to be seen as competent. They may also perceive themselves as more competent than gender diverse clients might perceive them to be. However, all four studies also assessed the participants' clinical knowledge, which may be a more objective measurement of the clinicians' 'competency', as the participants would not be able to achieve high scores unless they had an understanding of best practice. Riggs and Bartholomaeus (2016a) was the only study to include separate measurements of clinician 'Comfort' and 'Confidence' working with gender diverse clients, which add a useful subjective dimension to their findings.

All the described quantitative measures of competence, knowledge, attitudes and skills related to working with gender diverse clients are limited. The questionnaires make assumptions about the knowledge and skills required to support gender diverse clients, and rate the responses against these criteria. In addition, they treat gender diverse people as a homogenous group, not capturing the nuanced and diverse experiences of gender diverse people who might be seeking mental health support. Although the findings provide a snapshot of competency across a large sample of clinicians, the quantitative results lack richness and detail about how clinicians feel about their work with gender diverse clients, their confidence in different aspects of their work, and what contexts enable them to work more or less effectively with this group of clients.

Group 2: Qualitative Research Articles

Four studies in the systematic review used qualitative research methods to better understand mental health professionals' work with gender diverse clients. Israel et al. (2008) gathered data from 14 psychotherapists working with LGBT clients in general, Salpietro et al. (2019; n=12) and Lutz (2013; n=6) interviewed counsellors/therapists about their work with transgender clients specifically, and Rutter et al. (2010) analysed the reflective journal entries of two student counsellors who worked with one gender diverse couple. See Table 2 for the qualitative analysis used in each study.

Rutter et al. (2010) identified themes around the trainees not knowing where to go next in therapy, and all four studies identified the need for improving training programmes for working with gender diverse clients. Three studies mentioned the importance of generic therapeutic skills, such as therapeutic alliance and advocacy, when working with gender diverse clients (Israel et al., 2008; Lutz, 2013; Salpietro et al., 2019). Two studies also mentioned skills specific to working with gender diverse clients, such as the therapist's response to the client's gender, or hesitancy around discussing issues of sexual intimacy in a gender diverse couple (Israel et al., 2008; Rutter et al., 2010). The participants in Salpietro et al.'s study spoke of the 'essential knowledge' needed to work with gender diverse clients, such as awareness of gender concepts and transitioning. Lutz (2013) and Salpietro et al. (2019) describe how this knowledge often came from clinicians' personal experiences, or through keeping themselves informed, rather than formal training. Participants in Israel et al.'s (2008) study described therapy as less helpful for LGBT clients with more marginalised or discriminated identities, such as those with transgender identities, LGBT people of colour, or those with limited access to resources.

According to the guidelines suggested by Elliot et al. (1999), the research conducted by Salpietro et al. (2019) was of the highest quality: the authors clearly outlined their own

theoretical orientations and assumptions, described several credibility checks, and presented their findings coherently and with resonance. Their particular qualitative methodology required researchers to 'bracket' off their assumptions. Although the authors describe measures they took in order to do this, it could be argued that in qualitative analysis, their assumptions can never be removed entirely. Israel et al.'s (2008) study was assessed as good quality: the sample was well situated, and the authors described some credibility checks. However, the researchers did not state any of their own assumptions, did not provide any direct quotes from the interviews, and the themes were difficult for the reader to synthesise, due to them being presented in long lists with percentages. In addition, the research focused mostly on LGB issues, with limited findings about work with gender diverse clients.

Rutter et al.'s (2010) study was assessed as poor against the guidelines especially pertinent to qualitative research. The paper did well to situate the sample, and described some credibility checks. However, the researchers' assumptions and orientations were not stated, did not include any direct quotes, and only one theme was well discussed. At times, the authors could have been more respectful towards the trainees regarding their competence. Lutz's (2013) study was also assessed as poor quality. Lutz aimed to assess the therapists' competency in supporting gender diverse individuals. The research does this with more nuance and richness than the quantitative research above. However, the qualitative analysis is limited in depth and quality, reading more like survey results than a phenomenological analysis. Lutz also provided no demographic information about the participants.

Rutter et al. (2010) described a useful and detailed analysis of the work and reflections of two co-therapists working with a queer couple, rather than reporting general themes identified within a group of people. However, the findings were specific to the two white, heterosexual, cisgender trainee counsellors. Similarly, the majority of Salpietro et al.'s (2019) participants were female, white and cisgender. A strength of the research by Israel et al. (2008) is that the sample was relatively diverse, in terms of the gender, ethnicity, sexual orientation, location, education, and fields of practice of the therapists. However, all four studies collected data from counsellors or therapists, excluding any other kind of mental health professional. They also included limited discussion about the social and historical contexts the mental health professionals find themselves in.

Group 3: Mixed methods research articles

The final four research articles included in this systematic review used a combination of quantitative and qualitative methods to research mental health professionals' work with gender diverse clients. Whitman and Han (2017) surveyed 53 mental health professionals (e.g. psychiatrists, counsellors) about their work with gender diverse clients, and O'Hara et al. (2013) surveyed 87 trainee counsellors who provided counselling for gender diverse clients. Kawano et al. (2018) surveyed 361 dance/movement therapists about their work with LGBT clients, and Dentato et al. (2018) surveyed social work students and alumni of a drug and alcohol counselling module, as well as providers of this service, about working with LGBT clients (n=63).

Similar to the quantitative studies above, all four studies in this group used questionnaire measures to investigate professionals' attitudes and actions (Kawano et al., 2018), 'competence' (Dentato et al. 2018; O'hara et al., 2013; Whitman and Han, 2017), and 'preparedness' (Dentato et al., 2018; O'hara et al., 2013) for working with LGBT or gender diverse clients. Two studies included qualitative elements to the questionnaires which were

also analysed (Kawano et al., 2018; Whitman & Han, 2017). One study conducted two focus groups (O'Hara et al., 2013; n=7), and another study conducted interviews (Dentato et al., 2018; n=3) alongside the questionnaire. See Table 2 for the qualitative analysis used in each study.

Altogether, studies in the mixed methods group reported that those with more personal and professional contact with gender diverse individuals were more competent at working with this group of clients (O'Hara et al., 2013). Whitman and Han (2017) also reported that trainee clinicians were significantly more competent than licensed clinicians. The clinicians interviewed in in O'Hara et al.'s (2013) and Dentato et al.'s (2018) studies mentioned difficulties with terminology, knowledge presented through the media, uncertainties around how to work with gender diverse clients, and the limitations of their own training course to prepare them for this work. Whitman and Han identified themes in participants' problematic responses such as targeting a client's gender identity as an intervention for therapy, or imposing a religious/spiritual orientation onto a person's formulation. All authors made suggestions for improving current training programmes for working with gender diverse clients.

Both Dentato et al. (2018) and Kawano et al. (2018) investigated competencies and preparedness for working with LGBT clients in general, and reported a specific gap in clinicians' competencies working with gender diverse clients compared to LGB clients. Although Kawano et al. reported that therapists generally described affirmative practices, with good intentions, and half of Dentato et al.'s (2018) participants considered themselves competent to work with gender diverse clients, Whitman and Han (2017) reported disparities between clinicians' self-rated competence, and researcher-assessed competence working with gender diverse clients, thus questioning the validity of clinicians' self-reports in the other studies.

The mixed methods approach used by the studies in this group allows for broad, rich and triangulated data. All four studies used the qualitative data to add depth to their quantitative findings and were assessed as good quality against the guidelines shared by both qualitative and quantitative approaches (Elliot et al., 1999). However, it is perhaps expected that qualitative research in a mixed methods approach would not be of such high quality as in qualitative-only research. All but one of the studies (O' Hara et al., 2013) in this group were assessed to be of poor quality against the guidelines especially pertinent for qualitative research, as the majority of studies did not state their assumptions, did not describe any credibility checks, and had limited resonance. The studies in this group also tended to lack the depth of the quantitative-only and qualitative-only studies, often only presenting descriptive statistics or simple correlations in the quantitative sections, and limited thematic analysis in the qualitative sections.

Kawano et al.'s (2018) study was heavily dependent on therapists' self-reported attitudes and actions when working with LGBT clients, therefore the results may have been more affected by social desirability. Whitman and Han (2017) attempted to overcome this issue in their study by using a social desirability questionnaire, and a multi-dimensional assessment of competency, which included a 'knowledge assessment' and clinical vignettes. Participants' responses were rated by independent observers. The multi-dimensional approach to investigate clinician competency greatly improves the validity of this research.

The samples in all four studies were predominantly white, female, and heterosexual. Kawano et al., (2018) sampled from a wide geographical area, whereas O'Hara et al. (2013) and Dentato et al. (2018) only sampled from a single university or training course, respectively, limiting their generalisability to other contexts. However, Dentato et al.'s focus on one training programme allowed the researchers to identify strengths and limitations of a concrete example of training, make real-life changes as a result of the research, and make suggestions on how other training programmes might follow suit. Finally, Kawano et al. and Dentato et al. mostly reported findings related to working with LGB clients, only minimally describing clinicians' experiences with gender diverse people specifically.

Summary of findings from review

The studies in this review reported that clinicians with more training and experience with gender diverse clients were more competent working with this group, although most participants reported minimal training in the area. Younger psychologists, trainees, sexual, ethnic and racial minorities, older nurses, and female clinicians tended to be more competent, whereas psychiatrists, and those who reported themselves as more religious, tended to be less competent. The studies which investigated LGBT people in general reported that clinicians tended to be less competent in working with gender diverse clients compared to LGB clients.

All the studies identified the need for improved training for mental health professionals working with gender diverse clients. Participants described their uncertainty working with gender diverse clients, and the importance of generic therapeutic skills such as therapeutic alliance and advocacy when working with this group. Some studies mentioned specific skills and knowledge required for working with gender diverse clients such as the therapist's response to the client's gender identity, and awareness of gender concepts. Other studies reported some of the stigmatising beliefs or practices described by clinicians such as imposing religious or moral views onto a client's formulation, or seeing their gender identity as a target for intervention in therapy.

Critique of papers included in the review

Two of the research articles included in this review were conducted in Australia (Riggs and Bartholomaeus, 2016a; 2016b), and the rest were conducted in the USA. Although still Western contexts, both countries have very different healthcare systems, and queer social and historical contexts to the UK, making it difficult to draw conclusions about mental health professionals currently working in the UK public sector.

Several of the studies across the groups described how it is likely that their sample over-represented people who might have more experience or interest in working with gender diverse clients, as those are the people who would be more likely to volunteer to take part in the research (Riggs & Bartholomaeus, 2016a). The studies may be missing the responses and experiences of clinicians who feel less comfortable working with gender diverse clients, or have more stigmatising views.

Many of the studies also reported samples which were majority cisgender, female, heterosexual, and white, potentially excluding the experiences of mental health professionals outside of this demographic. However, this is perhaps expected and representative, given the demographics of the mental health workforce in Western countries. The majority of psychologists and mental health nurses in Australia are female (Australian Institute of Health

and Welfare, 2017). In the USA, the majority of psychologists are female (APA, 2015) and white (Lin, Stamm, & Christidis, 2018), as well as the majority of counsellors (DataUSA, 2017) and mental health social workers (DataUSA, 2018). At the time of writing, information about the sexual and gender diversity of the mental health workforce in these countries could not be found, nor could information about the ethnic diversity of mental health professionals in Australia, perhaps indicating a lack of institutional interest. It is also important to note that participants may not feel comfortable disclosing their sexual or gender diversity in research studies, or national surveys.

In their study, Salpietro et al. (2019) describe a theme related to the societal challenges and inadequacies of healthcare for gender diverse clients, and O'Hara et al. (2013) briefly mention representations of trans identities in the media. However, other than these two examples, the studies in this review are limited in their discussions of the contexts in which healthcare providers find themselves, and the role of discourse in shaping their views, experiences and work.

The majority of the studies sampled groups of therapists or counsellors. One study researched mental health nurses, and another a group of social workers, whereas only three studies included a range of mental health professionals in their samples. Although it is important for research to investigate the specific challenges related to working with gender diverse clients in each discipline, the professions do not work in isolation. In the UK, mental health professionals work in multi-disciplinary teams (MDTs), in a range of different contexts (e.g. inpatient, community). Therefore, a sample which attempts to capture this diversity may paint a richer picture than a homogenous group from a single profession.

I included in this review the few LGBT papers which reported specific findings about mental health professionals' work with gender diverse clients. The majority of papers with this broader focus were excluded from the review as they only reported findings related to LGB clients, or LGBT clients in general. However, even the LGBT papers included in this review mostly reported findings related to clinicians' work with LGB clients. This reflects a historical gap in the literature related to work with transgender (and bisexual) clients (Israel et al., 2008), with researchers largely focusing on work with lesbian and gay clients. Of the 12 studies included in this review, 7 of them focused on mental health professionals' work with gender diverse clients specifically, and 5 focused on work with LGBT clients in general. The trans-specific papers make up the majority of the papers from 2014, however between 2008 and 2014, the majority of papers investigated clinicians' work with LGBT clients in general. The recent increase in research articles focusing specifically on mental health professionals' work with gender diverse clients coincides with the general increase and visibility of gender diverse identities in recent years (Barker, 2017; Steinmetz, 2014).

Although some studies attempted to overcome limitations of social desirability (e.g. Dispenza & O'Hara, 2016; Whitman & Han, 2017), all the findings in this review were to some extent influenced by how the participants wished to be perceived. It is important to note the operations of power which may be enacted in the research studies, and the potential feared outcomes for the participants if they were to disclose discriminatory views or practices to the researchers. This is likely to be an issue for all research which asks mental health professionals about their practice, including the current study.

Rationale for the current study

As demonstrated above, the current literature exploring mental health professionals' work with gender diverse clients is limited. This study is the first to do such research in the UK – a country with a unique public mental health service. Data was gathered from a range of mental health professionals' work with gender diverse clients specifically, rather than LGBT clients in general, as gender diversity is an experience different from sexual diversity, and gender experiences are incredibly diverse in and of themselves.

Speaking from within a positivist framework, Whitman and Han (2017) reported that clinicians' self-reported 'competence' working with gender diverse clients may be inaccurate. It could be argued that even a more 'objective' measure of competence would be based on arbitrary criteria of what the researchers consider to be 'competence'. These criteria would likely be subject to assumptions, be specific to a moment in time, and may not be relevant to diverse experiences of gender and mental health. Therefore, a qualitative study of the accounts of mental health professionals, as opposed to an assessment of competence, could allow for a better understanding of the current contexts and discourses shaping their experiences. Thus, potentially highlighting ways forward for training and mental health services, so that clinicians are enabled to work in trans-inclusive ways.

As this research aims to explore the stories mental health professionals tell about supporting gender diverse clients, narrative analysis was used (e.g. Riessman, 2008). The analysis explored the stories mental health professionals tell about their experiences, as well as the wider narratives, and social/historical contexts which shape their stories, the ways gender and mental health are constructed, and the ways participants position themselves in their stories, in the interview, and in relation to wider discourses.

Richards et al. (2014) have provided a useful critique of academic writing about clinicians working in trans healthcare. They write that it is important to acknowledge that being 'trans' or a 'clinician' are not mutually exclusive, and there is no unified understanding of gender and healthcare which all 'clinicians' hold. They also mention the dearth of research studies directly gathering data from clinicians themselves, rather than generalizations from second or third hand information, particularly in the UK. By hearing the individual narratives of mental health professionals themselves, and not assuming that the clinicians will all be cisgender, this research attempts to overcome some of these challenges.

Aims and research questions

The overarching aim of this research is to study the experiences of mental health professionals in the UK who have supported gender diverse adults, with a view to better understand the challenges they might face, and the wider narratives which shape their stories.

The research question this project aims to investigate is:

> How do mental health professionals describe their experiences of providing care for gender diverse clients with mental health difficulties?

Within this, attention will be given to:

i. How do mental health professionals position themselves and their abilities within their narratives?
ii. How do their narratives construct gender and mental health?
iii. How are the above shaped by the local and broader contexts of their construction? i.e. local contexts (the research interview), organisational contexts of their work, and broader cultural contexts and discourses.

Chapter 2. Method

In this section I will describe how the study was developed, including the epistemological and theoretical position, the design and procedure of data collection, how the data was analysed, and measures taken to ensure quality.

Study Development

Epistemological position

Understandings of mental health and mental distress vary considerably across time and space. In the West, a diagnostic model, largely curated by different iterations of the DSM (APA, 2013), has dominated both popular and professional understandings of mental distress. However, within the broader mental health profession, a variety of theoretical frameworks exist, understanding mental distress from a wide range of perspectives. Some of these perspectives are described by Smail (2005), locating them on different dimensions, from social (e.g. narrative therapy) to individual (e.g. CBT), and from idealist (e.g. psychodynamic) to materialist (e.g. psychiatry). Similarly, Auerswald (1965) describes how systemic family therapy exemplifies a change in 'paradigm' from linear to non-linear epistemology. In addition, non-Western cultures have understood mental distress from an even broader range of perspectives (Bentall, 2004). Therefore, when asking participants for their experiences as a mental health professional, it is helpful to take a social constructionist position (e.g. Gergen, 2011), understanding mental distress from multiple perspectives, rather than a search for an underlying 'truth'.

Human understandings of gender also vary considerably over time and space, as I have described in the introduction. Historically, essentialist *Natural Law* has shaped public understandings of gender and sexuality, which is still common in many religious communities of today. Alternatively, Judith Butler (1990) argues that gender is entirely 'performance', and Lugones (2007) suggests that colonisation imposed a Western, binary understanding of gender onto indigenous communities. In addition, the medical community's understanding of gender diversity has moved away from 'illness' in the more recent developments of DSM-5 and ICD-11. Therefore, it is also helpful to think about gender from a social constructionist perspective, and understandings of gender as shaped by historical and social contexts (Jagose, 1996).

It is especially important in this research to acknowledge different perspectives and experiences of gender and mental health in this research. Taking a position on what is 'truth' about how gender and mental health interact could risk alienating different groups of mental health professionals and gender diverse people, who may understand them differently. This research aims to draw attention to the way mental health professionals construct their experiences of supporting gender diverse people, without judgment or attack (Reynolds, 2013), with the hope of improving these interactions for everyone.

By taking a social constructionist position, this research does not make claims about the 'truth' of the stories told by the participants, recognising that different people involved in the same event may construct their stories differently, with different discourses available to them. Therefore, narrative analysis is employed, paying particular attention to the wider social discourses infused in each participant's story. However, it is also important to acknowledge the challenging *material conditions* (Pearce, 2018) faced by gender diverse people accessing

mental health care. Therefore, throughout this research I have also paid close attention to the social conditions which set the scene for the stories told.

Why narrative?

As this research aims to explore the stories mental health professionals tell about supporting gender diverse people, a narrative method was employed. The concept of narrative in social science has taken on an array of definitions, from "a discrete unit of discourse" to "an entire life story" (Reissman, 2008, p. 5). Narratives can be understood as describing a particular event in time, (e.g. Gergen, 2011), or as a way of making meaning out of more general experiences (e.g. Squire, 2008). In addition, stories can be told at the level of the individual, as well as by groups of people, such as communities, governments, and organisations (Riessman, 2008). In this research I will use *story* to refer to the stories told by the participants during the interviews, and *narrative* to refer to wider social narratives and discourses available to the mental health professionals when they tell their stories.

Narrative methods are broad, opening up opportunities to understand stories from a range of approaches. Wells (2011) describes how narratives can be co-constructed by interviewer and interviewee, shaped by their audiences, and formed by wider societal discourses. Different narrative methodologies can be employed to pay particular attention to these and other elements, which can be adapted and combined (Riessman, 2008). Next, I will describe some of these methodologies, and those which are particularly relevant for this research.

Thematic narrative analysis is concerned with the content of the stories told, with prior theory informing the interpretation (Riessman, 2008). Similar to other qualitative methodologies, it involves finding thematic patterns across the stories of multiple participants, yet keeps their overarching story intact. In contrast, structural narrative analysis pays particular attention to how a story is told, such as the sequence of the narrative (e.g. Labov, 1997), its prosody or poetic structure (e.g. Gee, 1991), or how narrators construct their identity in their tellings (e.g. Gregg, 2006). Thus, structural narrative methods pay attention to local context – the conditions of the production of a narrative (Riessman, 2008).

Constructionist narrative analysis considers the broader social construction of a story within interpersonal, social and cultural relations (Esin et al., 2014). This involves attending to the way stories have been constructed through transcription, translation, the local context of the interview, and the historical and cultural contexts from which they were told (Esin et al., 2014). The method also involves analysing the positionings of the interviewer and interviewee, which Wells (2011) describes as "the communicative strategies used to assign the self or others to positions" (p. 93). Narrators can also communicate a position or stance in relation to discourses, aligning with or resisting cultural narratives which might be available to them.

In this research, I have drawn on thematic and constructionist narrative methodologies, in order to investigate the kinds of stories mental health professionals tell about their experiences working with gender diverse people, and how these narratives might align with, reiterate, or counter the broader social narratives available to them (Esin et al., 2014). In the analysis, I also draw particular attention to the organisational contexts (e.g. mental health service, healthcare system) which set the scene for the participants' stories.

A variety of qualitative methodologies were considered for this research. The flexibility of thematic analysis, for example would have offered opportunities to identify patterns in the

wider discourses drawn on by participants, however the simplicity of the method would not allow for claims to be made about language use (Braun & Clarke, 2006). Interpretative Phenomenological Analysis would have offered an opportunity to explore how professionals make sense of their experiences, however would not have allowed for such an in depth analysis of context and discourse. In addition, the requirement for a homogenous sample (Smith & Osborn, 2003) would have required sampling from only one mental health profession. Although narrative analysis does not allow for claims about the 'truth' of the stories told, one can analyse the local and broader contexts of the narrative construction, and the wider narratives drawn on by participants in their tellings.

Interviewing elites

Wells (2011) describes professional practice as an environment in which narratives are produced, due to the practitioners' shared training, skills, values, perspectives, as well as professional and legal frameworks. Thus, the mental health professionals in this research will have a shared specialist vocabulary to draw on when telling their stories, as well as shared healthcare cultures such as 'ward rounds', 'case presentations', and 'treatment pathways'. As a mental health professional myself, these narratives, vocabularies, cultures, and tacit knowledges are very familiar to me, contributing to the co-construction of the participants' stories from a place of shared understanding.

By focusing on professionals, this research could be considered 'elite-orientated'. Mikecz (2012) describes specific methodological challenges related to 'interviewing elites' such as gaining access, building trust, and rapport. He describes how an insider knowledge of the participants' culture, environment and norms, which I am fortunate to have, helps to facilitate trust and openness in the participants' telling. Mikecz (2012) also discusses the importance of interviewing elites, as a 'relatively unstudied' (Hunter, 1995) group, potentially protected from intrusion and criticism.

Service-user and Participant Consultation

Service-user consultation

Service-user consultation played a large role in developing the study design and interview guide. The design of the project was discussed at length with two gender diverse consultants (recruited through personal contact), who have accessed mainstream mental health services. It was through these discussions in the early phases of the study's development that a focus on interviewing professionals was considered important. Both service user consultants also gave feedback on the research proposal, specifically commenting on language use.

The proposed study design and initial draft of the interview guide were commented on by 22 gender diverse individuals through an online survey titled *Your Thoughts on Research into Trans Mental Health Care* (Appendix B). This was advertised (Appendix C) online by one of the service-user consultants, sharing the advert with their Facebook friends, and through their local Facebook groups and pages (Trans Leeds, Non-Binary Leeds, Non-binary action). The 22 respondents identified with a wide range of genders, such as non-binary, agender, male, female, trans male, trans masculine, and genderqueer. One respondent identified themselves as 'cis'. Their ages ranged from 18-24 to 55-64, and they were located across the UK.

The survey respondents gave largely positive feedback about the design and aims of the study, with one person writing "it's a project that needs to be done". One respondent wrote that due to the small size of the gender diverse community, pseudonyms may not sufficiently anonymise those spoken about in interviews. This has been taken into consideration in the writing of this report, excluding any identifying information. The gender 'non-binary' was also added to the opening of the interview question (Appendix D), as one respondent mentioned that they were unsure whether the research included non-binary people.

The respondents were invited to suggest questions for the mental health professionals interviewed. From their responses, the following question was added to the interview guide: *Has there been a time when you have supported trans, gender diverse or questioning people when other professionals showed a lack of knowledge? How did you manage this?*

Participant consultation

Two mental health professionals (Clinical Psychologist and Social worker) were consulted on the study design, participant information sheet, and interview questions. Both had experience of providing mental health care for gender diverse people. Following their feedback, interview questions were added about how the participant's service understands 'gender dysphoria', and how media stories might conflict with the participant's understanding of gender diversity, or interface with clinical practice.

Pilot

Prior to beginning data collection, one of the participant consultants agreed to pilot the interview, which took place over WhatsApp video. This gave me the opportunity to familiarise myself with the interview guide, opening and follow-up questions, and the narrative interview style (Jovchelovitch & Bauer, 2000). The pilot participant fed back that the interview "made sense", and also emphasised the importance of the participants having had significant enough experience working with gender diverse people in order to answer the interview questions.

Ethical considerations

Ethical approval was sought through University of Hertfordshire Ethics. Therefore, recruitment of participants did not take place through NHS routes, and data collection did not take place on NHS sites. Each participant read the Participant Information Sheet (Appendix E) and completed an online consent form (Appendix F) before taking part.

The research participants' identity has been kept confidential through anonymisation, and redacting any identifying information in the transcripts. To protect the confidentiality of the gender diverse individuals that the participants spoke of, the participants were asked to change the names and identifying information as they spoke, and further information was redacted in the transcripts.

To manage any disclosure of unethical practice, resources were prepared and offered to all research participants at the end of the interview, describing current best practice guidelines for appropriately working with gender diverse people (Appendix G).

Data protection

For participants who wished to use videocall technology, encrypted software was recommended (e.g. WhatsApp, Signal, Wire), however it was ultimately each participant's decision as to which communication technology they used.

Personal data was stored and processed in line with GDPR regulations, with a view to being published without any identifying personal information. The audio recordings of interviews were only viewed by the principal researcher, and one additional transcriber, who signed a confidentiality agreement prior to viewing the files (Appendix H). Electronic consent forms were created using the secure and GDPR-compliant website SurveyMonkey. At the end of the study, the Consent Form responses were deleted from SurveyMonkey.

The audio recordings, downloaded consent forms, and additional personal data were stored in password protected files, on an external hard drive. In line with the University of Hertfordshire Data Management Policy, anonymised data will remain securely stored on an external hard drive for a maximum of 5 years, after which the data will be destroyed (the University will be informed once the data has been destroyed). Data will be stored with participant numbers as much as possible, and no data will be transferred outside of Europe. Participants were told of their right to withdraw their data from the research project up until January 2020 (none of whom did), and a right to lodge a complaint to the Information Commissioner's Office (UK regulatory body for data protection). The anonymised data from this study may be used in future, ethically-approved research projects, to further the area of study. This has been included in the Participant Information Sheet (Appendix E). In this case, the anonymised data would need to be requested from the data steward (Lauren Canvin).

Ethical approval

This research was approved by the University of Hertfordshire Ethics Committee (protocol number: LMS/PGR/UH/03782) on 6th June 2019 (Appendices I, J). An ethics modification was approved on 15th August 2019 (Appendix K), following two minor amendments to the participant information sheet.

Study Design

Sampling

A purposeful sampling approach was used in order to obtain information-rich cases to study, relevant to the research questions (Patton, 2002). The sampling was purposeful in order to obtain participants from a range of mental health professions, and healthcare settings. The size of the sample was chosen to balance breadth and depth (Patton, 2002). Wells (2011) describes how this is also shaped by the limits of data collection, the richness of the data in relation to the study's purpose, and the extent to which the data is considered in relation to theoretical, empirical, and clinical literature. Therefore, due to the time constraints of the project, and the extensive linkages to wider narratives and literature, a sample size of 6-8 participants was decided.

Inclusion criteria

Clear inclusion criteria were established prior to recruitment. The participants had to be fluent in English, and a Mental Health Professional who worked (currently or previously) in the public sector. Such professionals could be Community Psychiatric Nurses, Social Workers, Support Workers, Care Co-ordinators, Psychiatrists, Psychologists, Occupational Therapists, or other allied health professionals. The mental health professionals could be qualified, in training, or have no formal mental health qualification. They must have had experience supporting at least one adult in the public sector who self-identified as trans, gender diverse, or questioned their gender identity. There was no minimum to the length of time they had supported this person, however the interaction must have involved some kind of assessment, decision, support or intervention (e.g. psychiatric review, therapeutic work), rather than simply administering psychiatric medication (e.g. a depot injection). The gender diverse person did not necessarily need to have had any physical interventions or accessed a Gender Identity Clinic. The participant's experience of supporting a gender diverse person was intentionally very broad to enable diversity of experiences and genders supported. The professional's experience of supporting a gender diverse person could not be in the context of a private or third sector organisation.

Recruitment

Participant recruitment primarily took place through social media, word of mouth, and invitation via email. Advertising materials can be found in Appendix C. The advert was posted in several Facebook groups dedicated to mental health professionals, after permissions were obtained from the group administrators. The advert was also posted on my personal social media accounts, and shared by my personal contacts (many of whom are mental health professionals) via social media and email.

These recruitment techniques resulted in 9 people offering to take part. Of these 9, 6 met the inclusion criteria and were included in the study. None of these 6 participants came from a psychiatry or medical background. Therefore, a purposeful sampling technique was used in order to recruit a participant from this profession. Further email invitations were sent via personal and professional contacts, and snowballed to other groups of psychiatrists. Finally, a psychiatrist with sufficient experience with gender diverse clients was recruited, completing the sample of participants.

Interview Modality

The majority of the interviews in this research took place remotely. This modality was chosen in order to maximise time-efficiency for time-poor mental health professionals, and allow for the collection of data across a wider geographical area (Lo Iacono et al., 2016). Each participant was given the choice as to how they wished to be interviewed. Two took place over Skype, four over telephone, and one participant chose to be interviewed in person. The face-to-face interview was conducted in a private room of a library familiar to both parties. Written permission to conduct the interview at this location was obtained.

Participants

The sample consisted of 7 mental health professionals, aged 27-48. The demographic information for each participant is outlined in Table 3.

Table 3.
Participant Demographic Information.

Pseudonym	Age	Gender	Sexuality	Ethnicity	Region	Profession (years)	Interview modality
Dan	31	Male	Heterosexual	White British	East	Clinical Psychologist (4)	Skype
Jenny	30	Female	Demisexual	British	East	Trainee Clinical Psychologist (2)	Face-to-Face
Linda	54	Female	Undisclosed	White British	East	Art Therapist (27)	Telephone
Elena	30	Female	Straight	Mixed (Caucasian & East Asian)	London	Mental Health Nurse (1)	Telephone
Anna	27	Female	Heterosexual	White British	Midlands	Social Worker (2)	Skype
William	38	Male	Straight	White British	East	Clinical Psychologist (8)	Telephone
Jane	48	Female	Heterosexual	White	South West	Consultant Psychiatrist (9)	Telephone

Although the study was open to professionals of any gender, all 7 participants were cisgender, and mostly female. Most participants also described themselves as heterosexual/straight, and White/White British. The participants were located in regions across England, primarily in the East. The sample consisted of a variety of mental health professions, including Art Therapy, Nursing, Social Work, and Psychiatry. Three of the participants were from the profession of Clinical Psychology. The participants' experience ranged from 1-27 years in their current occupation.

Procedure

Screening

All participants who expressed an interest in taking part in the research were sent the participant information sheet (Appendix E) and short screening and demographic questionnaire (Appendix L), which was completed before the participants were invited to interview. Those who met the inclusion criteria were invited to take part.

Data collection

Pre-interview

Immediately prior to the interview, each participant was asked to sign an online consent form (Appendix F), as well as consenting verbally. Before the narrative interview began, the participants were reminded of issues of confidentiality for both themselves, and the clients they were going to discuss (Appendix D).

A question about the participants' sexuality was not initially included in the demographic questionnaire. After consulting the literature, it was decided this would be important demographic information. One participant was asked how they would describe their sexuality in the pre-interview, and one referenced their sexuality in their talk. The remaining participants were asked over email, following the interview. As some participants may have found this an unexpected or intrusive question to be asked several weeks after taking part in an interview, it was stressed that the participants did not have to share their sexuality if they did not feel comfortable.

The narrative interview

Narrative data is typically gathered through a conversation between an interviewer and interviewee (Reissman, 2008; Wells, 2011), designed to elicit talk from the participant, in a storied form. The narrative interview style used in this research followed the procedure of Jovchelovitch and Bauer (2000), by firstly introducing the participant to the interests of the interviewer, followed by a phase of uninterrupted narration from the participant, and then a questioning phase, to elicit new material (Appendix D). The pre-prepared questions were linked to references made in the participant's main narration as much as possible. These included questions about the participant's organisational context, their skills, and the wider societal context.

Post-interview

After the narrative interview had finished, the participants were asked three further questions (Appendix D). All participants were offered the latest guidelines (Appendix G) around working with gender diverse people in mental health care settings. The participants were then asked whether they would be interested in reading the results of the study, and finally they were asked if they had any further questions about the research or their participation.

Analysis

Field Notes

During each interview brief field notes were taken to record information not captured in the audio-recording, such as participants' facial expressions, or my subjective responses (Appendix M). In addition, I wrote an entry in my reflective journal after each interview (Appendix N), to capture how I felt before, during, and after, any positions I felt the participant or I were taking, and other pertinent aspects of the local context. Shortly after each interview, the audio-recordings were listened to, making further notes about the local context, paying particular attention to why and when particular questions were chosen, and what may have contributed to my particular phrasings, hesitancies or ease with different parts of the interview (Appendix M).

Transcription

Esin et al. (2014) emphasise the importance of discussing the decisions involved in the transcription process, and how these decisions may have constructed the narratives to be analysed.

One interview was transcribed by myself, and the remaining six by a transcription service, which I then reviewed for accuracy. I then added transcription symbols to capture additional aspects of the speech, such as intonation, stresses, or pauses. Appendix O demonstrates the transcription symbols used in this research, which have been adapted from Jefferson (2004). In the transcription, a balance was struck between the readability of the transcripts and the amount of additional information that could be provided by the symbols (Jefferson, 2004), such that the transcript made coherent and readable narrative sense, with added non-verbal information adding richness to the data.

Both the transcription symbols and field notes add further information which are subject to the reader's constructions (Esin et al., 2014). For example, a sharp intake of breath may indicate nervousness or passion, which is subject to the interpretation of interviewer, analyst and reader. By adding symbols, a reader's attention may be drawn more closely to the non-verbal information, which might be otherwise overlooked if reading, or listening to the interview. After the transcription for each interview was completed, a short analysis was written to consider how the transcription might have contributed to the construction of the stories (Appendix P).

Individual narrative analysis

As described above, thematic and constructionist narrative methodologies were drawn on in the analysis. Reissman (1993) describes how in narrative analysis, 'different approaches can be combined; they are not mutually exclusive' (p. 2). Thematic analysis (also known as analysis of narrative content; Wells, 2011), was used to inform the *Reading for content* step below. The *Reading for position* step was informed by Constructionist Narrative Analysis, outlined by Esin et al., (2014), with additional reference to Wells' (2011) writings on positioning. Reissman (2008) describes how it is essential for dialogical/performance analyses (such as Constructionist Narrative Analysis), to include detail about the local context. Therefore, the *Reading for local context* step was included in the analysis, informed by Wells' (2011) writings on the co-construction of narratives. Finally, the *Reading for historical and social context* step draws on Constructionist Narrative Analysis (Esin et al., 2014).

Before any in-depth analysis took place, a reflective account was written about my position in the context of the research, specifically in relation to the participants and audiences, and the social, cultural and political contexts of the research (Esin et al., 2014; see *Introduction*). NVivo was used to aid the narrative analysis. Each transcription was imported into NVivo, and initial notes and reflections added, regarding the local context of the interview, and any other initial thoughts about positionings or discourse (Appendix Q). The following steps (reading for content, reading for position, reading for local context, reading for historical and social contexts), were taken for each individual interview.

Reading for content

Narrative segments were identified by reading through each transcript, and tentatively labelling different types of stories (Appendix R). Each segment was briefly summarised, and located within the participant's broader narrative, noting what occurred prior to each segment (Appendix S). These summaries were added to throughout the analysis as additional narrative segments or story types were identified after further listenings.

Reading for Position

Before continuing, I wrote a brief reflection (Appendix T) about how my position in the context of the research may have interacted with the position of the participant, how they may have positioned me, and how this may have affected the co-construction of the narrative (Esin et al., 2014). Each narrative segment was then listened to and read for positioning. Following Wells (2011), I considered how the participant positioned themselves in relation to the context of their work, their colleagues, and the clients they spoke about in their stories. Specific sections of text which demonstrated positioning were highlighted, coded, and annotated (Appendix U). Once the whole interview was read for position, notes were made about when different positions were taken (Appendix V).

Reading for local context

The segments were also read for local context. Following Wells (2011), notes were made about the co-construction of the narrative (Appendix W) specifically examining "how do those involved in storytelling relate to each other in narrative production?" (p. 27). Particular attention was also paid to when certain stories were told in the interview.

Reading for historical and social context

The interviews were also read for historical and social context (see Appendix X). Specific attention was paid to the organisational context in which the stories were set, broader social contexts, and any narratives or discourse the stories seemed to draw on. The position the participant took in relation to these narratives or discourses was also considered (Esin et al., 2014).

Individual participant stories

Once the above steps had been taken, the stories, positionings, local and social contexts of each participant's interview were pulled together. This formed the basis of the participant's individual story described in the *Analysis and Discussion* section below.

Wider narratives

Once the above steps had been taken for each individual interview, stories told across interviews were identified. Each interview was read through a final time, with these specific stories in mind, identifying different versions or examples of resistance to the stories which had not previously been noted. Each story type was then considered individually, and the positionings, local, social and historical contexts which participants drew on in their tellings were compared and contrasted. These overarching stories were linked to narratives in literature and popular discourse, forming the *Wider Narratives* section below.

Quality

In the systematic review above, I followed Elliot et al., (1999) to evaluate the quality of the existing literature around mental health professionals providing care for gender diverse

clients. Elliot et al., (1999) describe how many quality standards for quantitative research (such as experimental controls), are not relevant for qualitative research, often due to their differing epistemologies. The authors outlined several quality standards which are shared by qualitative and quantitative methods, such as 'appropriate methods', and 'respect for participants'. In addition, the authors outlined several quality standards specific (and central) to qualitative methods, such as 'owning one's perspective', and 'coherence'.

Tracy (2010), devised 'Eight Criteria of Quality in Qualitative Research': worthy topic; rich rigor; sincerity; credibility; resonance; significant contribution; ethics; and meaningful coherence. Tracy elaborated and expanded on previous quality standards, describing these eight criteria as practical teaching aids, which exemplify the values underpinning qualitative research as a whole, rather than a positivist list of criteria.

Wells (2011) focused specifically on the quality of narrative approaches, following Hammersley (1992), who devised two standards of 'trustworthiness' in qualitative research: truth (validity) and relevance. Wells discusses how validity could be understood in terms of the 'truthfulness' of the narrator's story, the 'meaningfulness' of the interpretations, or the influence of the research to promote change (p. 115-119).

In the following section, I will describe the attempts made in this research to follow criteria outlined by Tracy (2010), as they are practical and wide-reaching (Resonance, Significant Contribution, and Meaningful Coherence will be discussed in the *Conclusions* section below). However, as Hammersley (1992) argued that each qualitative method should have its own criteria for quality, the Validity and Relevance criteria for narrative analysis described by Wells (2011) will also be considered alongside Tracey (2010).

Worthy topic

Tracy (2010) describes good qualitative research as relevant, timely, significant, interesting, or evocative. With growing awareness of gender diverse identities in popular, political and medical contexts (Pearce, 2018), research into the mental health care of gender diverse people is highly timely and relevant. In addition, this research aims to be evocative and interesting by exploring the narratives and discourses which shape mental health professionals' stories, as opposed to a search for 'truth' about the events they describe.

Rich rigor

Tracy (2010) describes rigor as abundance of data, and the care and practice of data collection and analysis procedures. The data for this study had both breadth and depth appropriate for the study's goals by including seven separate interviews (30–60 min), with a variety of mental health professionals, working in different contexts. The interview guide (Appendix D) demonstrates the range of question areas. Audio-recordings were listened to multiple times to check the accuracy of 108 pages of transcripts. Each interview also generated one page of fieldnotes, which were completed within a few days of the interview, usually the same day. The steps taken to analyse the data are outlined above.

As this piece of research used a social constructionist epistemology, it is assumed that the researcher inevitably shapes the investigation in which they are engaged (Wells, 2011). Therefore, reflexivity during the narrative analysis is necessary for rigorous research. This was achieved through reflective journaling (Appendix Y), to reflect on how my position may

influence the analysis. In addition, I met with my supervisory team during the analysis phase to discuss my developing ideas, and identify blind spots (Appendix Z). I remained flexible in how the data would come together, and was prepared to change direction both in the analysis, and in the interview guide (Appendix AA). Further elements of reflexivity will be discussed below (see *Sincerity*).

Sincerity

Tracy (2010) describes the Sincerity criteria as reflexivity and transparency.

Reflexivity

Wells (2011) describes some important questions to ask in relation to reflexivity, when using a narrative methodology. She first asks about a researcher's position, and the emotional responses between the interviewer and interviewee. At the beginning of this dissertation, I have included an account of how I came to conduct this research, and the positions I have taken. As described above, I reflected on how my position may have influenced the data collection and analysis of each interview (Appendices P, T, Y), and the subjective reactions contributing to the conditions of the narrative productions (Appendices M, N, Q, W). Next, Wells (2011) asks about participant empowerment and consequences of the research. Several participants said they felt the research was important, and that their stories were heard, with a hope that conditions might be improved for mental health professionals and gender diverse people alike.

Wells (2011) also considers how the theoretical assumptions and methodological strategies may have affected the results of the study, and whether any alternative interpretations may be possible. As this study uses a constructionist epistemology and methodology, the analysis was not searching for the 'truth' about the stories told, instead looking into how people narrate their experiences. A different methodology with a critical realist perspective might draw different conclusions, about the reality of the interactions between mental health professionals and gender diverse individuals, which this research does not do. For this research to be as useful as possible for improving mental health care, the narrative methodology focuses on narrative content (the types of stories told) and social and historical contexts (wider narratives and discourse), paying less attention to narrative structure (e.g. poetic structure or prosody).

As well as through journaling, reflexivity during this research was aided by reflexive conversations with my supervisory team, during the design phase, prior to data collection, prior to data analysis, and during data analysis (Appendix AB). The reflexive bracketing questions outlined by Ahern (1999) were used to aid these conversations.

Transparency

Tracy (2010) writes that transparency refers to honesty about the research process, such as use of an "audit trail". As part of the audit trail for this study, I have provided screenshots of each of the steps of the analysis outlined above (Appendices Q, R, U, W, X). Similarly, Appendices Y-AB demonstrate examples where reflexivity has contributed to strengthening the methodology and analysis. Appendix AC demonstrates an example of my position changing subtly as the analysis proceeded.

My contextual knowledge at the time of data collection and data analysis changed as I began working at a gender identity service after most of the narrative interviews had been completed. Appendix AD gives an example of how my readings of the data changed with this additional contextual knowledge, and how this contributed to differences in interpretation of the data.

Credibility

Tracy (2010) writes that "credible reports are those that readers feel trustworthy enough to act on and make decisions in line with" (p. 842-843). It is important that this research is credible, in order to make suggestions about how mental health services could improve their practices for supporting gender diverse individuals. This was the wish of the service user consultants, and participants who took part. In addition, the research could impact on the lived experiences of gender diverse individuals seeking mental health support, again highlighting the importance of credibility.

Wells (2011) describes how adequate information about theoretical orientation, methodology, procedures, and conditions of narrative production, are important for trustworthiness, all of which have been described above. She also describes the importance of providing enough narrative material for the reader to come to their own decisions (Appendices Q-X), as well as narrative text alongside analysis and interpretation (see *Analysis and Discussion* below*)*. Full transcripts have not been provided in this dissertation, in order to maintain anonymity (see *Ethics* below). Thick descriptions of the narrators' organisational and wider social contexts have been provided, as well as examples of shared tacit knowledge (Tracy, 2010) between the participants and myself, as a fellow mental health professional. This tacit knowledge allowed me to have more of an insight into what was *not* said by the mental health professionals, contributing to the analysis below.

Tracy (2010) describes member-checking as an important aspect of credibility in qualitative research. However, Wells (2011) depicts this as particularly challenging in narrative methodologies, as narrators often seem surprised by their verbatim transcriptions and some feel 'objectified' by the analysis. In addition, as this research uses a social constructionist epistemology, the findings do not need to be 'checked' for their 'truth' (Tracy, 2010). Therefore, member-checking was not used in this study, however each participant mentioned that they were interested in hearing the findings of the completed study. Finally, by presenting multiple examples around five wider narratives (see below), data from multiple voices was triangulated (Tracy, 2010), or 'crystalised' (Ellingson, 2008).

Ethics

Tracy (2010) describes practices of attending to ethics in qualitative research. Procedural ethics are the formal processes of ethical approval, and issues such as confidentiality and consent (see *Ethical Considerations* above). This includes data protection, and the practice of redacting or generalising demographic details in order to prevent deductive disclosure. Tracy (2010) also describes how different research designs and methodologies evoke different situational ethics, whereby ethical judgements are made at every step of the research. For example, Wells (2011) discusses the complexities of anonymity in narrative research which involves analysis of participants' important life stories. Therefore, I have chosen not to reveal entire transcripts in this dissertation, so as not to compromise the anonymity of the mental

health professionals who took part, and importantly, their clients, who are not aware of this research taking place.

Tracy (2010) also describes relational ethics (e.g. respect to participants) and exit ethics (e.g. how results are shared) as important ethical practices. Wells (2011) describes how in narrative research, analysis involves re-representation of someone's story, which may implicitly pathologise the narrator (Squire, 2008). Therefore, throughout this dissertation, I have aimed to be as respectful to the participants and their clients as possible, and have held them in mind in the presentation of the findings, to avoid unjust or unintended consequences (Tracy, 2010).

Chapter 3. Analysis and Discussion

In this chapter I present the stories seven mental health professionals told about their experiences working with gender diverse people with mental health difficulties. Brief demographic information for each professional is provided in Table 3 above, and pseudonyms have been used for all professionals and others mentioned in the stories. I use the gendered language (names and pronouns) that interviewees used for their clients, whilst acknowledging that this may or may not fit with how the clients would describe themselves.

First, I present a brief overview of each professional's story: outlining the main stories they brought, the contexts of the clinicians' places of work, and the interview as the context of the narrative's construction. I will also include details of how stories were told, such as the positionings and wider discourses the participants drew on, paying particular attention to their construction of gender and mental health.

Following this, I draw together wider narratives brought up and resisted by the individuals: narratives of feeling deskilled; narratives of standing up to higher powers; narratives of separating different parts of a person; narratives of risk from men; and narratives of transwomen as dangerous. In keeping with a social constructionist epistemology, particular attention is paid to the historical and social contexts in which these stories are constructed, and ways in which broader discourses are drawn on and resisted.

Individual Stories

Dan's Story: There really isn't a lot of knowledge

Dan was a 31-year-old Clinical Psychologist who worked in a Secondary Mental Health team for young people aged 14-25. He had also interviewed gender diverse adults in the private sector as part of his Master's degree in Research Methods. Dan described his service as situated in a white, affluent, conservative area of the UK, where ideas of gender diversity were generally less well known, and the team had limited, if any, training in gender diversity. I asked him to speak particularly about his experiences providing mental healthcare for adults in the public sector, but recognised that these stories might link to stories in other contexts, or with younger people. The interview was conducted over Skype whilst he was at home, and the internet connection was good, so we could see and hear each other well.

Dan told stories about the challenges of working with gender diverse people in medical contexts where staff have limited knowledge on issues of gender diversity. He spoke of coming into conflict with both "medical colleagues" who have a medicalised and pathologizing view of gender-related issues, and "non-medical colleagues" who feel deskilled, unknowledgeable, and "taking that (#) perspective that (#) that there is something: inherently different about (.) trans or gender non-conforming young people[6]". Dan positioned himself as more of an expert in working with gender diverse clients than his colleagues, constructing his identity as the holder of "the knowledge". Later in the interview, he told a story of sharing this knowledge with the team.

[6] See Appendix O for an explanation of the transcription symbols used to provide non-verbal information present in the participants' talk.

In the interview, Dan demonstrated his knowledge about debates and discussions related to trans identities. He spoke of transwomen being excluded from women's spaces, and positioned himself very much against an essentialist perspective of "seeing them as a (3) 'man in a dress'". Throughout the interview he also firmly placed himself on the affirmative side of the affirmative-critical debate, criticising the "TERF community" who might say "well gender dysphoria is just trendy".

Dan spoke using medical language (e.g. "comorbidity of autism"), and references from clinical psychology (e.g. "psychologically minded") throughout the interview, as well as specific trans and queer references (e.g. "deadnaming", "misgendering"). These were areas of shared understanding between Dan and myself, and he appeared to assume I would understand the specialist terminology he used. He explicitly positioned himself in opposition to medical discourses around both gender (e.g. the diagnosis "gender identity disorder") and, at times, mental health (e.g. the diagnosis "emerging personality disorder"), in a way which often resonated with my own position. Dan also used humour and an emphatic tone throughout the interview, which made for a compelling and engaging conversation.

Jenny's Story: It always felt very precarious

Jenny was a 30-year-old Trainee Clinical Psychologist, who spoke about her experience working with a gender questioning person called "Dave" during a placement in a Community Mental Health Team. She described the service as "pressured", with a focus on "turnover", stringent no-show policies, and "readiness for psychology" groups, which she disagreed with. She spoke of working in a busy team which did not communicate well, with "conservative" and "dismissive" attitudes towards gender diversity. The interview with Jenny took place in person, in a private room of a library familiar to both of us.

Jenny told a story of conflict between herself and the service, who asked her to do "CBT for depression" with Dave, whereas Jenny felt that he needed a space to explore and reflect on his gender. Jenny told me her impression was that she was not allowed to discuss Dave's gender because it "was not in our remit". Throughout the interview she positioned herself alongside Dave, and in opposition to the team. She described therapeutic work that helped Dave balance "the different parts of himself", which seemed to have been separated by healthcare and societal contexts. She said this work was "precarious" and "threatened" by the service which had instructed her to do different work with Dave. Later in the interview, Jenny appeared to position herself as an activist, subverting the "rules" given to her if she didn't think they were "right". She spoke of "batting away" problematic opinions and attitudes, taking an active role in trying to make change in the team.

As Trainee Clinical Psychologists, Jenny and I had a shared context of understanding (e.g. placement supervisors), and a shared language of medical and clinical psychology terms (e.g. "CBT", "third wave values"), as well as shared knowledge from narrative therapy (e.g. using the client's words), and queer discourses (e.g. "heteronormative relationship"). When referring to medical concepts such as "presenting problem" or "CBT for his low mood", Jenny often spoke with sarcasm, eye rolls, or a mocking tone. To me, this suggested that in telling her stories, she assumed we shared a critical and constructionist position, over a medical or pathologizing one, in relation to mental health care. She also seemed to construct gender in a constructionist way, referring to Dave as having been "male gender-ed".

Linda's Story: Everyone's trying their best

Linda was a 54-year-old Art Therapist, who spoke about her experiences working with someone named "Jack" on a male ward of a newly established Low Secure Unit. Linda said that the unit was not well resourced, and the service users' "requests" progressed very slowly. She told me Jack had also been waiting a long time to be seen by a Gender Identity Clinic. I spoke to Linda on the phone, whilst she was in the office at work. The phone line was not completely clear, so sometimes we did not quite hear each other.

Linda emphasised that the team couldn't meet all Jack's requests related to expressing a female gender identity as they were concerned about his risk from other service users. Linda told me that because of this, and the long wait for the gender clinic, Jack no longer wished to continue with therapies, which meant his placement at the unit ended abruptly, and he was transferred elsewhere. In the initial tellings of this story, Linda's overriding position was of being part of a team where "everyone's trying (.) their best", in what she described as "quite a difficult environment". As the interview progressed, she told the story more from Jack's perspective, and the struggles he was going through, rather than from the perspective of the team.

Linda regularly used medical terms such as "personality disorder", "behaviour escalated" and "disengaged from therapy" to tell her story. She also framed gender issues in a medical way, describing them as a "condition", and sometimes using outdated and essentialist language such as "sex change" and a male name and pronouns. Towards the end of the interview however, Lisa's talk suggested she was supportive of trans identities, speaking of waiting times being too long.

When speaking about issues of gender diversity, Linda's talk was slower, and more hesitant, with many false starts and self-corrections. However, when talking about other topics, such as training on the ward, she was brighter, and more fluent in her talk. My position as someone working to improve mental healthcare for gender diverse individuals may have made it difficult for her to speak fluently about issues of gender diversity, as she may have been concerned with how she came across. Linda often spoke from the position of the whole team rather than from her personal position, which may also have been due to concerns about how I might perceive her as an individual.

Elena's Story: People are getting a bit better

Elena was a 30-year-old Mental Health Nurse, who managed an acute male inpatient ward, which she described as "dynamic", "busy", "very short staffed", with "bed management (.) demanding beds↓". She told me staff tend to think "very:: (.) clinically" and "biologically". Elena positioned herself as coming from a different perspective, describing herself as having a "psychology background". On the ward itself, the staff and service users come from a range of "cultural" and "religious backgrounds." I spoke to Elena over the phone, when she was at home, after work. The phone line was good, and we could hear each other clearly

Elena told stories of the growth of herself and her team in relation to caring for gender diverse people on the ward. She drew particular attention to people who she had not expected to change their views about gender diversity due to them being "older", or "very religious", challenging narratives about people with these characteristics. Her stories connect to tell a message of hope that a team may struggle in the beginning to support a gender diverse

person, and they may even have "stereotypes and (.) prejudices", however, "most people are more open↓" and can learn to adapt their practice and support people.

Elena danced between positioning herself very much alongside and proud of her team, and at other times criticizing them for their views or actions. She hesitated at first when describing practice which she later felt was incorrect, she diffused the responsibility with phrases such as "the team" or "people" or "everybody thought". As the interview progressed, and after sharing a few laughs with me, she seemed more comfortable in reflecting on her own practice, telling stories of her "anxiety" when working with gender diverse patients.

Elena drew on medical discourse when describing the processes and context of the ward, however she also spoke in opposition to this discourse when describing her preference for "holistic" mental healthcare. She also drew on a variety of trans and queer discourses, describing "non-binary" and "no gender" identities, and challenged several assumptions linked to trans identities. For example, learning that her trans patients did not need or want to keep their identities hidden.

Anna's Story: He had to compromise his own identity

Anna was a 27-year-old Social Worker, who worked in a forensic mental health hospital, which she described as a "restrictive environment". The context seemed to restrict both the patients' freedom to express their gender however they wished, and also the "person-centred", and "relationship-based" practice that Anna believed in. She described a context where "there was a lack of: (.) um: (.) awareness↑ or:: training↑" around gender diversity. The interview took place over Skype, whilst she was at home, however the internet connection was poor at times, muffling the sound.

Anna told a story of "John", a gender diverse person who was transferred to the hospital from prison. She spoke about processes and pathways in a medicalised way, and described John as having a diagnosis of "paranoid schizophrenia". She also described his gender expression in the procedural language of the hospital, saying that he "disclosed' that prior to going to prison, he had "identified as (.) a woman", and as he began to feel more comfortable on the ward, he made "requests" to "wear female clothes", particularly a "nighty". However, Anna described the ward as an "all-male environment", where the staff were in "shock" about John's requests. She said the team felt his requests would make him "vulnerable". Anna described the team as "pathologising" John's gender identity, and discussions about him were had without him, "behind the scenes". She positioned herself in opposition to clinicians, saying that he "wasn't relapsing", and his gender identity was a "completely different thing" to his mental health.

Similar to Linda, Anna's talk about John's gender identity was marked by a slower pace, frequent hesitations, and an appearance of taking care with language (e.g. "but (.) what (.) came (.) apparent in getting to know: um: John, uh:: was that he::: (1) had disclosed that he:: had ↑previously…"), whereas she spoke more fluently about other topics, such as the forensic setting. This suggests to me that she may have been concerned with how she was coming across when talking to me about gender diversity. In addition, similar to Elena, Anna began the interview with stories criticising the wider team, but as the interview progressed, she began to tell stories reflecting on her own practice, describing it as "really bad↑", and positioning herself as inexperienced.

William's Story: I might not always know the right questions to ask

William was a 38-year-old Clinical Psychologist, who worked in a Community Mental Health Team, which he said was located in a "White British, middle class::, um: relatively:: well-off area", with conservative attitudes. I spoke to William over the phone whilst he was at work, and the phone line was clear.

William told a story of a person he had assessed for psychological therapy, who transitioned from living as a man for most of her life, to identifying as a woman. William moved between positions of certainty and uncertainty in his story, saying he was unsure what should be "expected" when going through the "transition process", at the same time as drawing on his expert knowledge of mental health, and what he had learned from "training↑ in gender identity" from a charity called "Gendered Intelligence".

In the first half of the interview, there were moments when William seemed careful and hesitant, particularly when talking about issues from a more gender critical perspective. For example, when questioning "to what extent you kind of (.) um:: accept [their gender identity] as- as- um:: (.) as the case". However, after I mentioned that one of my interview questions had come from gender diverse service users, he spoke from a more affirmative and constructionist perspective, and with fewer hesitations. For example, "it's basically a problem with society trying to fit everyone into these two categories:". He mentioned a few times about the importance of not being judged for things he might say, explicitly saying "I don't want to be judged!" at the end of our interview. He had potentially perceived me as coming from an affirmative position, and this fear of being "judged" may have closed down some of his stories related to questioning a person's gender identity.

During the interview, William largely spoke using medical discourse, which he seemed to align himself with, most of the time. He spoke of assessing clients' "eligibility for secondary care" which depended on whether their gender dysphoria was "related to a mental illness or not↓" or "a life event that (.) someone: needs to work↑ through↓." William also considered whether a person's "identity disturbance" might be a feature of "Emotionally Unstable Personality Disorder" or because "they feel like they're- they're living in the wrong gender↑". Therefore, he seemed to move between critical and affirmative perspectives on trans identities.

Jane's Story: I think everybody sits on their hands

Jane was a 48-year-old Consultant Psychiatrist at a male Low Secure Unit. To set the scene of her stories, she told me that admissions to secure services such as hers were "agreed by a panel", which involved lengthy bureaucratic processes such as "conference meetings" and "discussions". The interview took place whilst the UK was in Lockdown due to the COVID-19 pandemic. I called her whilst she was at home, however the phone line cut out occasionally, and she was interrupted a couple of times by family members.

From the beginning, Jane positioned herself as having "had very limited contact" working with gender diverse people, however she seemed to come with stories she particularly wanted to share with me: a story of a transman who she felt was being "managed really well↓" in a male Low Secure Unit; and a story of a transwoman who was wasn't accepted by any female secure units and "just discharged: back into the community↓". Jane shared with me that she "said yes" to the interview to shed light on the "interesting and complicated… ethical and-

and moral" issues of caring for gender diverse people in secure environments. Due to her senior role, and frequent reminders that her experience was limited (e.g. "I- I did warn you that I haven't had much experience↓"), I found it difficult to push for more specific and personal experiences, meaning that much of the interview resembled more of a case presentation than a storied conversation. As the interview progressed, Jane took a more activist position, mentioning that next time a gender diverse person required an admission to services, she would "really push for more (.) equality."

Jane used dated and essentialist language at times (e.g. "cross-dressing", "a man…living as… a woman"). However, she positioned herself in opposition to an essentialist perspective, and professionals who might say ""well, they're male↓ therefore they should just be (.) male↓"". She used the service users' preferred pronouns as much as possible, correcting herself when she noticed she had not been. Jane spoke from medical discourses throughout the interview and described gender identity as a "stressor", the potential "root cause" of other mental health issues, and described physical interventions as "treatment". However, she also spoke of seeing someone "as a whole person↓" and spoke explicitly in opposition to the practice of labelling gender non-conformity as something "that comes: from- from mania".

Wider Narratives

In this section I describe five wider narratives which were drawn on and/or resisted across participants' stories. I begin by discussing how the participants' stories weave in these narratives, the positionings the storytellers take, and the local contexts of their construction. I will then end each section by discussing where these narratives can be found in existing literature and popular discourse.

Narratives of feeling deskilled: I don't want to say the wrong thing and I don't want to offend them

In my interview, I opened up opportunities for participants to reflect on their own skills and confidence, as well as those of their colleagues. In their stories, many participants drew on and/or resisted narratives of *feeling deskilled* when working with gender diverse clients. Towards the start of his interview, Dan told a generalised story about how gender diverse clients are immediately passed on to "psychology" or himself, as the "local gender expert", positioning himself as the person *with* the skills. He explicitly speaks to the *feeling deskilled* narrative, locating this in his colleagues. For example,

> Dan: taking that (#) perspective that (#) that there is something: inherently different about (.) trans or gender non-conforming young people ↑ [Lauren: hmm] and (.) feeling very deskilled and and not able to kind of (1) work with them (#) that kind of n-feeling that their (.) more generalist skills don't- don't fit, or or or won't be good enough:

Dan talks of gender diverse people being "inherently different", which is reminiscent of discourses which ascribe an innate pathology to queer identities (Pearce, 2018). Jenny also drew on narratives of feeling deskilled when talking about her colleagues. She told a story of attending a training course (unrelated to gender identity), where "really experienced clinicians" did not have the confidence to apply their skills in a "new context." She linked

this to how clinicians might feel about working with gender diverse people, challenging their narratives of feeling deskilled:

> Jenny: it's almost as if you put someone who's gender questioning in front of a really experienced clinician and they go, "Oh, I couldn't possibly do that. I don't know what to do!" Yeah, do ↑you? (.) I mean, they're a gender questioning person, but they're still a person, (.) just like everyone else you work with!

Dan and Jenny more frequently ascribed *feeling deskilled* to others, in contrast to their own more expert position. However, the other participants aligned with *feeling deskilled* themselves, to a greater or lesser degree. Most of the participants seemed more open to describing their own difficulties in their stories once the interview had progressed, and we had built a rapport (e.g. *Elena's Story* above). This could also be seen as the speakers attempting to establish credibility as professionals in their narratives (e.g. Labov, 2010), before telling stories of their own personal challenges or difficulties.

Elena both drew on and resisted the narrative of *feeling deskilled*, when I asked her about her confidence working with gender diverse people. She took a position of uncertainty:

> Elena: I didn't- maybe I didn't have enough experiences (.) at work to make me: very, very confident. And I might not (.) be (.) never (.) completely confident because it's- (.) it's just something that I can't relate to completely. I can:: (.) empathise and I can: (.) see it and I can advocate for it, but it's not- it's very- it's different (.) to (.) me↑ (.) but- (.) Well, I don't know! But then giving ↑care is giving ↓care. (#) You know, if you- if you: if you're delivering care (.) then it should be: (.) it's the same↑ (.) but it's just the:: (.) you just worry for them↑

Elena seemed to move between *feeling deskilled* if she "can't relate" to a person, and resisting this narrative, saying "but then giving care is giving care", before moving to a position of anxiety about gender diverse people on her ward coming to harm, saying "I don't want them to get hurt", shortly after this segment. She seemed to be speaking to the broader social context of victimisation of gender diverse people, which she told me could also happen on her male acute ward.

Jane also drew on the *feeling deskilled* narrative. She explicitly mentioned her "limited experience" before most of her answers to my questions, seemingly as a caveat to her answers, and positioning herself as a non-expert. When I asked her about her confidence, she told a story of seeking supervision for her work with a gender diverse patient:

> Jane: I made contact with the- with the- the local specialist quite quickly to just say, "You know↓ this is- these are my thoughts↓ Um:: what do you think↓ uh: am I doing the right thing↓" Um: I was asking for supervision quite a lot because it was- ˚it was outside of my- um: my experience really↑˚

Despite mentioning her limited experience, she speaks less of her feelings of being deskilled and not knowing what to do, and more of taking the active step of seeking support from the "local specialist", in a manner a mental health professional might be expected to when facing a situation beyond their training or experience (e.g. BPS, 2018).

William drew on the *feeling deskilled* narrative when I asked him how he felt working with his gender diverse client. He described initially feeling "uncomfortable", as he didn't "want to say the wrong thing" or "offend them". He also worried about appearing "ignorant", which was reminiscent of the narratives of threat to expertise and power, outlined by Poteat et al. (2013). After mentioning that he had had some training on gender identity which helped him have some confidence (potentially to establish some credibility in his story; Labov, 2010), William described some of the questions that he wrestled with when working with his client:

> William: I was aware: I might not always: know the right questions to ask↑ um:: for example, I wasn't sure: about (.) the extent to which I should be exploring↑ about surgery↑ and kind of, :hhh hh you know, what surgery they'd had↑ or what they want to have↑ or: :hhh hhh um: (.) whether that was at all relevant↑ to their mental state↑

In his talk, William questions his role in exploring "surgery" with his client. Historically, community mental health professionals have had a significant role in this exploration. Pearce (2018) describes that prior to 2013, patients had to be referred to a gender clinic from a local mental health practitioner. And although referrals now can come directly from a GP, many gender diverse patients are still first referred to mental health services. In addition, the WPATH (2012) *Standards of Care* require that two mental health professionals approve a referral for genital reconstruction surgery. This complicated and changing landscape of mental health professionals' role in gender diverse patients' pathways may have led to William's confusion about his role, and may further contribute to clinicians' experiences of *feeling deskilled*. In addition, William's worries about "surgery" could also be understood as an example of cisgender people's intrusive curiosity about genital surgery, and gender diverse people's bodies, which is widespread in popular discourse (Twist, 2016).

Whereas William mentioned worrying about saying the "wrong thing", two other participants spoke about the negative impact of "fear" of getting it "wrong" in their stories. For example, I asked Jenny what sort of training, education or resources she or her service might have needed. Shortly after speaking of other professionals feeling deskilled, Jenny added:

> Jenny: I do wonder if there's this scary::-ness:: associated with people who: question their gender or (.) who are trans or (.) anything else along the spectrum↑ that you might somehow get it wrong? And I think in that fear, (.) we are getting wrong:↑

Similarly, after I asked Anna what sort of training, education or resources her team might need, she replied:

> Anna: (2) I ↑think just kind of basic- (1) providing a space to have a conversation↑ about it (.) and maybe kind of like myth busting as well. I think (.) I think (.) what stops people from having conversations is, um: (.) a fear that you are saying the wrong thing↑ So, then you don't end up saying anything at all↑

Both Anna and Jenny locate this *fear of getting it wrong* in other people, positioning themselves as people who are cognizant of this problem. They both gave these answers when I asked them what additional training might have been useful for their service, opening space for them to speak from a de-centred position, the service perspective, rather than an individual one. However, in these excerpts, both Anna and Jenny moved from speaking about "people" to speaking about "we" or "you", thus including everyone (and themselves) as having the *fear of getting it wrong*. This hesitancy and fear may be coming from a broader

context of hesitancy when clinicians talk to clients they see as 'different' from them, for example those of a different race or ethnicity. This has also been described as "the discrimination of the restraint in risk-taking" (Gunaratnam, 2007, cited by Nolte, 2007), when people become overly careful not to offend, inhibiting the openness and curiosity they might offer to other clients (Nolte, 2007).

By virtue of my interview schedule, all the participants' narratives moved to talking about how things could be made better in their services. Many of the participants spoke of directly challenging the narrative of feeling deskilled, with "proper training↑" to "just get the facts right↑" (Elena), covering "the basics" (Dan), and information about gender diverse people's "lived experience" (Linda). The participants may have understood there to be some "facts" and truths about working with gender diverse people, which mental health professionals should be educated in.

Several of the participants also spoke about "opening up dialogues" (Jenny), "providing a space to have a conversation↑" (Anna), a "sort of discussion" (Jane). William described training he had received where the trainers "created an environment" which "enabled us to kind of (.) ask anything that we were unsure about↑ or kind of not feel judged↑". The participants seemed to speak about learning through discussion and exploration of different ideas and perspectives, which may be easier in an environment where participants don't feel "judged".

Narratives of healthcare professionals feeling deskilled when working with gender diverse people, are highly prevalent in the literature. One of the physicians in Snelgrove et al.'s (2012) study was quoted as saying that they "didn't know where to go or who to talk to" (p. 4), which became a centralising theory of the research. Similarly, in Poteat et al.'s (2013) study, most of the healthcare providers mentioned feeling "ambivalent about or unprepared for transgender patients" (p. 26). Poteat et al. suggest that healthcare providers might then stigmatise gender diverse patients, to regain the power in the clinician-patient relationship.

Looking at mental healthcare specifically, O'hara et al. (2013) found that all the counsellors in their study "initially felt incompetent to work with transgender people because of their lack of exposure and knowledge" (p. 246). Similarly, Rutter et al. (2010) described how two student counsellors in their study "felt worried that they did not know enough information to help the clients" (p. 73).

These narratives of *feeling deskilled* have been drawn on, and resisted in the stories told by the participants in this study. Some participants mostly located the feelings of being deskilled in their colleagues, whereas others spoke of their own feelings of uncertainty in working with gender diverse clients. Some participants moved between positioning themselves as deskilled, and challenging this narrative, whereas others challenged it throughout their stories, firmly saying that clinicians *do* have the skills to work with gender diverse people. All participants gave suggestions for improving training for mental health professionals, drawing on both education about 'the facts', as well as opening space for discussion.

Narratives of standing up to higher powers: Not sure I followed their rules. In fact, I know I didn't

In the interview schedule, I explicitly asked the participants to tell me about the different pressures they faced when working with gender diverse people, and how they negotiated

these pressures. In answering these questions, many participants told stories which drew on narratives of *standing up to higher powers* or 'Speaking truth to power' (e.g. Sium & Ritskes, 2013), either as something the participants had done in the past, or hoped to do in the future.

Several participants described conflicts in their stories, between what higher powers wanted, and what they or their client felt they needed. Jenny told a story in which she was instructed to do "CBT for depression" with a client who was experiencing distress related to questioning his gender, and she felt this therapy "wasn't right" for him. Similarly, Jane told a story of trying to find a suitable low secure unit for a gender diverse person, however the "regional panel" suggested she be "discharged back into the community", which made Jane "really angry". In both these stories, Jenny and Jane positioned themselves alongside their clients, and in opposition to the higher powers.

William and Dan both told stories of challenging other professionals' decisions to simply refer a gender diverse person to a gender clinic, rather than offering them support in mainstream services:

> William: there was a- (.) an attitude of, :hhh um:: "oh this person: is experiencing: (.) gender dysphoria and we should- we should (.) send them to: (.) :hhh a specialist service like the Gender Identity Clinic" :hh rather than: treating them ourselves in mainstream services: :hhh um: (.) whereas (.) um, I was of the attitude- well, I was kind of being led by the client really, about what they actually wanted and needed

> Dan: if gender dysphoria is even mentioned just to kind of refer on very mindlessly (Lauren: Hmm) umm: there have been a few conflicts where I've (#) been kind of pushing for (#) us to do a lot more: of the kind of initial understanding and digging and making sense of some of those experiences

Similarly, Jenny told a story of how this had previously happened to her client before she met him:

> Jenny: Towards the ↑start: of (.) um:, my work with Dave:, ↑um:, during the assessment: hhh I mean Dave:: hhhh Dave had been sort of in contact with that service before↑ (.) um, and again it just kind of resulted in a referral to the Gender Identity Clinic↑ (.) and a discharge.

These stories were told in the organisational context of mental health services under financial pressure, and a focus on "turnover" (Jenny). Gender diverse clients might be referred from mental health services to other NHS services, or "signposted elsewhere" (William), in order to reduce waiting times for other patients. Dan described the Gender Identity Clinic as a "magical clinical" where other professionals believe clinicians "should be doing all the digging". The existence of these specialist services may strengthen the *feeling deskilled* narrative, as mental health professionals may see themselves as not having the specialist skills needed to support gender diverse individuals, thus referring them elsewhere. William, Dan and Jenny, on the other hand, resist this narrative in their stories, saying that gender diverse people *can* be supported in mainstream services, and *stand up* against those who say they can't.

The participants' stories varied in how difficult they found it to *stand up* to or subvert the system, in order to provide appropriate mental health care for their gender diverse clients.

Elena's talk seemed to suggest that she found it easy to stand up for her patients. I asked her how she might have supported gender diverse people when other professionals have shown a lack of knowledge, which potentially opened up space for stories of *standing up.* Elena took a position of authority in her reply:

> Elena: I'm more senior (.) I have more of a say↑ (.) in things↑ (.) but obviously I have- I can't just make decisions unless- I have to like (.) justify it (.) and, um: (.) and get the team on board but yeah, absolutely I've done that- that- advocate things↑ and (.) talk to different: (.) agencies about it↑ and like: (#) kind of- yeah! Just- just support (.) what I believe in and what the patient wants.

Elena described how she used her *own* power and authority to advocate for what she felt her patients needed. However, my question directly asked for examples of how she has supported gender diverse people when others have shown a lack of knowledge, which could have closed down space for stories of when she has struggled to do this.

In contrast, when reflecting on what she had learned from her experiences, Anna told a story of finding it challenging to *stand up* to those who had more power than her:

> Anna: working with professionals who might see:: things differently↓ to you↑ is (.) the thing that I find (.) one of the most difficult things about (.) this, you know↓ this job↑ Um:: (.) and especially kind of maybe challenging (.) perceptions where people have been in their job for like (.) 50 years↑ and they're super-duper qualified↑

Anna's story speaks to a hierarchical organizational context in healthcare services, where challenging professionals with more experience or qualifications may be frowned upon. Power imbalances related to age, gender, and profession may also have been at play for Anna, making it difficult for her to *stand up* to more powerful others. Although positioning herself as inexperienced, and unable to challenge others, Anna also takes an activist position, noting that there was something in the team that needed challenging.

Jenny also took an activist position, speaking of how she disagreed with her superiors, and subverted the power of those above her:

> Jenny: I kind of felt like I'd been given an impossible task to do↑ (.) because I just don't see how you can ever (.) talk to someone around their mental health while ignoring (2) what he felt was the root of it as well↑, which was- :hh n- through our conversations, I did not do (1) CBT as it were. We were more into sort of (.) third wave values:::

Jenny refers to "third wave" CBT, specifically Acceptance and Commitment Therapy (ACT; Hayes et al., 2006), which focuses on living a life in line with your "values". She later described using this model to allow space for Dave to talk about his gender "in a very careful framework", thus bending the "rules" in order to do the work that she and Dave felt he needed.

As the interview neared the end, Anna, Jane, and Elena all told stories of feeling more able to take this activist position now, than they had done prior to their difficult experiences:

> Anna: I probably feel more confident now, to have more of (.) those open conversations↑
>
> Jane: I think I'd push for things to go a bit faster↑ if we got another case↑ and (.) don't (.) let it (.) slide, it's not- that's not fair, that's not equa- It's not equivo- equivocal↓
>
> Elena: I think, now- now- I'm just more confident in like advocating↑ for:: (#) trans people or non-binary people↑ (.) in general↑

These three stories are infused with narratives of personal growth from challenging experiences, also known as 'quest narratives' (Frank, 2013). The structure of the research interview (e.g. asking what they learned from their experiences) may have opened up space for these kinds of stories, with participants positioning themselves as future advocates and activists in their conversations with me. The interview may have closed down stories ending with them *not* feeling compelled to improve mental healthcare for gender diverse clients in the future. The culture of 'Continuing Professional Development' (CPD) in the healthcare professions, may have also made it difficult for participants to tell stories of *not* continuing to improve their learning and practice.

Explicit examples of healthcare professionals *standing up to higher powers* are difficult to find in the literature. There are, however, several examples of how the healthcare system creates 'barriers' to gender diverse individuals in accessing appropriate physical and mental health care, which professionals may find themselves in opposition to.

In their survey of transgender people in the USA, Shipherd et al. (2010) found that over half the sample had experienced psychological distress, yet had not received any help from mental health services. Some of the participants reported that this was due to having had bad experiences with mental health services themselves, or hearing about such experiences from others. These kinds of stories were also told by counsellors in Salpietro et al. (2019)'s study, describing how healthcare providers might misgender clients, or refer them elsewhere. Similarly, Pearce (2018, p. 111) describes how a tendency for mental health providers to regard gender diverse clients' mental health problems only in terms of their transition (also known as 'Trans Broken Arm Syndrome'), means that trans clients may find it difficult to access support for mental health issues unrelated to their transition.

The participants in this study told stories of *standing up* for gender diverse clients when faced with systemic barriers, such as inappropriate practice, being rejected from services, or referred elsewhere. The participants seemed to have different relationships with *standing up*, some spoke of finding it easier than others. Several participants took an activist position, and spoke of their desire to improve their own and others' practice going forwards.

Narratives of separating different parts of a person: when he spoke about it, he talked about it in a kind of separate fashion

In telling their stories of working with gender diverse clients, several participants drew on and/or resisted narratives of how different *parts* of a person (e.g. gender and mental health) had to be separated, along the lines carved out by the healthcare system.

William told a story which involved separating mental health from gender experiences. He described feeling uncertain about how to understand his client's distress, wondering whether her distress was due to experiences of transition, mental health difficulties, or both:

> William: I wasn't sure about (.) what- what was the kind of normal:: thing to be: expected↑ kind of going through that transition process as opposed to what might be:: a:: (.) a kind of mental health difficulty↑ (#) because (.) I should imagine that ↑going through the ↑process is pretty stressful in itself↑ (3) Um, so I guess, I was kind of exploring: (.) with them their:: their experiences of that and then they were quite clear: to me that they felt that (.) um:: (.) that how they were feeling currently: wasn't :hhh as a result of transitioning↑

In this story, William's client explicitly says her experiences of transitioning and mental health were not connected. This could be another example of a 'Trans Broken Arm Syndrome' story, if William had assumed his client's distress was linked to her transition when it wasn't. On the other hand, William later mentioned that gender dysphoria could be seen as "a life event that (.) someone: needs to work↑ through↓", which he said might exclude them from receiving "secondary care". Therefore, in this organisational context of limited resources, and stringent inclusion criteria, this story may also be an example of a gender diverse person having to separate themselves into parts (i.e. separate out the transitioning part), in order to access mental health support.

A few of the participants told stories of their gender diverse clients having to separate different parts of their identity, and be different people, in different contexts. Anna told a story of John, who had "identified as (.) a woman" prior to going to prison, but presented as "male" in prison and hospital. She continued the story:

> Anna: but when he (.) came into hospital, um: felt more comfortable to talk about his- his previous identity (.) and: his: I guess, his wish to, um, (.) again, uh, connect back in with, um: (.) his previous identity, as, as he kind of called it↑ (.) Um: when he- when he spoke about it, he: um: (.) talk- talked about it in a kind of separate (.) fashion.

In this story, hospital became the space Jack hoped to reconnect with a part of his identity which had been separated out. However, the story goes that this was not possible for him, and barriers were put in place which prevented him from expressing his gender the way he wished (see *Anna's Story* above). Linda also told a story of Jack, who was not able to freely express his gender in a forensic unit (see *Linda' Story* above). These stories were told in the broader context of transwomen being at risk of violence from men (Perry & Dyck, 2013; see *Narratives of risk from men* below*)* which Anna described as the reason for Jack not feeling comfortable identifying as a woman whilst in prison, and why the MDT were reluctant to allow him to express his gender openly on the ward.

Jenny also told a story of someone who separated parts of their gender identity, in a community setting. She spoke about Dave who used to "dress as a woman" when he was away from his family, as he felt they would not accept it. She said he gave this "side" of himself a name, "Lucy", and Dave used to say Lucy had her own "personality". When I asked her about experiences she felt went well, Jenny spoke of the therapeutic work with Dave which she described as bringing together these two parts of himself:

> Jenny: he used to say, “Happy enough,” (.) as if (.) you know, "I've, I think I've found a way that maybe I can be happy enough↑(.) where I can-" (#) We’d talked about sort of (.) balancing:, (#) balancing the different parts of himself (.) um (.) and talked about (.) finding a way to be able to (#) connect with (#) both parts of himself while (.) not (.) sacrificing:- (#) and that was his word, sacrificing his family↑.

Throughout the interview, Jenny positioned herself as alongside Dave, trying to make sure the story was as close to Dave’s narrative as possible. With phrases such as “and that was his word”, she was explicit about using Dave’s own words, and attempting not to put her own, professional words on his narrative (Gergen & Kaye, 1992). His words, “happy enough” suggest coming to a better place than he was before, yet not as happy as he could be. Several participants told stories of the negative consequences (e.g. losing family), and discrimination faced by people who transition to living as women. This challenging social context may set the scene for Dave’s story of only reaching “happy enough”.

Jane, Jenny and Elena all mentioned the importance of seeing a “whole person” or working “holistically”. For example, Jane spoke of seeing a “whole person” when telling a story of doing positive work with a gender diverse client, mentioning that not doing this might have been unhelpful for them:

> Jane: I think it's- it’s seeing them↓ as- as (1) uh:: as a whole person↑ and- and ignoring: that↓ or just, um, not allowing them↓ that space to: to question it↓ would’ve- would’ve prevented them↓ moving (1) on↑

Similarly, when I asked Dan about difficult experiences, he told a story of a “complete break-down of the relationship” with a gender diverse client, when he gave them the “impression” that their dysphoria was not “important”, or “valid to work on” in therapy, and instead focused on other “therapeutic goals”. These stories resist the narrative of *separating different parts of a person*, as they challenge the idea that different parts, diagnoses, or experiences a person has, must be worked with separately. After I asked Jenny what she had learned from her experiences, she explicitly resisted the *separating different parts* narrative saying:

> Jenny: how on earth are you ever supposed to separate someone- (#) one aspect of someone: (.) that's been labelled (.) from another aspect of someone (.) and that was very flowery language- :hh UM, HOW (.) on earth (.) you are supposed to (.) treat someone with mental health problems, which is X, Y or Z (.) um, but we just don't talk about the messy gender stuff.

By using the word “labelled”, she speaks to the medical practice of ascribing diagnostic terms for different categories of experience, drawing attention to their social construction (Gergen, 2011), and positioning herself in opposition to medical discourse. She also seemed to contrast a linear medical framework of seeing mental health problems as “X, Y or Z”, with the “messy” conversations about gender, suggesting that the “gender stuff” didn’t fit within the linear medical framework. She then resisted this idea, saying that in fact “it ↑wasn't that messy” when she spoke to Dave about his gender.

As Jenny mentioned (saying “I know this interview’s all about that”), I was asking for stories about working with gender diverse people, bringing the gender part of their clients’ identity to the foreground. This potentially opened up stories where a person’s gender identity was

understood as something separate from other parts of them, and potentially closed down stories about working with 'a person' who happens to be gender diverse.

It is perhaps unsurprising that narratives of *separating different parts of a person* were drawn on in the participants' stories, given the history of the mental health profession. Mental health (and illness) has been in the hands of medical professionals since the end of the 18th century, at the dawn of 'modern thinking' (Foucault, 1964). Thus, the current mental health profession has grown out of a modernist context, with modernist assumptions (Gergen & Kaye, 1992). One such assumption from modernist science was the codification and categorisation of nature, thought to be rooted in the practices of colonialism (Tuhiwai-Smith, 1999). Through the revisions of the DSM, the practice of codifying experiences of mental distress into diagnoses, with precise criteria, was strongly embedded in the psychiatric profession by the mid to late 20th century (Bentall, 2004). Thus, narratives of separating people with distress into categories and parts (e.g. depression with a comorbidity of anxiety), are rooted in this wider medical and modernist discourse of codification. Narratives of seeing a 'whole person', would oppose this medical discourse, as well as practices of prioritising the client's narrative of their distress over the scientific or medical one (Gergen & Kaye, 1992).

Narratives of gender diverse people having to separate out different parts of themselves in healthcare settings are common in the literature. In her analysis of Twitter posts related to trans healthcare, Pearce (2018, p. 132) quoted one person who tweeted that they hid their "anxiety and self harm" from doctors at the gender clinic as they did not "feel safe telling them", and another who experienced anxiety about whether they will have to "disclose trans status" to their doctor. Similarly, when telling a story of their experiences navigating UK healthcare, H Howitt (2020, p. 216) wrote:

> that's having to choose between being sick and being trans to access
> the services you need
> you deserve
> you are righteously angry at not receiving
> You have a body. It is a trans body. It is a disabled body. It is a
> traumatised body. And it is still a body. Don't let the institutionalised
> compartmentalisation you are experiencing seep into your wholeness
> and split you apart.

These stories describe how people have had to separate or 'compartmentalise' themselves, along lines carved out by the healthcare systems, in order to access services. Similar stories were told by the participants in the current study. Participants told stories of the separation of mental health and gender experiences, as well as the separation of 'male' and 'female' identities. Some participants spoke about how their clients' experiences of gender and mental health might be separate or connected, and others spoke about the importance of seeing someone as a 'whole person'.

Narratives of risk from men: it's a male unit and she was dressing as a female and that was just all too risky

All four participants who worked in inpatient settings told stories of their gender diverse clients' risk from (cis) men on their 'male' wards. Most of the participants eluded to this risk, without fully explaining what it was, or what was behind it:

> Linda: He requested to:: :hhh um: (.) dress in: women's clothing for example, but he was in a communal (.) all-male environment :hhh So: it was: (.) um:: something they didn't particularly want (.) others (.) to (.) be:: party to. So that was difficult.
>
> Anna: worries about his vulnerability if he was to:: um:: (2) kind of start presenting again as- as- a female↑ I think there were very real concerns that the: (.) the MDT (.) had (.) for his wellbeing↑
>
> Jane: she was in seclusion, but they were worried about how could you bring her out↑ because it's (.) a male↑ unit and she was dressing as a female↑ and that was just all too risky↑:
>
> Elena: we: thought- (.) well, he has to be on one-to-one because he- he's at risk for sure! Just simply because (.) he's trans.

All four participants' stories drew on narratives of *risk from men*, if their clients were to "dress in women's clothing" or for simply being "trans". Linda, Anna, and Jane told these narratives like 'just-so stories', without going into much detail about this assumption - that by virtue of the other patients' male-ness, their clients were at risk. Elena, on the other hand, explained this assumption as coming from her team's "own (.) stereotypes and (.) prejudices" about the vulnerability of gender diverse people. These stories were told in the context of mental health wards, where medical professionals have complete power over their patients' lives. In their stories, the participants positioned the power in the staff team's hands, and drew on a narrative of 'doctor knows best' which is common in medical discourse (e.g. Fennel, 1998).

All these stories also involved decisions which were made based on the narrative of *risk from men*, that resulted in gender diverse people experiencing more restrictive care. The person in Jane's story was kept in seclusion, Elena's was kept on "one-to-one", and the people in Anna and Linda's stories were prevented from wearing the clothes they desired. These narratives of restrictive care echo the story of Jaden Prendergast (2017) who was admitted to a psychiatric unit. He writes: "She then told me that transgender people have a high risk of sexual assault and violence, therefore it was for MY safety to be isolated". Similarly, these narratives are also present in the frequent media stories of transwomen being kept in solitary confinement whilst in prison, in 'protective custody' (e.g. Calico, 2018).

The participants positioned themselves in different places of responsibility in regard to these restrictive care decisions. Anna spoke of the "very real concerns" of "the MDT" if John were to wear a "nighty", aligning herself with the broader perspective of the MDT, at the same time as diffusing the responsibility across everyone, and away from herself. Linda positioned herself away from the decisions of the team regarding Jack's clothing, referring to the team as "they". However, for most of the interview, she used the word "we" to refer to the team, suggesting that she may feel less comfortable to position herself alongside care decisions related to Jack's gender. Jane, a Consultant Psychiatrist, seemed very comfortable owning her position in her decision making, for example, "as male low secure, I was (.) very clear that she (.) was not for us". She used the word "they" only when describing the decisions made by other services, or panels. However, during the interviews, I presented as a researcher interested in improving mental healthcare for gender diverse people. This local context may have opened up space for participants to tell stories where they have taken an affirmative approach to gender (e.g. Jane), and closed down space for participants to position themselves

as individuals who *prevented* someone expressing their gender in mental health services (e.g. Anna, Linda), thus locating these decisions as coming from the wider team.

Elena was the only participant who told stories of transmen at risk from other men on the ward. Early in the interview I asked her to tell me about any specific people she remembered working with. She told a story a transman who initially experienced harassment from two male patients on the ward that were "putting him down::". Elena explained that the other patients eventually "got used to it" and "the risk decreased↑". Despite this, the "one-to-one" remained:

> Elena: there was no clear-cut, um (.) answer to it. So, we just kind of managing that kind of (.) anxiety in the team and just to manage that, it took maybe↓ (.) an extra week↑ (.) just for people to be comfortable with (.) taking off the one-to-one. (Lauren: wow) Um:: and then afterwards, was absolutely fine

Later, I asked Elena for an example of when she might have learned something through working with a gender diverse client. She told a story of another transman who was admitted to the ward, who spoke "openly" about his identity which created anxiety in the team:

> Elena: And he talked about everything quite like openly↑ (.) So:: (.) so:: (.) this patient, everybody was like, "Oh my God! He's talking like (.) proper openly to everybody! He doesn't CARE: (.) if people know or don't know↑" (.) And people were scared of- (.) um:: him being a target because of that↑

Similar to the previous story, Elena described there being a lot of anxiety about the person's safety. She continued the story, describing that the patient himself asked Elena to trust that he would be safe, and he would let her know if there were any issues with the other patients. She said she followed his request, he remained safe from harm, and "it worked out well!" In these stories, Elena positioned herself as someone who was in the wrong, and had to get over her "anxiety", "prejudices" and "stereotypes" about transmen being vulnerable if they don't keep their identity a secret. Through her stories of conversations with and trust in her gender diverse patients, she resisted the narratives of restrictive care, and narratives of *risk from men*. However, it must be noted that these were stories of transmen only, therefore these narratives may be more dominant in stories involving transwomen.

When I asked Linda about additional training, she would have found helpful, she spoke of wanting to learn more about the "lived experience" of gender diverse people. She added:

> Linda: it's difficult to know :hh um: (.) staff to know↓ (.) without the training or understanding :hh of how people experience (.) people coming- :hh people being around: males:, some of the things males: might say:: some of the prejudice- (.) Some of the prejudice that they might experience.

Her talk speaks to the paucity of narratives available to mental health professionals about gender diverse people "being around: males", which could contribute to the dominance of the narratives of gender diverse people being at *risk from men*, and thus perpetuating restrictive practice.

Narratives of gender-based violence towards gender diverse people around the world are common in the mainstream media, research literature, and collective consciousness of queer

communities. Several pieces of research have reported that trans populations are at an increased risk of experiencing violence (Fish, 2007; Reisner et al., 2016; Scanlon et al. 2010), particularly transwomen (Jauk, 2013; Perry & Dyck, 2013), and gender non-conforming people who don't follow normative gender expression (Namaste, 1996). Schilt and Westbrook (2009) describe how transwomen experience more harassment for the "double sin of both abandoning masculinity and choosing femininity". The stories of violence told by gender diverse people in Jauk's (2013) study were exclusively perpetrated by (cis) men. Similarly, Perry and Dyck (2013) described a narrative of "young men heading out for an evening of 'tranny bashing'", which was told across the transwomen who they interviewed. These stories are also told in the broader social context of vulnerable women (cis or trans), being at risk of violence from men (Hearn et al., 2016).

However, in recent years there have been increasing media stories about transwomen at risk of violence from cis women, particularly linked to the debates around transwomen using female bathrooms (e.g. Sharman, 2019), and stories of transwomen being kept in isolation, even when detained in a female prison (e.g. Manson, 2019). Although gender-based violence against gender diverse people can occur between people of any gender, there seems to be a particularly strong narrative of violence directed towards transfeminine[7] people, perpetrated by (cis) men. This narrative of risk from men extends into the exclusively 'male' environments of prisons (e.g. Sylvia Rivera Law Project, 2007) and mental health hospitals (e.g. Prendergast, 2017), where many of the stories in this research were set.

The participants in this study told stories which drew on narratives of *risk from men*, if clients expressed femininity whilst admitted to a male inpatient ward. These stories often drew on narratives of restrictive practice, to 'protect' the gender diverse clients, and participants positioned themselves as having more or less responsibility for these care decisions in their stories. Elena resisted the narratives of risk from men when telling stories of the transmen admitted to her ward, however no one resisted these narratives when talking about transwomen. It is important to note that the participants did not speak of whether or not the (cis) men on their wards had offending histories against women, which could have also set the scene for their stories of *risk from men.*

Narratives of transwomen as dangerous: the trans woman in the prison who's been hurting people

Finally, narratives of *transwomen as dangerous* were also drawn on/resisted in the participants' stories. Both Elena and Jane told stories of transwomen who exposed their genitals whilst admitted to female wards. They both temporarily swapped to using he/him pronouns when describing the explicit behaviours of the transwomen, but used their preferred she/her pronouns for the rest of their stories. This could be an example of the dominant, essentialist discourse of connecting a person's gender to their genital status, which may be most difficult to resist when speaking of the genitals themselves. Both participants questioned the safety of other women on the wards:

> Elena: but that distressed a lot of the women (.) <u>in</u> the ward (.) because a lot of them went through a lot of (.) <u>sexual abuse</u> in the past↑

[7] 'Transfeminine' is a term used to describe people who identify with femininity to a greater or lesser degree and were assigned male at birth (Gender Wiki, n. d.).

> Jane: And it was felt then unsafe for the females↑

The stories drew on discourses of transwomen being a risk to other women, by virtue of their genitals, which Bettcher (2007) suggests "is predicated upon the identification of penis with rapist" (p. 57). At the same time, Elena draws on the wider context of female inpatient services, where many women have experienced past sexual abuse (Dwyer et al., 2019), most commonly perpetrated by (cis) men. In their tellings of these stories, both Elena and Jane remained respectful, positioning themselves alongside the transwomen, describing them as not well:

> Elena: She was just, she wasn't well, she was like in a manic (.) episode.

> Jane: she was quite un-, she was very well, unwell and manic

Both participants drew on the medical discourse of mental illness, and being 'manic'. By locating the problem in the transwomen's mental health difficulties, Elena and Jane seem to be taking an ally[8] position, suggesting that the transwomen were not to blame for their behaviours, and they would not behave in this way if they were 'well'.

Jane contrasted this story with another story of a person in secure services who she described as "not transitioning" but "dressing" as "female", who had "changed their name by deed poll". She described:

> Jane: but their index offence↓ is- is rape. Um: (.) and- and therefore: they're ↑not safe↓ to be: in a female unit↓ even if they are:: (.) declaring: themselves female, it- it- it- they're not safe to be: (.) in a- in a ward with (.) other females.

This story closely follows the narrative of *transwomen as dangerous*. By describing the person as "not transitioning" and "declaring themselves as female" there is perhaps an element of suspicion in Jane's talk, that the person may just be "dressing" as a woman to gain access to women's spaces. However, Jane positions her argument as coming from a risk perspective, as opposed to a gender critical one, emphasising that if there aren't "sexual risks" then "it's easier" to place transwomen on a female ward.

Similarly, Elena continued her story, telling me that the transwoman in her story was eventually moved to another "calmer" female ward, where people were not so "triggered", and the person "got better", telling a story which resists the narratives of *transwomen as dangerous*. However, neither Jane nor Elena chose to tell stories of gender diverse patients who were admitted to female wards, who did not pose some kind of risk to other women.

In the interview, I asked all the participants about media stories related to trans identities that had caught their attention. Elena, William, and Jenny all mentioned the debates around gender diverse people using toilets, which are thick with narratives of *transwomen as dangerous* (Pearce, 2018). Dan was the only participant who explicitly linked media stories to clinical practice, specifically that of his colleagues, with him taking the more expert position. He told a story of having conversations with his colleagues about whether or not the transwomen they support can be referred to "women's refuges". He described some

[8] Reynolds (2010) describes an ally as "a person who belongs to a group which has particular privileges, and who works alongside people from groups that are oppressed in relation to that privilege" (p. 13).

conversations as having an "inbuilt bias" towards seeing a transwoman as a "man in a dress". He continued to say that these conversations were "not helped by" a particular media story:

> Dan: the particularly famous case, I can't remember their name, the the the woman (.) the trans woman in the prison who's been (.) hurting people and (.) was (.) quite (.) big a few months ago – that that's not helped.

Dan, positioning himself in opposition to this narrative, describes the role of media stories in strengthening the narrative of *transwomen as dangerous*, and feeding into the discussions and decision making of mental health professionals. This echoes the finding from the trainee counsellors in O'Hara et al.'s (2013) study, who mentioned the role of the media in their practice. One participant said, "The media is where I got most of my stereotypical knowledge from just watching TV" (p. 246).

Narratives of transwomen as dangerous have been long established in medical, gender critical, and popular discourses. Cauldwell (1949, cited by Pearce, 2018, p. 25) described the 'psychopathic transexual' as prone to lies and deceit, and in the 1960s, much of the medical community understood 'transsexuals' as 'socio-paths' (Stone, 1991). In her book, *The Transsexual Empire,* Raymond (1979) describes 'transsexualism' as a creation of men, whereby *deviant males* (p. 183) appropriate women's bodies and 'invade' women's spaces. Bettcher (2007) challenges these narratives in her deconstruction of the "persistent stereotype of transpeople as deceivers and the equation of deception with rape" (p. 47). In her book, Pearce (2018) connects the 'deceptive transsexual' narrative to the widespread debates around gender diverse people using toilets that align with their gender identity. She notes that "opponents of this approach…frequently argue (without evidence) that it will afford 'men' the opportunity to spy on and perhaps commit sexual violence against young (white) girls" (p. 49). In addition, in her lecture *Transgender Moral Panic – A Brief History* (2018), Pearce connects narratives of transwomen as dangerous, to narratives of "the threat of blackness", and of "gay people specifically portrayed as a danger to children", as mechanisms of a white supremacist empire, "to maintain masculine, forthright, white men… and nice women who will bear children for them".

Narratives of *transwomen as dangerous* can also be seen in the mainstream media debates around gendered hospital wards. In January 2019, there was a plethora of stories across mainstream media outlets, about an "NHS trans row as men get access to women's wards if they identify as female" (Lucas, 2019; McGrath, 2019; Tominey & Walsh, 2019). In October 2019, NHS England (2019) released their guidance on *Delivering Same-Sex Accommodation,* stipulating that "Trans people should be accommodated according to their presentation" (p. 12), which made headlines in many popular news outlets (e.g. Boyd, 2019; Swerling & Walsh, 2019). A few months later, critical news stories circulated about how "Women who complain about sharing wards with men are 'transphobic'" (The Christian Institute, 2019; Thompson, 2019), and by March 2020, the National Health Service in Greater Glasgow and Clyde put their Same-Sex Accommodation policy under review (McLaughlin, 2020; Showalter, 2020).

The interviews in this piece of research took place between September 2019 and March 2020, whilst this public debate was unfolding. Although none of the participants explicitly mentioned these media stories, the debates around transwomen in single-gender wards were present in both Elena and Jane's narratives. Elena resisted the narrative of *transwomen as dangerous* when she told a story of a transwoman having a successful admission to a female

ward, and Jane complicated the picture when talking about a person who had a history of sexual violence towards women. Several participants also drew on media stories of *transwomen as dangerous* during their interviews, and Dan spoke of how these stories might influence clinical practice.

Chapter 4. Conclusions

Summary of Analysis

This study aimed to investigate how mental health professionals describe their experiences providing care for gender diverse clients with mental health difficulties. Within this overarching research question, I was particularly interested in exploring: how participants positioned themselves and their abilities within their narratives; how their narratives construct gender and mental health; and how their stories are shaped by the local and broader contexts of their construction. Findings related to each of these aims is summarised below.

How participants positioned themselves and their abilities

As described above, narratives of clinicians *feeling deskilled* when providing physical or mental healthcare to gender diverse individuals are common in the literature (e.g. O'hara et al., 2013; Snelgrove et al., 2012). The participants in this study held different positions in relation to the narrative of *feeling deskilled*. Some participants spoke of the narrative explicitly, locating this 'feeling' in other clinicians, and challenging the narrative, saying that clinicians *do* have the skills to support gender diverse individuals. Other participants moved between aligning with *feeling deskilled,* and challenging this narrative, whereas others aligned with *feeling deskilled* throughout their talk. Several participants began their interview taking more of a de-centred position, reflecting on or criticising the actions of their colleagues, before later moving on to reflecting on their own skills, confidence and decisions, perhaps once they had established credibility in their narrative (Labov, 2010), or felt safe opening up to a stranger.

Many of the participants also told stories of *standing up to higher powers,* positioning themselves alongside their gender diverse clients, as activists or allies, challenging the decisions of their team or superiors. In their stories, some participants found it easier to stand up for their gender diverse clients than others, depending on the power they held. Reynolds (2010) describes how "we can all be allies to each other in a constant flow depending on our contexts and relationships of power" (p. 13), which fits with the current study. Jane and Elena spoke of finding the *standing up* easier, as they held positions of power in their services. Anna, on the other hand spoke of finding it harder to *stand up* to her more senior colleagues, and Jenny spoke of subverting the instructions of her superiors, which made the work very "precarious". In their stories, both Anna and Jenny positioned themselves as having more junior roles, and limited power. Most of the participants also positioned themselves as future activists, hoping to *stand up* for their gender diverse clients in the future, drawing on 'quest narratives' (Frank, 2013) of growth from their difficult experiences. However, the local context may have had an influence on participants taking this position (see *Local Context* below).

Several of the articles reviewed assessed clinicians' 'competence', preparedness or 'knowledge' for working with gender diverse clients (e.g. Johnson & Federman, 2014; Lutz, 2013; Riggs & Bartholomaeus, 2016a; 2016b). In these studies, the clinicians' 'competence' was assessed against certain criteria and knowledge. Several of the participants in this study echoed this idea, saying that there are certain 'facts' clinicians need to know in order to provide care for gender diverse clients. Salpietro et al. (2019) termed this 'essential knowledge', such as awareness of gender concepts and transitioning. However, the participants in the current study also mentioned the importance of having space to have 'open

conversations' without the fear of being judged or 'getting it wrong', when developing skills to provide care for gender diverse clients. This had not been captured in the literature previously.

Participants' constructions of gender and mental health

All the participants drew on medicalised language in their stories, to describe their organisations, operating procedures, and pathways, or to describe their clients' difficulties, diagnoses or treatment. Most of the participants also seemed to use a 'case presentation' style of talking when introducing their clients, and the care they were provided. This may have been due to the shared tacit knowledges and specialist vocabularies available to both the participants and myself, as mental health professionals (Wells, 2011), or perhaps as a way for the participants to establish credibility in their narratives (Labov, 2010), by using 'expert' terminology.

Some participants also spoke of gender diversity within a medical framework, referring to gender experiences as a 'condition', or as the 'root cause' of their clients' mental health difficulties. However, other participants actively resisted a medicalised or biological framework for understanding both mental health and gender diversity, explicitly drawing attention to how these ideas may be socially constructed, and speaking more of gender experiences as identity rather than pathology.

Several participants told stories which drew on or resisted narratives of *separating different parts of a person*, which are commonly found in the narratives of gender diverse people who have accessed mental health care (Howitt, 2020; Pearce, 2018). Some participants drew on a diagnostic approach in their stories, describing how their clients' experiences of gender and mental health might be separate or connected. Whereas others spoke about the importance of seeing their clients as a 'whole person' in their stories, resisting narratives of *separating different parts of a person.*

Although some participants used dated or gender essentialist language at times, most participants spoke from a constructionist and affirmative perspective when talking about their clients, respecting their identified genders, and recognizing the impact of social contexts on their clients' gender possibilities (Pearce, 2018). Gender critical ideas came up rarely, and were mostly resisted in the participants' narratives. One participant wrestled between critical and affirmative perspectives when trying to understand their client's distress. This is a similar picture to that found in the research literature, that clinicians generally describe affirmative practices, with good intentions (Kawano et al., 2018), and tend to have positive attitudes towards gender diverse clients (Kanamori et al., 2017), as opposed to constructing gender diversity as pathological, immoral, or unnatural. However, gender critical perspectives on gender diversity are re-emerging in the literature, and mainstream culture (e.g. Brunskell-Evans & Moore, 2019), painting a more complex picture of narratives for clinicians to draw on when understanding their clients' experiences.

Contexts of the narrative construction

Local context

Several of the studies included in the systematic review considered the role of 'social desirability' in their research (e.g. Dispenza & O'Hara, 2016; Whitman & Han, 2017).

Similarly, all the stories told in the current study would have been shaped by how the participants wished to be perceived during and after the interview, and by potential feared outcomes if they were to disclose discriminatory or unethical practice.

Throughout the interviews, I positioned myself as a mental health professional with an interest in improving mental health care for gender diverse people. Due to my non-verbal and verbal cues (e.g. 'hmm', 'yes') when participants spoke in an affirmative way, and including an interview question designed by gender diverse service users, the participants may have positioned me as taking an affirmative perspective, and as potentially unsympathetic towards discriminatory practice or 'incorrect' terminology. In addition, several participants mentioned how challenging it can be to talk about gender diversity. These difficulties may have influenced the types of stories participants told, or the way they told them. The participants would have also told their stories with audience in mind (Riessman, 2008), considering other professionals who may read the results of this research.

This local context may have opened up space for stories where participants took an affirmative, activist approach, and closed down stories from a more gender critical perspective. Many participants appeared more hesitant and less fluent when talking about issues of gender diversity, compared to other issues, which may have been out of concern for how they were coming across when telling their stories. One participant explicitly mentioned that they did not want to be 'judged', which may have also shaped the kinds of stories they told and positions they took. In addition, the interview experience, and culture of CPD in mental health practice may have opened up space for stories which ended with participants learning from their experiences, and doing more next time, drawing on 'quest narratives' of personal growth (Frank, 2013), and closing down space for stories which ended with the participant *not* continuing to improve their practice when providing care for gender diverse clients.

Organisational context

The vast majority of stories told by the participants were set during a time of austerity measures and funding cuts to public mental health services in the UK, and after the restructurings of the Health and Social Care Act 2012. The participants described financial pressures, a focus on 'turnover', limited resources, and stringent inclusion criteria when talking about their organisations. They mentioned lengthy bureaucratic processes, and practices of 'signposting elsewhere' and 'discharge' to reduce waiting times for other patients. Most participants also spoke of specialist gender clinics, with extremely long waiting times for clients to be seen. This organizational context sets the scenes for many of the stories told, and seemed particularly relevant to stories of *separating different parts of a person*, where gender diverse clients may have to present or hide different 'parts' of themselves in order to gain access to services.

All participants described minimal knowledge and training available to mental health professionals regarding gender diversity, with most having sought it for themselves, and all participants mentioned the need for improved training in this area. This was commonly discussed in the research literature, and across all studies included in the systematic review (e.g. Johnson & Federman, 2014; Lutz, 2013; Riggs & Bartholomaeus, 2016b).

Historical and social context

The stories told in this study were infused with historical and social ideas of masculinity, femininity and gender diversity. Several participants spoke of the stigma, shock and unusualness of people assigned male at birth expressing femininity, such as wearing clothes generally ascribed to women, both on the male wards of inpatient hospitals, and in the community. On the wards, there were stories about gender diverse individuals' potential risk from other patients if they were to be seen wearing 'women's' clothes. In the community, stories were told about rejection from family, and having to express femininity in secret.

These stories were told in the historical and social context of heteronormativity[9], and patriarchy. Namaste (1996) describes how heteronormativity is policed through violence against people who deviate from the assumptions of their gender, such as 'effeminate' men, or 'masculine' women. In addition, Schilt & Westbrook (2009) describe the 'double sin' of transwomen who both abandon masculinity and choose femininity. Namaste (1996) provides a useful analysis of diverse gender expression in terms of the public-private dichotomy. She writes that the public sphere has historically been seen as belonging to (heterosexual) men, and "entrance into the public sphere is secured through the enactment of a sanctioned gender identity". She adds that those who violate this pose a "fundamental challenge to public space and how it is defined and secured through gender" (p. 226). Many of the stories told in this research could be seen as drawing on this public-private dichotomy, as the people assigned male at birth were forced to express femininity in private (e.g. in secret, in their rooms, or in seclusion), as a result of the assumed risk of harm arising from violating the rules of the public sphere.

The stories were also told in a historical and social context where transwomen are often portrayed as deviant and dangerous (e.g. Raymond, 1979), particularly in 'female-only' spaces such as bathrooms, prisons and women's refuges. In addition, the research interviews took place whilst public debates about 'same-sex accommodation' in hospitals were unfolding in the media, with headlines such as "NHS trans row as men get access to women's wards if they identify as female" (Tominey & Walsh, 2019). Several of the stories told in this research were infused with narratives of *transwomen as dangerous,* particularly in inpatient settings. The participants mostly told these stories whilst also resisting this narrative. This was done either by holding an 'ally' position and emphasizing that the women in the stories were 'not well', or by taking a position more concerned with 'risk', emphasizing that only the transwomen with histories of sexual violence were a 'risk' to other women.

The narratives of *risk from men* and of *transwomen as dangerous* could be seen as two sides of the same coin – seeing transwomen as men, and men as dangerous (Bettcher, 2007). Similarly, through these narratives, transwomen in hospital care are seen as both dangerous (to women) and vulnerable (from men), resulting in a double bind when making decisions about where they should be placed.

Fewer stories were told about transmen, or about people assigned female at birth exploring their gender identity. Some research literature suggests that people in the adult trans population are most commonly transwomen, and less commonly transmen or other genders (e.g. Arcelus et al., 2015), which could explain this finding. In addition, social and historical

[9] Socio-legal, cultural, organisational and interpersonal practices that derive from and reinforce presumptions that there are only two (immutable) sexes, it is 'natural' for people of different sexes to be attracted to one another, and any alternative to this norm is seen as variation, if not deviant (Kitzinger, 2005).

ideas about diverse gender expressions have more commonly focused on transwomen and men who express femininity, both in the medical literature (e.g. Benjamin, 1954), and in popular culture. Similarly, gender non-conformity in people assigned male at birth has also been seen as more unusual and less acceptable than in people assigned female at birth, thus pathologised more. Therefore, the participants in this study may have also told more stories of transwomen and men who express femininity because these stories may have been more in line with their ideas of what 'counts' as gender diversity, and more memorable or remarkable than their encounters with people assigned female at birth who express masculinity.

Implications for clinical practice

This research has taken a social constructionist position and does not make claims about the 'truth' of the stories told by participants. However, I have also been concerned with the material conditions faced by gender diverse people accessing mental health services, made up in part by the policies, procedures and care decisions of mental health professionals. Therefore, in this section I suggest some implications for clinical practice based on the findings from this research, with a hope to improve this social reality.

All participants, and research articles reviewed, spoke of the need for more and improved training for mental health professionals providing care for gender diverse individuals. As well as 'essential knowledge' (Salpietro et al., 2019) related to gender diversity, participants called for training which opens up a non-judgmental space for discussion. Space for discussion is particularly important as narratives around both gender diversity and mental health are complex and in constant flux, making it difficult to speak from a place of certainty or 'truth'. It may be helpful for training to consider and discuss some of the stories commonly told by mental health professionals and gender diverse individuals seeking mental healthcare, such as the separation of different 'parts' of a person, or of expressing gender diversity in 'male' environments. In addition, professionals could consider how they may use their general clinical skills when working with gender diverse individuals (Israel et al., 2008; Lutz, 2013; Salpietro et al., 2019). Several participants in this study spoke of gender diverse individuals having to wait a long time to be seen by specialist gender services, therefore it is important that mainstream mental health services feel empowered to support people during this waiting time, as well as those who are not waiting for services.

It is important to consider how wider narratives may have a role in shaping the decisions mental health professionals make when providing (or withholding) mental healthcare for gender diverse individuals. For example, participants told stories which assumed that people assigned male at birth were at risk from (cis) men on the ward if they expressed femininity. No stories were told about how these situations were managed without hiding their gender expression from the other patients. Care decisions based on the assumption of risk may work to perpetuate the narratives of *risk from men* and the 'rules' around which gender expressions are 'allowed' in the public sphere (Namaste, 1996). One participant described how this "anxiety" about risk contributed to more restrictive care for a transman on her ward, which was ultimately unwarranted. Through working collaboratively with gender diverse clients, and listening to their perspectives, careful attempts could be made to reduce the stigma around gender diversity on inpatient wards, allowing people to share or express their gender if they wish to do so.

One participant told a story of a transwoman who was rejected from all the female secure units applied to. Unfortunately, narratives of *transwomen as dangerous* are likely to be

contributing to stories such as this, as well as stories of restrictive care (e.g. Manson, 2019). The participants in this study suggested that the risk profiles of each individual, and the vulnerabilities of other service users should be taken into account when making these care decisions. Although sensible, this raises questions about the potential differences in treatment between transwomen and ciswomen who have histories of violence or sexual violence towards women, or the placement of women who have experienced violence or sexual violence perpetrated by other women. Similar questions could be raised about cismen who have histories of violence or sexual violence towards men, yet are still placed with other vulnerable men, and cismen who have experienced violence or sexual violence at the hands of other men. Policies around 'same-sex accommodation' (NHS England, 2019) in the health service are constantly (and currently) evolving, and it is important that policy-makers hold in mind the influence of powerful narratives related to gender diverse individuals' mental health care.

Finally, several participants spoke of the importance of seeing their clients as a 'whole person', as opposed to only seeing a certain 'part', a view shared by Howitt (2020). Heng et al. (2019) describe how clinicians should take a holistic approach when providing care to gender diverse individuals, particularly during transition, to enable them to access support from a range of sources, beyond medical services alone.

Methodological considerations

Strengths

This research was the first study to interview mental health professionals in the UK about their work providing care to gender diverse adults. It is also one of only a handful of studies in this area which uses an entirely qualitative methodology, and the first study to use narrative analysis. By analysing narratives, this research avoids the pitfalls of determining clinicians' 'competence' to work with gender diverse individuals, instead exploring the complexities, nuance and dilemmas faced by mental health professionals.

By examining the multiplicity and diversity of mental health professionals' accounts, avoiding generalisations, speaking to clinicians in the UK themselves, and reflexively considering and articulating my own position throughout this research, I have followed Richards et al.'s (2014) recommendations when writing about trans healthcare.

Quality

Three of the quality criteria outlined by Tracy (2010; resonance; meaningful coherence; and significant contribution) were not discussed in the Method section but discussed here instead. Tracy (2010) defined resonance as a piece of research's ability to meaningfully reverberate and affect an audience. Writing as a mental health professional myself, who has worked in similar and different contexts to my participants, some of their stories resonated deeply with me. I hoped to portray these stories, and their connections with social and historical contexts, to resonate with other mental health professionals who may read this research, and continue to make care decisions on a daily basis.

I have attempted to conduct and write this research as meaningfully coherent by achieving the aims outlined in the introduction, using a methodology and writing about the findings in a way which is consistent with my epistemological position, and drawing on theoretical,

popular, and research literature throughout. Finally, by resonating with mental health professionals, and considering practical implications for both clinical work and policies related to the mental healthcare of gender diverse individuals, I hope that this research may make a significant contribution to the literature.

Limitations

I have discussed some of ways the local context of the interviews may have influenced the kinds of stories told by the participants in this research, such as my position as a mental health professional, conducting research with the hope of improving mental healthcare for gender diverse individuals. This position was also made clear in the recruitment materials, which may have influenced who chose to take part. The advert may have attracted people who also have a particular interest in improving mental healthcare for this population. In addition, my positive responses of 'hmm' and 'yes' when participants spoke from an affirmative perspective may have closed down stories or positions from other perspectives. Participants and stories from a more gender critical perspective could be obtained by using more neutral recruitment material, such as 'research into mental healthcare for gender diverse individuals', and explicitly mentioning to participants that all perspectives were welcome.

Similarly, maintaining the role of research interviewer was challenging, and I often found myself acting out of my clinical role, such as validating the participants' experiences. If I had responded less strongly to the participants' talk, a greater diversity of stories may have been told. On the other hand, for some participants, my warm and validating responses may have opened up space for them to talk more comfortably about difficult topics.

Similar to the studies in the systematic review, most of the participants were white, heterosexual, and female. However, again similar to the studies reviewed, this reflects the demographics of mental health professionals in the UK. On 29th February 2020, 74% of mental health staff in the NHS were female, 75% were white, and 73% were heterosexual (NHS Digital, 2020). Therefore, it is somewhat expected that the sample would represent these proportions, however the research is limited by the paucity of narratives from people outside these demographics.

Although the research project was open to gender diverse clinicians who wished to volunteer, the sample only included cisgender participants. NHS Digital does not currently hold data on the proportions of gender diverse staff, therefore it is difficult to estimate the proportion of gender diverse staff in the health service. Notwithstanding, the research would have been made richer by including the narratives of clinicians with diverse gender identities, and would have avoided the separation of 'trans people' and 'clinicians', which is commonly seen in research into trans healthcare (Richards et al., 2014).

The demographics of the gender diverse clients discussed by the participants were also limited. Most stories told were about transwomen and people assigned male at birth, and none of the participants spoke about other intersecting identities such as their clients' race or ability. One participant spoke about intersections of gender identity, mental health, and class. Similarly, only one participant told a story about someone who identified as non-binary. Therefore, stories of mental health professionals' work with these populations are not represented in this research.

Finally, there are limitations of conducting interviews via Skype and over the phone. Firstly, the sound quality was inaudible at times, which meant some of the participants' talk was missed (King & Horrocks, 2010). In addition, non-verbal cues (e.g. facial expression, body language) can be difficult or impossible to read, particularly in phone interviews (Lo Iacono et al., 2016). These non-verbal cues provided valuable information during the face-to-face interview, which was unavailable in the other interviews. Lo Iacono et al. also suggest that it may be more difficult to build rapport during Skype or telephone interviews, which may have influenced the kinds of stories and positions the participants offered.

Further research

As this research was limited by the demographics of mental health professionals who took part, and the gender diverse clients they spoke of, further research could use purposeful sampling methods to recruit a more diverse range of participants, who have worked with more diverse clients, so that a richer variety of stories are heard. Stories of supporting transmen, and non-binary clients, and those with other marginalised intersecting identities would be particularly valuable. In addition, this research only focused on clinicians working in the public sector. Several service user consultants mentioned that research involving clinicians working in private and third sectors would also be beneficial, as many gender diverse individuals seek mental health support outside the public sector.

Several ideas for further research come from the findings of the research itself. For example, it would be interesting to further explore the stories of gender diverse individuals admitted to single-gender wards, the extent to which their desires were taken into account, any examples of restrictive care, and the outcomes of different placements. It would also be useful to learn from stories of clinicians who have supported someone as a 'whole person', and stories of male wards which have embraced diverse genders and expressions, to share examples of dissenting narratives, and inclusive mental healthcare. I have also outlined some recommendations for training mental health professionals supporting gender diverse clients. It may be useful to conduct research which explores the helpfulness of training which provides the space for open discussion, as well as the 'essential knowledge' (Salpietro et al., 2019) for working with gender diversity.

Learning and reflections

This research has been a challenging yet inspiring journey. It has opened my eyes to some of the complexities, dilemmas, and nuances tackled by mental health professionals providing care for gender diverse individuals, and the usefulness of narrative and social constructionist approaches when considering these complexities. At the same time, this research has allowed me to reflect on the limitations of a social constructionist approach when thinking about the material implications these narratives have on clinical practice, and on the lives of gender diverse individuals.

I began this journey two years ago holding a lot more frustration with professionals than I am now. Through taking the perspective of each participant, particularly those speaking in opposition to my own, I have been able to think about and discuss these issues with more compassion and nuance, attempting to meet people where they are, without judgment or attack (Reynolds, 2013). On this journey, I have learned to recognise the humanity, multiplicity and complexity of the participants and clients (Richards et al., 2014). I hope that further research will continue this approach of listening to both gender diverse individuals

and professionals, as well as those who inhabit both these identities, to better understand the challenges and complexities involved, and find a way forward together.

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Appendices

Appendix A. Quality Checks for Articles Reviewed

Guidelines Shared by Both Qualitative and Quantitative Approaches

Authors	Context and purpose	Appropriate methods	Respect for participants	Specification of methods	Appropriate discussion	Clarity of presentation	Contribution to knowledge
Johnson & Federman (2014)	Made very clear	Appropriate for a large cross-sectional study, although low response rate	throughout	very clear	very clear - however mostly directed at LGB issues, or considering LGBT issues 'as a whole'	very clear	useful snapshot of current attitudes, training, experience and practice,
Riggs and Bartholomaeus (2016a)	Made very clear	Appropriate use of variety of measures	throughout	throughout	very useful link to previous research, and implications of findings	very clear	useful contributions for improving training for Mental health professionals
Riggs and Bartholomaeus (2016b)	Made very clear	Appropriate for a large cross-sectional study, although low response rate	throughout	throughout	Limited discussion of research findings, focused more on clinical and education implications and needs	very clear	Useful call for more guidelines education and training for MH nurses around trans mental health care
Dispenza & O'Hara (2016)	Made very clear	Appropriate for searching for statistical correlates	throughout	throughout	Useful links to previous research and implications for the future	very clear	Makes explicit links between counsellor identity and competency working with trans clients. Implications for training
Israel et al. (2008)	Made very clear	Appropriate method to provide a snapshot of wide-ranging themes without going into qualitative depth	throughout	very clear	very clear - however mostly directed at LGB issues	Mostly clear - sometimes difficult to follow long list of themes and percentages	useful contribution to begin to think about factors which could make therapy more/less useful

Authors	Context and purpose	Appropriate methods	Respect for participants	Specification of methods	Appropriate discussion	Clarity of presentation	Contribution to knowledge
Salpietro, Ausloos and Clark (2019)	Made very clear	Appropriate methods for exploration of the experiences of cis counsellors	throughout	very clear	appropriate summary of themes, and links to improvements to the profession and further research	very clear	very useful to home in on counsellors' experiences of working with trans* clients specifically, not LGBT in general
Rutter et al (2010)	Made very clear	Appropriate method for analysing reflections on this specific case	Could be more respectful towards the trainees' competence at times	throughout	Useful discussion on themes, reflections and implications	very clear	Useful thoughts on improving counselling training and supervision of cases with queer couples
Lutz (2013)	Context made clear, however purpose of the current study very unclear	The research was not very phenomenological, more assessing participants answers against criteria	throughout	throughout	Appropriate discussion of conclusions and implications	Aims not entirely clear throughout the paper	outlines practices from 'experts' with a hope to improve training for therapists to better equip them in supporting transgender clients
O'Hara et al (2013)	Made very clear	Appropriate mixed methods approach for rich data	throughout	throughout	Good linking of qual and quan data with previous research and future recommendations	very clear	Provides several useful recommendations to counsellors, educators and supervisors
Dentato et al (2018)	Clear	Appropriate mixed methods approach for a range of data. Limited analysis of qualitative data	throughout	throughout	Attempts to draw together qual and quan results, and makes recommendations	Very drawn out in places. Unclear aims and sample until later on in the article.	Makes useful recommendations for improving drug and alcohol counselling training.
Kawano et al (2018)	Clear	Appropriate methods to get a snapshot of dance movement therapists' attitudes however limited in accurately representing their actions	throughout	throughout	Useful summary of the large number of findings. Links to previous research.	clear	Limited contribution due to social desirability
Whitman and Han (2017)	Clear	Appropriate mixed methods approach to improve validity of measuring clinician competence	throughout	throughout	Clear summary of findings, linking to previous research, clinical and training implications	Very clear	Very useful contribution in terms of methods, as well as recommendations

Guidelines Especially Pertinent to Qualitative Research

Authors	Owning one's perspective	Situating the sample	Grounding in examples	Providing credibility checks	Coherence	Accomplishing general vs. specific research tasks	Resonating with readers
Israel et al. (2008)	researchers described their own identities and experiences, however, did not state personal assumptions/theoretical assumptions	demographic information such as gender, sexuality, ethnicity, age, education, number of years in the field, experience working with LGBT clients, LGBT training, work setting	Authors identified themes which came up in the interviews, however provided no direct quotes	Interviews coded by three members of research team, and discrepancies argued until consensus arose. No member-check mentioned.	Themes organised into broader categories, however difficult to synthesise the long list of themes and percentages from the text	Authors clearly outline the limitations of sample in the generalisability of the findings, despite attempts to get a diverse sample	limited resonance due to surface-level analysis of qual data and listing themes with percentages.
Salpietro, Ausloos and Clark (2019)	Researchers clearly outlined their theoretical orientations and assumptions, as well as their gender identities	clearly described demographics such as gender, ethnicity, age, years of practice, location, education, state/independent license, experience working with trans* clients, and training on working with trans* clients	quotes from interviews used throughout to illuminate themes	Regular research meetings, coding by third researcher, member checking, reflexive journals, and complete transcripts.	clear taxonomy of themes, and how they linked to everyday practice	Recognised the homogeneity of the sample in terms of gender and ethnicity	High resonance with a reader who also has clients, as the themes, ideas and quotations resonate with these common experiences and values.

Authors	Owning one's perspective	Situating the sample	Grounding in examples	Providing credibility checks	Coherence	Accomplishing general vs. specific research tasks	Resonating with readers
Rutter et al (2010)	Researchers' assumptions and orientations not stated	demographic information about the trainee counsellors provided such as age, ethnicity, sexuality, gender, training programme, area of USA	Authors summarised the themes which came up in the reflective journals for each question, however did not give verbatim examples of their responses	The two authors coded the journals independently then compared their codes with each other. No other mention of credibility checks.	Provides very coherent account of the theme of discomfort around discussing sexuality. However other themes aren't well discussed	Could do more to recognise the specificity of this research, however, makes links to supervisors' other experiences of providing training, and wider contexts	Limited resonance due to lack of direct quotes. However, hesitancy of the participants described by the authors may be a shared experience and resonate with other counsellors
Lutz (2013)	Researchers assumptions' and orientations not stated	Very limited demographic information about participants, only whether their therapy training was masters or doctoral level	Quotes from interviews used throughout to illuminate themes	Peer reviewers confirmed themes identified by the researcher. No other mention of credibility checks.	Themes organised around broader categories, however difficult to synthesise findings as aims unclear	Researcher outlines a specific research task of contributing increased depth of understanding	Reads more like a survey of responses than qualitative analysis at times, limiting the resonance.
O'Hara et al (2013)	Reflective conversations before and during analysis, however authors' assumptions and orientations were not explicitly described	Demographic data provided e.g. gender, ethnicity, age, region, training level	Quotations used to illuminate each of the themes described	Member checking. All codes reached through consensus of first and second authors, audited by third author	Very coherent descriptions of the themes which emerged in the data	Specificity of the qual data, yet findings correspond with quan data from larger sample.	High resonance as describes a variety of concerns, worries, hopes and experiences of counsellors in their training

Authors	Owning one's perspective	Situating the sample	Grounding in examples	Providing credibility checks	Coherence	Accomplishing general vs. specific research tasks	Resonating with readers
Dentato et al (2018)	Researchers' assumptions and orientations not stated	Gender, ethnicity, sexuality and training level of the sample described	Several quotes included	None described	Long quotes from interview with limited analysis. Summaries of qual findings could be clearer.	Specifically gathers data from one training course in America.	Interview quotes help to provide some resonance to an otherwise difficult to read paper
Kawano et al (2018)	Researchers' assumptions and orientations not stated	age, gender, years in profession, education, Country, therepeutic orientation, LGBT+ training described	Several quotes included	None described	Mostly long quotes with limited analysis. Difficult to pull out coherent themes in these places.	Large number of respondents from large geographical area. General/specific task unclear.	Some parts resonate where themes are analysed, and summarised. However, mostly reports percentages with little resonance.
Whitman and Han (2017)	Researchers' assumptions and orientations not stated	Sample not well situated. Demographic information not provided.	Authors provided quotes to illustrate themes in the qualitative date	None described	Qual and quan data described coherently alongside each other	Attempts to be generalisable, however limited response rate. In depth analysis of problematic reponses provides rich data	Some parts resonate where themes are analysed, and summarised. However, mostly reports percentages with little resonance.

Appendix B. Service User Consultation Survey

Your Thoughts on Research into Trans Mental Health Care

About me

My name is Lauren Canvin, I am a queer trainee clinical psychologist with an interest in trans mental health care. I am concerned about the difficult experiences trans, gender diverse and gender questioning people have had with mental health professionals in the public sector. As a mental health professional myself, I have also witnessed the struggle from the other side, noticing how health care professionals often feel deskilled and unable to support trans, gender diverse and gender questioning people seeking mental health care.

In this survey I will provide you with some information about the research I will be conducting for my doctoral thesis. This survey should last approximately 15 minutes.
For the remainder of this survey I will use the term 'trans' to refer to trans, gender diverse and gender questioning people.

Research Team
I have a team of two supervisors and two consultants, with a range of gender identities.
[*Internal Supervisor – Name and Email*]
[*External Supervisor – Name and Email*]

Demographic Questions

How do you describe your gender identity?
What is your age range?
UK Region

About the study

Surveys suggest that trans people in the UK experience significantly high levels of mental health difficulties, but also describe having negative experiences accessing both physical and mental health care. At the same time, health professionals have described feeling deskilled, and lacking confidence in their ability to support trans people.

Research with health care professionals tends to largely focus on physical health care, and most studies have taken place in North America and Australia. Therefore, it seems important that the experiences and stories of mental health professionals in the UK are studied. This is particularly important as political and media narratives around trans identities are complicated, contradictory, and rapidly changing, which can result in feelings of uncertainly. It is important to understand the challenges faced by mental health professionals, and what might be shaping their experiences. This understanding could contribute to improving current provisions and training for mental health professionals to better support trans individuals presenting to services.

Aims and research questions

The overarching aim of this research project is to study the experiences of mental health professionals in the UK who have supported trans, gender diverse, or gender questioning

adults, with a view to better understand the challenges they might face.

This project aims to answer the question:

How do mental health professionals describe their experiences of attempting to support trans, gender diverse, or gender questioning people with mental health difficulties?

Within this, attention will be given to:

How much do mental health professionals feel they are able support trans, gender diverse or gender questioning people?

How do they understand gender and mental health?

What is the impact of local and broader contexts? e.g. the organisation they work in, broader cultural contexts and discourses.

Do you have any thoughts, feedback, questions or concerns with the design and aims of the study so far?

Do you have any thoughts on the language used in the information so far?

Procedure

Participants

Each participant must be a Mental Health Professional who works, or has worked, in the public sector. E.g. Community Psychiatric Nurse, Social Worker, Support Worker, Care Co-ordinator, Psychiatrist, Psychologist, Occupational Therapist, or other allied health professional.

The mental health professional may be qualified, in training, or have obtained no formal mental health qualification.

They must have had experience supporting at least one adult in the public sector who self-identified as trans, gender diverse, or questioned their gender identity.

There is no minimum to the length of time they supported this person, however the interaction must have involved some kind of assessment, decision, support or intervention (e.g. psychiatric review), rather than simply administering psychiatric medication (e.g. a depot injection).

The trans/gender questioning person does not necessarily need to have had any trans related medical intervention, or accessed a Gender Identity Clinic.

The participant's experience of supporting a trans/gender questioning person is intentionally very broad to enable diversity of experiences and genders supported.

The professional's experience of supporting a trans/gender questioning person must not be in the context of a private or third sector organisation.

Do you have any thoughts, feedback, questions or concerns with the participants who will be interviews?

Confidentiality of the trans, gender diverse, and gender questioning people mentioned

Before asking any questions, participants will be given the following instructions:

'As I'm sure you are aware, confidentiality of all parties involved is highly important. All names and identifying details will be of course be anonymized. What pseudonym would you like me to use for you when writing up the research?

Due to the nature of this research, I will be asking you to share your stories of working with trans, gender diverse, or gender questioning individuals in your work. I hope that you would be able to change their name and details too as you speak to me, as you would naturally when talking about people in your care. If you use a real name, or some details that might compromise someone's anonymity, I will of course change their name or information for you in the report.'

Do you have any thoughts, feedback, questions or concerns with the confidentiality of the people mentioned?

On this page you can read the interview guide for the research interviews

[Interview Guide]

Do you have any thoughts, feedback, questions or concerns with the interview?

Your interview questions

As part of my research interview, I would like to ask more questions from trans, gender diverse, or gender questioning people.

Do you have any specific questions, or general areas you would like the mental health professionals to be asked about?

Thank You!

Thank you so much for taking the time to complete this survey, and shaping research in this very important area.

Feel free to email me on [email] if you would like me to reply to any of your questions and concerns about the research or this survey.

Enter your email address here if you would like to find out about the results of this research.

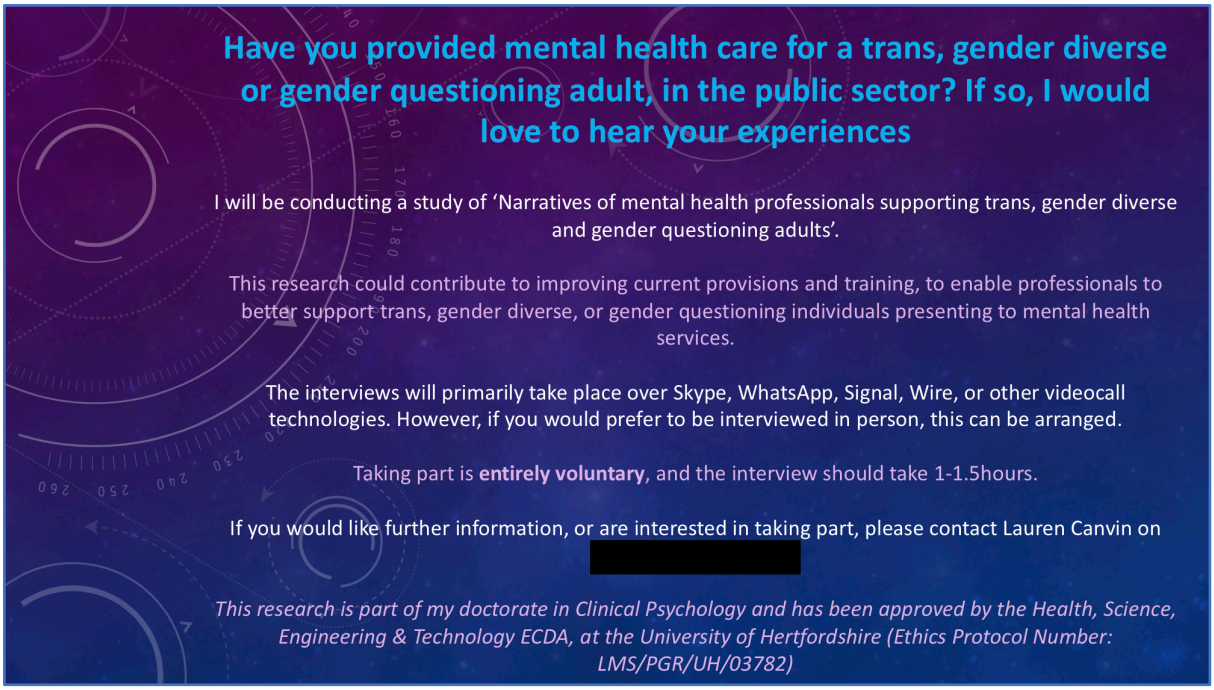
Appendix C. Advertisements

Service User Consultation Survey

Your Thoughts on Research into Trans Mental Health Care

If you identify as trans, gender diverse, or gender questioning, and have experienced mental health difficulties, I would love to hear your thoughts on a piece of research I am conducting. In this research I will be interviewing mental health professionals who have provided support for trans, gender diverse, or gender questioning people. If you have 15 minutes to spare, please consider completing this online survey.
[Link]
All suggestions, thoughts, feedback or concerns are welcome!
Please contact Lauren Canvin [Email] if you have any questions ☺

The current study



Appendix D. Interview Guide

Preamble:

As I'm sure you are aware, confidentiality of all parties involved is highly important. All names and identifying details will of course be anonymized. What pseudonym would you like me to use for you when writing up the research?

Due to the nature of this research, I will be asking you to share your stories of working with trans, gender diverse, non-binary or gender questioning individuals in your work. I hope that you would be able to change their name and details too as you speak to me, as you would naturally when talking about people in your care. If you use a real name, or some details that might compromise someone's anonymity, I will of course change their name or information for you in the report.

Opening question:

I would like you to share with me your stories of working with trans, gender diverse, non-binary, or gender questioning people, who have sought help for mental health difficulties. I would like to hear about **positive, negative, or neutral experiences** you have had, and how these experiences might have **shaped the way you feel about how you might work with this group of people in future**. You could start by telling me about how you first came to work with a trans, gender diverse, non-binary, or gender questioning person. Or you could start wherever you feel works best for you.

Questioning phase:

How did you feel when working with this person?

Organizational context

What was it like more generally, working in the service where you met this person? Can you tell me a bit more about your experience of working there?

What external pressures were put on you, either in general, or in relation to this? Can you give me an example of a time when you noticed this?

Can you tell me about any specific times when you tried to negotiate conflicts between service requirements and what you felt were the person's needs?

Could you tell me about how other people responded when you told them you were working with someone with gender related issues? Who? What did they say?

Can you tell me about a time when other people in your service have spoken about trans, gender diverse, or gender questioning people that you or they have been working with? Have there been any other times? Different or similar?

What was your experience of the service's relationship with the diagnosis 'Gender Dysphoria'?

Skills

Can you share with me an experience that was difficult or challenging? For example, any times it went wrong?

How did you feel about it at the time? How about now?

Can you share with me an experience which you felt went well?

What have you learned from your experiences?

Can you tell me about anything from your personal experience/background that informed your practice?

Have you been provided with any specific training, education or resources on gender issues? How did this come about?

What additional training, education or resources do you feel you might need?

How confident did you feel in your ability to support a trans, gender diverse, or gender questioning person initially?

How has this changed over time?

(Survey Q) Has there been a time when you have supported trans, gender diverse, or questioning people when other professionals showed a lack of knowledge? How did you manage this?

Wider societal context

Which media stories or legislation changes around trans identities have caught your attention? Can you tell me about any times when you became aware of these?

(Any conflicts with your own beliefs?)
(Influence on clinical practice?)

End

Are there any other parts of the story that you would like to share with me?

How do you feel after sharing your stories and experiences?

Further information:

Ideas and guidance around working with trans, gender diverse, and gender questioning people is constantly evolving, and rapidly changing, which leaves many people concerned about whether they have the most up to date information. I was wondering whether you would be interested in reading the latest guidelines in this area?

Would you be interested in reading the results of this piece of research?

Do you have any further questions for me, regarding this research and/or your participation?

Appendix E. Participant Information Sheet

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC6: PARTICIPANT INFORMATION SHEET

1 **Title of study**

Narratives of mental health professionals supporting trans, gender diverse and gender questioning adults

2 **Introduction**

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulations governing the conduct of studies involving human participants can be accessed via this link:

http://sitem.herts.ac.uk/secreg/upr/RE01.htm

Thank you for reading this.

3 **What is the purpose of this study?**

This research aims to better understand the experiences of Mental Health Professionals who have worked with trans, gender diverse, or gender questioning individuals in the public sector. This research is part of the requirement for the Professional Doctorate in Clinical Psychology at the University of Hertfordshire.

4 **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign an online Consent Form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason, and withdraw your data before January 2020.

5 **Are there any age or other restrictions that may prevent me from participating?**

Participants must be over 18, and speak fluent English. It is a requirement that you have supported a trans, gender diverse, or gender questioning person seeking help with mental health difficulties, in the public sector. There is no minimum to the length of time you supported this person, however the interaction must have involved some kind of assessment, decision, support or intervention (e.g. psychiatric review), rather than simply administering medication (e.g. a depot injection). The trans/gender diverse/questioning person does not necessarily need to have had any trans related medical intervention, or accessed a Gender Identity Clinic.

6 **How long will my part in the study take?**

If you decide to take part in this study, you will be invited to take part in an interview (through videocall technology, or in person) which will last approximately 1.5 hours. The project will be completed in June 2020.

7 **What will happen to me if I take part?**

Firstly, you will be asked to answer some questions over email to gather demographic information, and check you are suitable for the research. If you are suitable, then you will be invited for an interview lasting approximately 1.5 hours. This interview will be audiorecorded and transcribed. You will be invited to share your stories of supporting trans, gender diverse, or gender questioning people. In the event of any significant change to the aim or design of the study you will be informed, and asked to renew your consent to participate in it. You may withdraw from the study at any time without disadvantage or having to give a reason.

8 **What are the possible disadvantages, risks or side effects of taking part?**

There is very little risk involved in taking part in this research, procedures will be put in place to ensure your data remains entirely confidential (see below). You will be invited to share experiences you may have had, however you can choose how much or how little you share. You do not need to share anything that would make you feel uncomfortable.

9 **What are the possible benefits of taking part?**

A better understanding of the experiences of mental health professionals could help to improve current provisions and training, to enable professionals to better support trans, gender diverse, or gender questioning individuals presenting to mental health services.

10 **How will my taking part in this study be kept confidential?**

All information gathered will be stored on a password protected hard drive. Your name and any other identifying information will be anonymized.

Due to the nature of this research, you will be asked to share your stories of supporting trans, gender diverse, or gender questioning individuals in your work. We ask that you change their name and details as you talk. If you accidentally say their name, or any other identifying information, their details will be changed for you.

11 **Audio Recordings**

The interview will be recorded using a password protected audio-recording device. This audio recording will be stored on a, password protected hard drive, and deleted 5 years after data collection. The audio recordings will be listened to by the research team for transcription and data analysis. If anyone else is involved in the transcription process, they will be asked to sign a confidentiality agreement before listening to the audio recordings.

12 **What will happen to the data collected within this study?**

The data from your interview will be analysed along with other participants to identify particular themes when it comes to supporting trans, gender diverse, or gender questioning people in public sector mental health services.

Personal data will be stored and processed in line with GDPR regulations. The principal researcher (Lauren Canvin) will be the identified data controller, and the data will be used for a doctoral research project, with a view to being published in an academic journal, without any identifying personal information. The personal data (including audio recordings of interviews) will only be viewed by the research team. If anyone else is involved in the transcription process, they will be asked to sign a confidentiality agreement before listening to the audio recordings, which will be saved with

pseudonyms. The data will be stored in password protected files, on a password protected laptop and password protected external hard drive for a maximum of 5 years, after which it will be destroyed. Data will be stored with pseudonyms as much as possible, and no data will be transferred outside of Europe. Participants have a right to withdraw their data from the research project up until January 2020, and a right to lodge a complaint to the Information Commissioner's Office.

13 **Will the data be required for use in further studies?**

The data from this study may be analysed for further studies which come out of the current project.

14 **Who has reviewed this study?**

The University of Hertfordshire Social Sciences, Arts and Humanities Ethics Committee with Delegated Authority

The UH protocol number is LMS/PGR/UH/03782

15 **Factors that might put others at risk**

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities.

16 **Who can I contact if I have any questions?**

If you would like further information or would like to discuss any details
[Email]

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar.

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix F. Consent Form

FORM EC3
CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

This research has been approved by the Health, Science, Engineering & Technology ECDA, at the University of Hertfordshire (Ethics Protocol Number: LMS/PGR/UH/03782)

Name:

Contact Details (email or postal address):

I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

Yes ☐

I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

Yes ☐

In giving my consent to participate in this study, I understand that voice recording will take place and I have been informed of how/whether this recording will be transmitted/displayed.

Yes ☐

I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

Yes ☐

I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

Yes ☐

I have been told that I may at some time in the future be contacted again in connection with this or another study.
Yes ☐

I hereby freely agree to take part in the study entitled ‘Narratives of mental health professionals supporting trans, gender diverse and gender questioning adults’

Yes ☐

Date:

Appendix G. Current Guidelines for working with gender diverse individuals

All participants were sent these three documents post-interview, along with the following summaries to help them find the documents most helpful to them.

BPS: Guidelines for psychologists working with gender, sexuality and relationship diversity

These guidelines are aimed at applied psychologists working with mental distress, but may also be applied in associated psychological fields. Indeed, the principles they are based upon, derived as they are from both the literature and best practice agreement of experts in the field, may be applied to other disciplines, such as counselling, psychotherapy, psychiatry, medicine, nursing and social work

WPATH: Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People

World Professional Association for Transgender Health V7 – standards of care for transgender people. Recommendations for physical health care, trans-specific medical treatment. Page 21 section on mental health care (related to transition and not).

Memorandum of Understanding on Conversion Therapy in the UK

The primary purpose of this Memorandum of Understanding (MoU) is the protection of the public through a commitment to ending the practice of ‘conversion therapy’ in the UK. Supported by several national clinical bodies.

Appendix H: Transcriber Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

I , _____ ,

agree to transcribe the interviews sent to me by Lauren Canvin for the purpose of her doctoral research. I will not share the audio files with anyone, and delete them immediately after transcribing. I will not share any information from the audio files, either about the speakers in the interview, or the people they discuss, with anyone.

Signed _____

Date: _____

Files:

[List of files]

Total: __ mins

Appendix I. Ethics Application Form

UNIVERSITY OF HERTFORDSHIRE

FORM EC1A: APPLICATION FOR ETHICS APPROVAL OF A STUDY INVOLVING HUMAN PARTICIPANTS (Individual or Group Applications)

Please complete this form if you wish to undertake a study involving human participants.

Applicants are advised to refer to the Ethics Approval StudyNet Site and read the Guidance Notes (GN) before completing this form.

http://www.studynet2.herts.ac.uk/ptl/common/ethics.nsf/Homepage?ReadForm

Use of this form is mandatory [see UPR RE01, 'Studies Involving Human Participants', SS 7.1-7.3]

Approval must be sought **and granted** before any investigation involving human participants begins [UPR RE01, S 4.4 (iii)]

If you require any further guidance, please contact either hsetecda@herts.ac.uk or ssahecda@herts.ac.uk

Abbreviations: GN = Guidance Notes UPR = University Policies and Regulations

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THE STUDY

Q1 Please give the title of the proposed study

Narratives of mental health professionals supporting trans, gender diverse and gender questioning adults

THE APPLICANT

Q2 Name of applicant/(principal) investigator (person undertaking this study)

Lauren Canvin

Student registration number/Staff number

16081711

Email address

XXXXXXXXXX

Status:

☐Undergraduate (Foundation) ☐Undergraduate (BSc, BA)

☐Postgraduate (taught) ☒Postgraduate (research)

☐Staff ☐Other

If other, please provide details here:

Click here to enter text.

School/Department:
DClinPsy

If application is from a student NOT based at University of Hertfordshire, please give the name of the partner institution: Click here to enter text.

Name of Programme (eg BSc (Hons) Computer Science): Doctorate in Clinical Psychology (DClinPsy)

Module name and module code: N/A

Name of Supervisor: Dr Wendy Solomons Supervisor's email: XXXXXXXXXX

Name of Module Leader if applicant is undertaking a taught programme/module:

N/A

Names and student/staff numbers for any additional investigators involved in this study

Dr Jos Twist (not UH staff)

Is this study being conducted in collaboration with another university or institution and/or does it involve working with colleagues from another institution?

☒Yes ☐No

If yes, provide details here:

Dr Jos Twist is currently based at the Gender Identity Development Services (GIDS), Tavistock and Portman

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DETAILS OF THE PROPOSED STUDY

Q3 Please give a short synopsis of your proposed study, stating its aims and highlighting where these aims relate to the use of human participants (See GN 2.2.3)

Recent years have seen an increase in representation of trans people in the media (e.g. Steinmetz, 2014), increased legal protections for people identifying as trans, and a growing influence of trans people and trans ideas in the sphere of health (Pearce, 2018). At the time of writing, the Gender Recognition Act (2004) is in the process of being reformed, which aims to improve the processes of gaining legal gender

recognition for trans and non-binary people. However, this increase in representation and legal protection has been met with stories of 'moral panic' in some sections of the media (Barker, 2017; Stone, 2018), which aim to question the rights, self-determination, and even the existence of trans and non-binary people.

Trans people appear at a high risk of suffering from mental health difficulties, but describe having negative experiences accessing both physical and mental health care in the UK (e.g. Ellis et al., 2015). At the same time, health professionals have described feeling deskilled, and lacking confidence in their ability to support trans people (Snelgrove et al., 2012; Poteat et al., 2013; Riggs and Bartholomaeus, 2016).

However, the research with health care professionals has largely concentrated on physical health care, and taken place in North America and Australia. Therefore, it appears important that the experiences and stories of mental health professionals in the UK are studied, particularly as political and media narratives around trans identities are complicated, contradictory, and rapidly changing, which can result in feelings of uncertainly. It is important to understand the challenges faced by mental health professionals, and what might be shaping their experiences. This understanding could contribute to improving current provisions and training for mental health professionals to better support trans individuals presenting to services.

The overarching aim of this research project is to study the experiences of mental health professionals in the UK who have supported trans adults, with a view to better understand the challenges they might face.

Q4 Please give a brief explanation of the design of the study and the methods and procedures used. You should clearly state the nature of the involvement the human participants will have in your proposed study and the extent of their commitment. Ensure you provide sufficient detail for the Committee to, particularly in relation to the human participants. Refer to any Standard Operating Procedures SOPs under which you are operating here. (See GN 2.2.4).

As this research aims to explore the stories mental health professionals tell about supporting trans/gender questioning people, a narrative method will be employed (e.g. Reissman, 2008).

The study will use 1:1 narrative interviews (e.g. Wells, 2011) to collect data. These interviews will take place over Whatsapp, Signal, Wire, Skype or other videocall technologies where appropriate, to maximise time-efficiency for time-poor mental health professionals, and allow for the collection of data across a wider geographical area (e.g. Lo Lacono et al., 2016). Face-to-face interviewing will be made available to those who would prefer not to use videocall technology.

After being given information about the study (See Participant Information Sheet, Appendix A), the participant will be asked to sign an electronic Consent Form (Appendix B). The narrative interview will then begin. Examples of the kinds of questions used in the narrative interview can be found in Appendix C.

The interviews will be audio-recorded and transcribed, either by the principal investigator, or through using a transcription service. The interviews will then be analysed using narrative methodologies.

Q5 Does the study involve the administration of substances?

☐Yes ☒No

PLEASE NOTE: If you have answered yes to this question you must ensure that the study would not be considered a clinical trial of an investigational medical product. To help you, please refer to the link below from the Medicines and Healthcare Products Regulatory Agency:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/317952/Algothrim.pdf

To help you determine whether NHS REC approval is required, you may wish to consult the Health Research Authority (HRA) decision tool: http://www.hra-decisiontools.org.uk/ethics/

If your study is considered a clinical trial and it is decided that ethical approval will be sought from the HRA, please stop completing this form and use Form EC1D, 'NHS Protocol Registration Request'; you should also seek guidance from Research Sponsorship.

I confirm that I have referred to the Medicines and Healthcare Products Regulatory Agency information and confirm that that my study is not considered a clinical trial of a medicinal product.

Please type your name here: Lauren Canvin

Date: 04/05/2019

Q6.1 Please give the starting date for your recruitment and data collection: 01.07.2019

Q6.2 Please give the finishing date for you data collection: 01.06.2020
(For meaning of 'starting date' and 'finishing date',

see GN 2.2.6)

Q7 Where will the study take place?

University of Hertfordshire. Interviews will be

conducted via videocall unless the participant wishes to be

interviewed in person. In this case, a semi-public location

(e.g. room in a public library, public meeting place)

convenient to the participant will be organised on an ad hoc

basis.

Please refer to the Guidance Notes (GN 2.2.7) which set out clearly what permissions are required;

Please tick all the statements below which apply to this study

☐ I confirm that I have obtained permission to access my intended group of participants and that the agreement is attached to this application

☐ I confirm that I have obtained permission to carry out my study on University premises in areas outside the Schools and that the agreement is attached to this application

☐ I confirm that I have obtained permission to carry out my study at an off-campus location and that the agreement is attached to this application

☒ I have yet to obtain permission but I understand that this will be necessary before I commence my study and that the original copies of the permission letters must be verified by my supervisor by the time I submit my results

☐ This study involves working with minors/vulnerable participants. I/we have obtained permission from the organisation (including UH/UH Partner Institutions when appropriate) in which the study is to take place and which is responsible for the minors/vulnerable participants. The permission states the DBS requirements of the organisation for this study and confirms I/we have satisfied their DBS requirements where necessary.
NB If your study involves minors/vulnerable participants, please refer to Q18 to ensure you
comply with the University's requirement regarding Disclosure and Barring Service clearance.

☐ Permission is not required for my study as:

Click here to enter text.

HARMS, HAZARDS AND RISKS

Q8 It might be appropriate to conduct a risk assessment for the proposed study. Please use Form EC5 if the answer to any of the questions below is 'yes'.

You may also be required to complete a School specific Risk Assessment form as some Schools have indicated that their risk assessment paperwork is mandatory for any study. **Please consult your supervisor for guidance.**

If you are required to complete and submit a School specific risk assessment, please append it to your completed EC5 form. If there are no additional risks, other than the ones noted in your School specific Risk Assessment, you may state 'Included in <names of School> Risk Assessment' in the relevant sections of the EC5 form.

Will this study involve any of the following?

Invasive Procedures/administration of any substance/s? ☐YES ☒

NO

Are there potential hazards to participant/investigator(s) from the proposed study? (Physical/Emotional) ☐YES ☒NO

Will or could aftercare and/or support be needed by participants? ☐YES ☒NO

IF 'YES' YOU MUST COMPLETE EC1 APPENDIX 1 AND INCLUDE IT WITH YOUR APPLICATION

Is the study being conducted off-campus (i.e. not at UH/UH Partner?) ☒YES ☐NO

It might be appropriate to conduct a risk assessment of the proposed location for your study (in respect of the hazards/risks affecting both the participants and/or investigators) (this might be relevant for on-campus locations as well). Please use Form EC5 and, if required, a School-specific risk assessment (See GN 2.2.8 of the Guidance Notes).

If you do not consider it necessary to make a risk assessment, please give your reasons:

The majority of interviews will occur over video call. However, if participants do not wish to be interviewed over video call, I will organise a location convenient for them to be interviewed on an ad hoc basis. Risk assessment for this eventuality has been conducted in the LMS School Risk Assessment (See Appendix D).

ABOUT YOUR PARTICIPANTS

Q9 Please give a brief description of the kind of people you hope/intend to have as participants, for instance, a sample of the general population, University students, people affected by a particular medical condition, children within a given age group, employees of a particular firm, people who support a particular political party, and state whether there are any upper or lower age restrictions.

The participants must be fluent in English, and a Mental Health Professional who works, or has worked, in the public sector, for example as a Community Psychiatric Nurse, Social Worker, Support Worker, Care Co-ordinator, Psychiatrist, Psychologist, Occupational Therapist, or other allied health professional. The mental health professional may be qualified, in training, or obtained no formal mental health qualification. They must have had experience supporting at least one adult in the public sector who self-identified as trans, gender diverse, or questioned their gender identity. There is no minimum to the length of time they supported this person, however the interaction must have involved some kind of assessment, decision, support or intervention (e.g. psychiatric review), rather than simply administering psychiatric medication (e.g. a depot injection). The trans, gender diverse, or gender questioning person does not necessarily need to have had any trans

related medical intervention, or accessed a Gender Identity Clinic. The participant's experience of supporting a trans/gender diverse/questioning person is intentionally very broad to enable diversity of experiences and genders supported. The professional's experience of supporting a trans/gender diverse/questioning person must not be in the context of a private or third sector organisation.

Q10 Please state here the maximum number of participants you hope will participate in your study. Please indicate the maximum numbers of participants for ***each*** method of data collection.

8

Q11 By completing this form, you are indicating that you are reasonably sure that you will be successful in obtaining the number of participants which you hope/intend to recruit. Please outline here your recruitment (sampling) method and how you will advertise your study. (See GN 2.2.9).

Advertisement of this study will take place through mental health professional bodies (e.g. Nursing and Midwifery Council, British Association for Counselling and Psychotherapy, British Association of Social Workers etc.). The study will also be advertised through social media, mailing lists, and word of mouth. Participants will not be recruited through NHS services. Potential participants will be screened over email (using UH email address) to determine whether they meet the inclusion criteria. Recruitment will close once a maximum of 8 participants have been screened as suitable. If more than 8 suitable participants are identified, the participants for this study will be randomly selected from the group of suitable participants.

CONFIDENTIALITY AND CONSENT

(For guidance on issues relating to consent, see GN 2.2.10, GN 3.1 and UPR RE01, SS 2.3 and 2.4 and the Ethics Approval StudyNet Site FAQs)

Q12 How will you obtain consent from the participants? Please explain the consent process for each method of data collection identified in Q4

☒ Informed consent using EC3 and EC6 (equivalent)

☐ Implied consent (e.g. via participant information at the start of the questionnaire/survey etc)

☐ Consent by proxy (for example, given by parent/guardian)

Use this space to describe how consent is to be obtained and recorded for each method of data collection. The information you give must be sufficient to enable the Committee to understand exactly what it is that prospective participants are being asked to agree to.

Participants will be sent an electronic version of the Participant Information Sheet

(Appendix A) and an online Consent Form (Appendix B). If they are happy to continue, I will ask them to submit the Consent Form online. I will also ask them to give verbal consent during the recording of the interview.

If you do not intend to obtain consent from participants please explain why it is considered unnecessary or impossible or otherwise inappropriate to seek consent.

N/A

Q13 If the participant is a minor (under 18 years of age) or is unable for any reason to give full consent on their own, state here whose consent will be obtained and how? (See especially GN 3.6 and 3.7)

N/A

Q14.1 Will anyone other than yourself and the participants be present with you when conducting this study? (See GN 2.2.10)

☐YES ☒NO

If YES, please state the relationship between anyone else who is present other than the applicant and/or participants (eg health professional, parent/guardian of the participant).

N/A

Q14.2 Will the proposed study be conducted in private?

☒YES ☐NO

If 'No', what steps will be taken to ensure confidentiality of the participants' information. (See GN 2.2.10):

N/A

Q15 Are personal data of any sort (such as name, age, gender, occupation, contact details or images) to be obtained from or in respect of any participant? (See GN 2.2.11) (You will be required to adhere to the arrangements declared in this application concerning confidentiality of data and its storage. The Participant Information Sheet (Form EC6 or equivalent) must explain the arrangements clearly.)

☒YES ☐NO

If YES, give details of personal data to be gathered and indicate how it will be stored.

Demographic information such as age, gender, occupation, length of time working in the profession, ethnicity, region within the UK, will be gathered over email, using the UH email address. Any identifying information will be redacted or changed in the publication of the research. Participants' names will be changed to pseudonyms as much as possible in the storage of the information.

Participants' contact details (e.g. email address, Skype ID) will be stored in order to conduct the

screening process, organise the interviews, and for any follow-up communication post-interview. After the study is completed, contact details will be removed from the contact lists on email or Skype accounts, but stored in password protected files

All the personal data will be stored in password protected files, on a password protected laptop and password protected external harddrive. In accordance with the BPS and APA regulations, all personal data collected will be retained for a maximum duration of 5 years after the study has been completed.

Will you be making audio-visual recordings?

☒YES ☐NO

If YES, give details of the types recording to be made and indicate how they will be stored.

The audio recordings will be made using the audio recording software on the password protected laptop. The files will be password protected, labelled with pseudonyms, and stored on the laptop and external harddrive.

There will be no video recordings.

State what steps will be taken to prevent or regulate access to personal data/audio-visual recordings beyond the immediate investigative team, as indicated in the Participant Information Sheet.

Indicate what assurances will be given to participants about the security of, and access to, personal data/audio-visual recordings, as indicated in the Participant Information Sheet.

The recordings will only be listened to by the research team. If anyone else is involved in the transcription process, they will be asked to sign a confidentiality agreement before listening to the audio recordings, which will be given pseudonym labels. The data will be stored in password protected files, on a password protected laptop and external harddrive for a maximum of 5 years, after which it will be destroyed. Data will be stored with pseudonyms as much as possible, and no data will be transferred outside of Europe. Participants have a right to withdraw their data from the research project up until January 2020, and a right to lodge a complaint to the Information Commissioner's Office.

State as far as you are able to do so how long personal data/audio-visual recordings collected/made during the study will be retained and what arrangements have been made for its/their secure storage, as indicated in the Participant Information Sheet.

The data will be stored in password protected files, on a password protected laptop and external harddrive for a maximum of 5 years, after which it will be destroyed. Data will be stored with pseudonyms as much as possible, and no data will be transferred outside of Europe. Participants have a right to withdraw their data from the research project up until January 2020, and a right to lodge a complaint to the Information Commissioner's Office.

Will data be anonymised

prior to storage? ☒YES

☐NO

Q16 Is it intended (or possible) that data might be used beyond the present study?

(See GN 2.2.10) ☒YES ☐NO

If YES, please indicate the kind of further use that is intended (or which may be possible).

The data from this study may be used in future research projects, to further the area of study. This has been included in the Participant Information Sheet (Appendix A)

If NO, will the data be kept for a set period and then destroyed under

secure conditions? ☒YES ☐NO

If NO, please explain why not:

N/A

Q17 Consent Forms: what arrangements have been made for the storage of Consent Forms and for how long?

Electronic consent forms will be created using the secure and GDPR-compliant website SurveyMonkey. The downloaded Consent Forms will be stored in password protected files, on a password protected laptop and password protected external hard drive for a maximum of 5 years, after which they will be destroyed. At the end of the study, the Consent Form responses will be deleted from SurveyMonkey.

Q18 If the activity/activities involve work with children and/or vulnerable adults satisfactory Disclosure and Barring Service (DBS) clearance may be required by investigators. You are required to check with the organisation (including UH/UH Partners where appropriate) responsible for the minors/vulnerable participants whether or not they require DBS clearance.

Any permission from the organisation confirming their approval for you to undertake the activities
with the children/vulnerable group for which they are responsible should make specific reference to any DBS requirements they impose and their permission letter/email must be included with your application.

More information is available via the DBS website - https://www.gov.uk/government/organisations/disclosure-and-barring-service

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REWARDS

Q19.1 Are you receiving any financial or other reward connected with this study? (See GN 2.2.14 and UPR RE01, S 2.3)

☐YES ☒NO

If YES, give details here:

N/A

Q19.2 Are participants going to receive any financial or other reward connected with the study? (Please note that the University does not allow participants to be given a financial inducement.) (See UPR RE01, S 2.3)

☐YES ☒NO

If YES, provide details here:

N/A

Q19.3 Will anybody else (including any other members of the investigative team) receive any financial or other reward connected with this study?

☐YES ☒NO

If YES, provide details here:

N/A

OTHER RELEVANT MATTERS

Q20 Enter here anything else you want to say in support of your application, or which you believe may assist the Committee in reaching its decision.

Due to the nature of this research, participants will be asked to share their stories of supporting trans or gender questioning individuals in their work. They will be asked to change the names and details of the service users as they talk. If they were to accidentally say their name, or any other identifying information, the service users' details will be changed in the transcription process.

To manage ay disclosure of unethical practice, resources will be prepared and offered to all research participants at the end of the interview, describing current best practice guidelines for appropriately working with trans/gender diverse/questioning people (e.g. from BPS, memorandum of understanding on conversion therapy, etc.).

DOCUMENTS TO BE ATTACHED

Please indicate below which documents are attached to

this application:

☐ Permission to access groups of participants from student body

☐Permission to use University premises beyond areas of School

☐Schools Permission from off-campus location(s) to be used to conduct this study

☒Risk Assessment(s) in respect of hazards/risks affecting participants/investigator(s)

☒Copy of Consent Form (See Form EC3/EC4)

☒ Copy of Form EC6 (Participant Info Sheet)

☒A copy of the proposed questionnaire and/or interview schedule (if appropriate for this study). For unstructured methods, please provide details of the subject areas that will be covered and any boundaries that have been agreed with your Supervisor

☐Any other relevant documents, such as a debrief, meeting report. Please provide details here:

DECLARATIONS

1 DECLARATION BY APPLICANT

1.1 I undertake, to the best of my ability, to abide by UPR RE01, 'Studies Involving the Use of Human Participants', in carrying out the study.

1.2 I undertake to explain the nature of the study and all possible risks to potential participants,

1.3 Data relating to participants will be handled with great care. No data relating to named or identifiable participants will be passed on to others without the written consent of the participants concerned, unless they have already consented to such sharing of data when they agreed to take part in the study.

1.4 All participants will be informed **(a)** that they are not obliged to take part in the study, and **(b)** that they may withdraw at any time without disadvantage or having to give a reason.

(**NOTE**: Where the participant is a minor or is otherwise unable, for any reason, to give full consent on their own, references here to participants being given an explanation or information, or being asked to give their consent, are to be understood as referring to the person giving consent on their behalf. (See Q 12; also GN Pt. 3, and especially 3.6 & 3.7))

Enter your name here: Lauren Canvin Date 06/05/2019

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2 GROUP APPLICATION

(If you are making this application on behalf of a group of students/staff, please complete this section as well)

I confirm that I have agreement of the other members of the group to sign this declaration on their behalf

Enter your name here: Click here to enter text. Date Click here to enter a date.

DECLARATION BY SUPERVISOR (see GN 2.1.6)

I confirm that the proposed study has been appropriately vetted within the School in respect of its aims and methods; that I have discussed this application for Ethics Committee approval with the applicant and approve its submission; that I accept responsibility for guiding the applicant so as to ensure compliance with the terms of the protocol and with any applicable ethical code(s); and that if there are conditions of the approval, they have been met.

Enter your name here: Wendy Solomons Date 24/05/2019

Appendix J. Ethics Approval Notification

University of Hertfordshire UH

HEALTH SCIENCE ENGINEERING & TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Lauren Canvin

CC Dr Wendy Solomons

FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair.

DATE 06/06/2019

Protocol number: **LMS/PGR/UH/03782**

Title of study: Narratives of mental health professionals supporting trans, gender diverse and gender questioning adults

Your application for ethics approval has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

This approval is valid:

From: 01/07/2019

To: 01/06/2020

Additional workers: **Dr Jos Twist (not UH staff)**

Please note:

If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and your completed consent paperwork to this ECDA once your study is complete. You are also required to complete and submit an EC7 Protocol Monitoring Form if you are a member of staff. This form is available via the Ethics Approval StudyNet Site via the 'Application Forms' page http://www.studynet1.herts.ac.uk/ptl/common/ethics.nsf/Teaching+Documents?Openview&count=9999&restricttocategory=Application+Forms

Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval (if you are a student) and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

Appendix K. Ethics Approval Notification following minor amendments

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Lauren Canvin

CC Dr. Wendy Solomons

FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair.

DATE 15/08/2019

Protocol number: **aLMS/PGR/UH/03782(1)**

Title of study: Narratives of mental health professionals supporting trans, gender diverse and gender questioning adults

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Dr Jos Twist

Modification: Detailed in EC2.

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Original protocol: Any conditions relating to the original protocol approval remain and must be complied with.

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 15/08/2019

To: 01/06/2020

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit a further EC2 request.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A or as detailed in the EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.
Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

Appendix L. Screening and Demographic Questionnaire

Questions
Age:
Gender:
Ethnicity:
Profession:
Years in Profession:
Region:
Experience working with trans/gender diverse/questioning people:
Was this experience in public, private, or third sector?:
Are you fluent in English?:
Which kind of videocall technology would you prefer?:
(Whatsapp, Wire, and Signal use encryption, Skype or any other technology of your choosing would also be fine). If you would prefer to be interviewed in person, let me know.

Appendix M. Excerpt of Field Notes

Notes taken during interview

Brief notes were made (red) during the interview to record information not captured through audio-recording:

> Can you share with me an experience that was difficult or challenging? For example, any times it went wrong?
> How did you feel about it at the time? How about now?
>
> Looked expectantly at me before this question
> Can you share with me an experience which you felt went well?
>
> What have you learned from your experiences?
> "treat someone…." In air quotes
> Sits up as she says ' I suppose its umm.. what I might learn"
>
> Can you tell me about anything from your personal experience/background that informed your practice (note times if I can't ask it)
> Bobbing up and down as say 'geezer' clench fist as said 'means to be a man'
> Whispered 'on the way' in a mocking way
>
> Have you been provided with any specific training, education or resources on gender issues? How did this come about? (was doing up my lace so broken start)
>
> What additional training, education or resources do you feel you might need
> I nodded my head
>
> How confident did you feel in your ability to support a trans, gender diverse, or gender questioning person initially?
> Shaking body when saying 'in the space with [name]' rolled eyes at 'fine'

Notes taken during listenings shortly after interview

Brief notes were made (green) whilst listening to the interview shortly after the interview to record subjective information not captured through audio-recording

> Can you share with me an experience that was difficult or challenging? For example, any times it went wrong?
> How did you feel about it at the time? How about now?
> Memories myself coming up of difficulties working in cmht
>
> Looked expectantly at me before this question
> Can you share with me an experience which you felt went well?
>
> What have you learned from your experiences?
> "treat someone…." In air quotes
> Sits up as she says ' I suppose its umm.. what I might learn"

Can you tell me about anything from your personal experience/background that informed your practice (note times if I can't ask it)
Bobbing up and down as say 'geezer' clench fist as said 'means to be a man'
Whispered 'on the way' in a mocking way

Slipping into more of an interview style questioning from me, struggling to link up to previous questions
Started to try linking up this question, but she argued against my summary – I had the wrong impression
Have you been provided with any specific training, education or resources on gender issues? How did this come about? (was doing up my lace so broken start)

What additional training, education or resources do you feel you might need
(I specifically linked this question to her service as she mentioned no training there)
I nodded my head vigorously at her response as I agree so much

How confident did you feel in your ability to support a trans, gender diverse, or gender questioning person initially?
Shaking body when saying 'in the space with [name]' rolled eyes at 'fine'

Appendix N. Reflective journal entry after one of the narrative interviews

I definitely felt happier after this interview as it felt like the data I had hoped to gather – experiences of MH professionals with little knowledge in trans/gender issues. Although again I did feel like it was a very professional conversation with a lot of generalisations, and statements rather than narratives. At the end I was pleased with how reflective she was on her experience, and the need for more resources in this area. I think I was feeling nervous when interviewing her as I felt she positioned herself in line with the MDT view the whole time, as a team 'trying their best' and I was afraid of how she might feel or react if my questions seemed to suggest criticism, of the way people in her team were working. I also felt awkward as an interviewer, ungrounded. At times hearing difficult experiences and resisting going into therapist mode, at times feeling like we are having a case discussion in a meeting and pushing to elicit narratives, and then feeling awkward again when my questions asked how she was feeling. Hoping that with practice I will be able to ground myself as a narrative interviewer that can do each of these things without feeling 'awkward'.

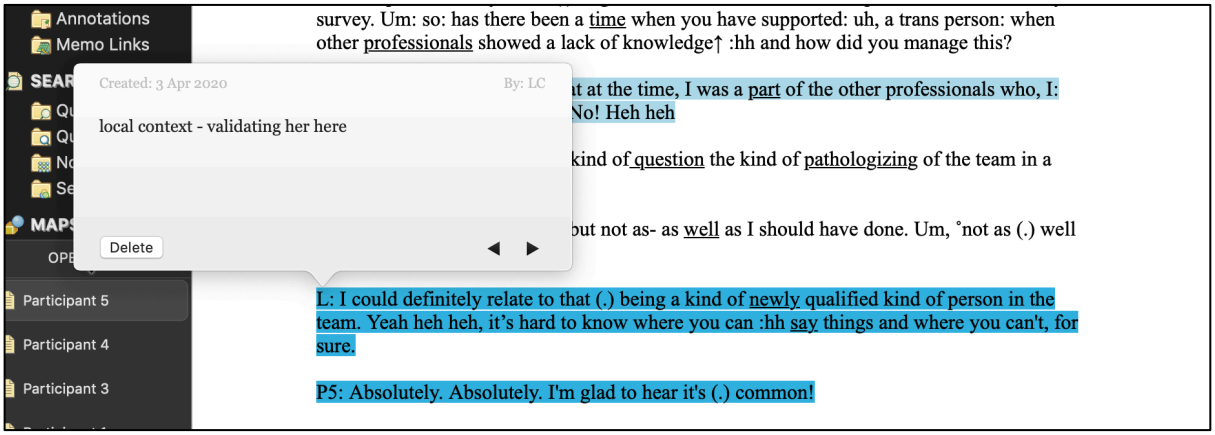
Appendix O. Transcription Symbols
Adapted from Jefferson (2004).

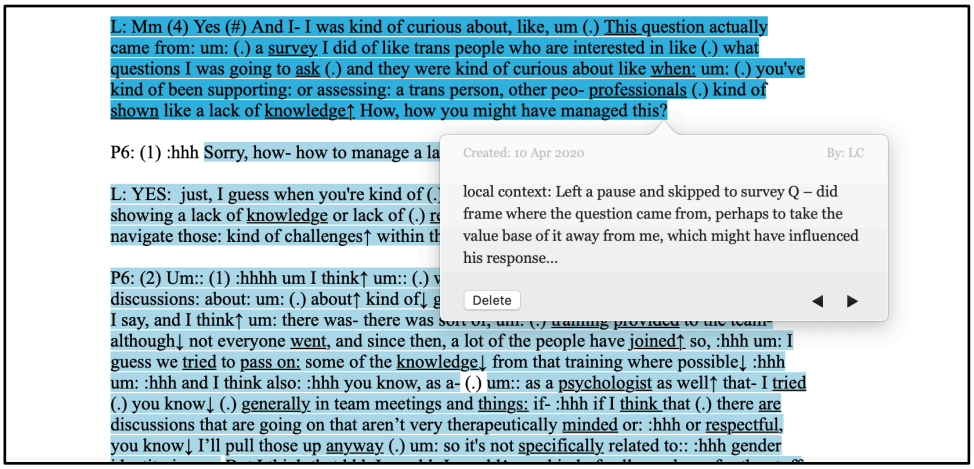
Transcription Symbol	Example	Symbol Use
[square brackets]	L: Hmm, [cool..] D: [Now,] interestingly it's like [NAME] can assess them	Onset and end of speech which overlaps. Also used to redact text for confidentiality purposes.
= equals sign	D: and (.) feeling very de= L: [hmm] D: [=skilled]	When there is no gap between the end of one line and the start of the next
(2)	Um (6) I can't really remember	Elapsed time in seconds
(.)	and (.) talk about how	A brief gap in the flow of the speech
(#)	and so (#) in doing that	A slightly longer gap in the flow, shorter than 1 second
underline	the issues that they all face	some form of stress on a word or part of a word, via pitch and/or amplitude
:: colons	Um:: like: for example	Indicate prolongation of the sound just before. More colons represent more prolongation
↑↓ arrows	My colleague might understand it better↑	Indicate particularly high or low pitch
.,? ""	anything like that?	Full stop, comma, question marks and speech marks retain their conventional use
UPPERCASE	I DON'T KNOW↓ but	Especially loud words or sounds compared to the surrounding talk
°Degree signs°	°for probably a couple of years↓°	Words which are spoken softly compared to the surrounding talk
- dash	I'm only there- I'm only there:	Indicates a cut-off
:hh	:hh Um (.) he did	Intake of breath. More h's indicate a longer breath
hh	Uh hhh (.) and	Exhale. More h's indicate a longer breath
heh	I don't mind. Heh heh heh	Indicates laughter. The more heh's, the longer and more obvious the laughter
(text in parentheses)	(laughing)	Transcriber notes, non-speech elements, or inaudible speech
…	never working for them…	Indicates that speech trails off

Appendix P. Example of reflections on transcription

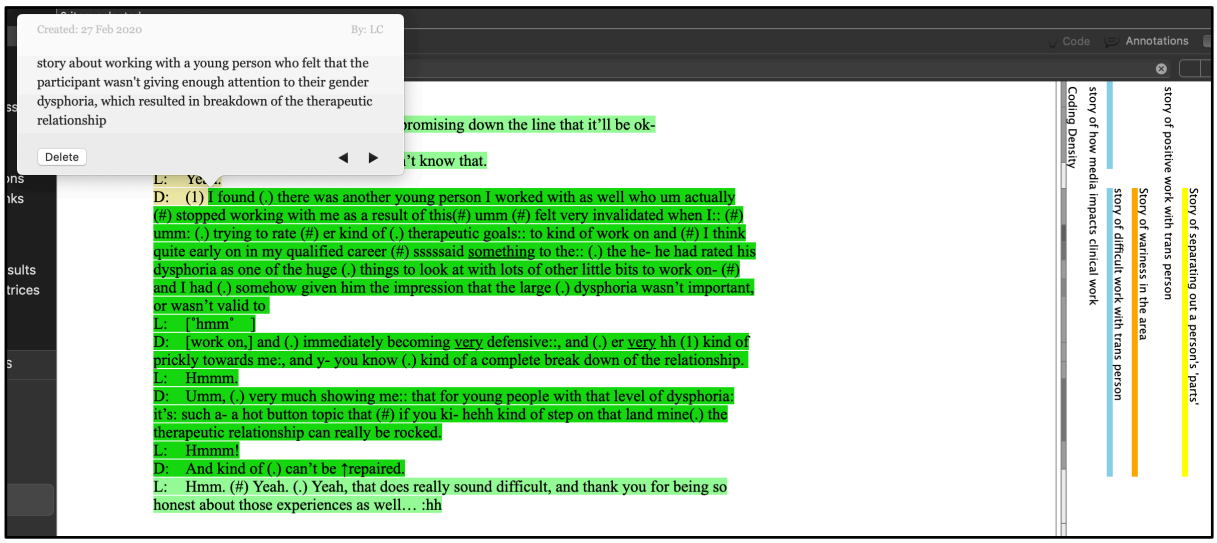
For this transcription, the person I was interviewing had a slight accent, so the stresses on the words and places in the sentence seemed to be in different places than some other participants, who had accents more similar to mine. I wondered whether when listening to her speak I may have found it difficult to discriminate between words which were intentionally stressed by the speaker, and words which sounded stressed to me, but were in fact due to the prosody of her speech. She also spoke much faster than the other participants so far, however the transcription and symbols do not capture this, other than, perhaps the larger amount of text.

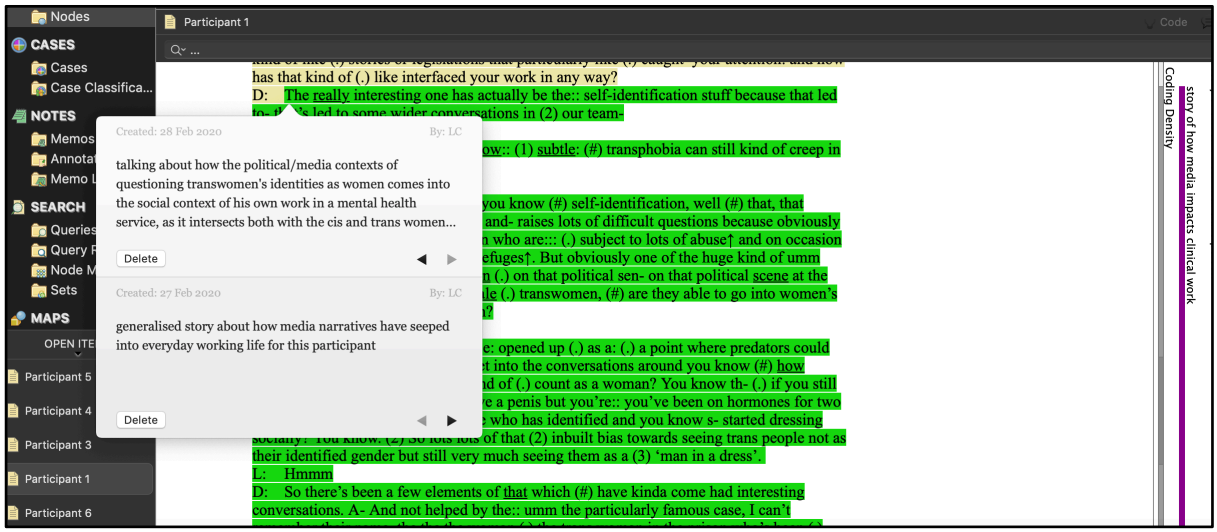
Appendix Q. Examples of initial annotations on transcripts.





Appendix R. Examples of identifying initial stories.





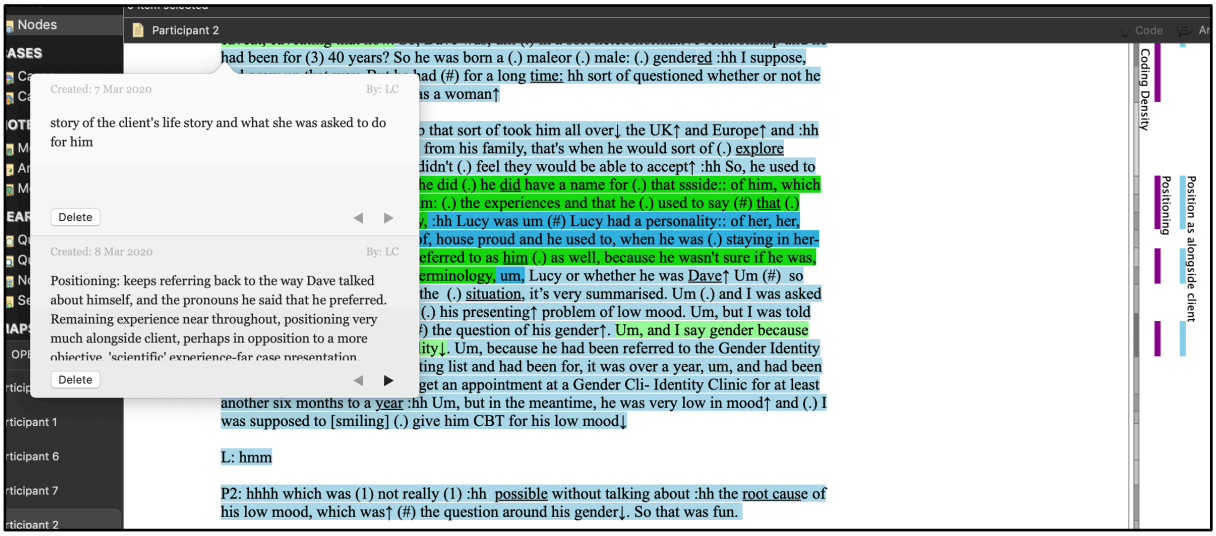
Appendix S. Notes on locating stories in broader narrative

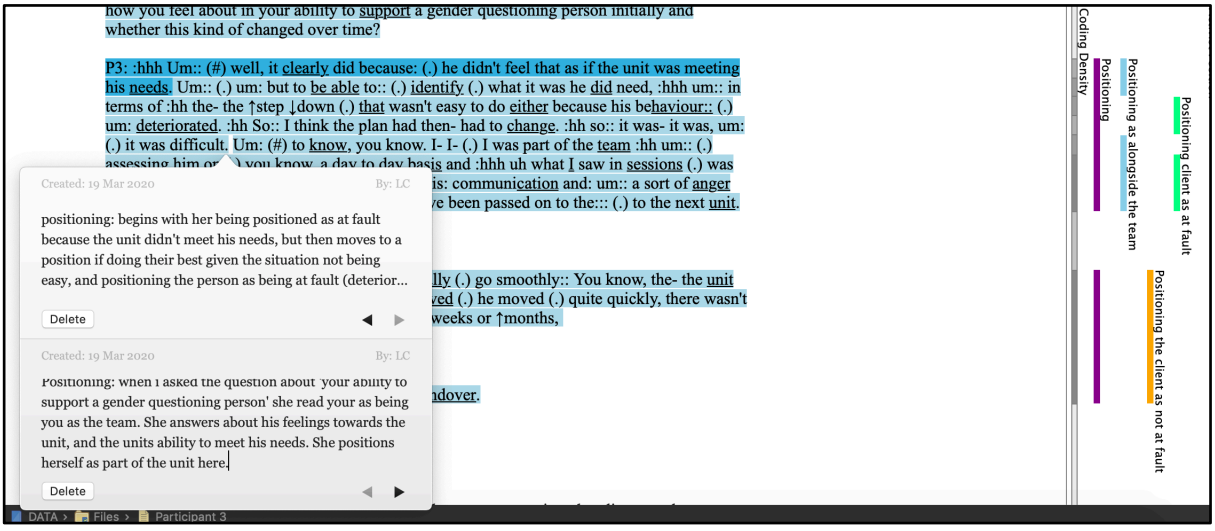
Stories	Notes
I asked about a difficult experience working with gender diverse person, he answered that 'two come to mind' he began with a potentially easier story about the challenges of the situation Story 7. A story of the challenges of helping a trans young person with self-esteem and emotional regulation when so many of their difficulties are related to their gender, and thoughts and feelings related to secondary sex characteristics. Participant spoke about the difficulty of holding hope in those moments when the future is so uncertain. (a story of difficult work with trans person)	where I am working now will have an impact on what jumps out at me. Uncertainty is a big thing we talk about, holding hope in times of uncertainty, job of psychologists generally whatever the context.
Moved onto a potentially more difficult story to tell which involved his own challenges Story 8. A story about a young person who felt that the participant wasn't giving enough attention to their gender dysphoria, which resulted in the breakdown of their therapeutic relationship. (a story of difficult work with trans person) (a story about wariness about this area)	counter to the expertise position, generous to share this with me, perhaps reluctance, could have just stopped going to therapy *This story was identified as a story of separating out a person's parts later in the analysis*
I asked him for a story of a positive experience. He answered with two stories, the first where he was very validating (and used a lot of trans-specific terms)… Story 9. A story about some positive work with a young person, where the participant was very validating of their identity, in a context where the young person was receiving a lot of invalidation from their family. (a story of a positive experience with a trans person)	demonstrating he knows the terminology

Appendix T. Example of reflections on positions taken by participant and myself

The participant knew that I was a trainee clinical psychologist doing research into trans mental health care, but also someone who had also worked in forensic inpatient units. She may have positioned herself in alignment to me in some respects, of both being mental health practitioners in a team. She may have also positioned herself as an expert in relation to me in some respects to mental health care on a ward, having decades more experience. In areas related to trans issues it is likely that she would have positioned me as more of the expert. As mental health practitioners we have a shared language and context of understanding working in the NHS, but potentially different epistemologies, schools of thoughts, constructions of mental health and gender.

Appendix U. Examples of reading for positioning.





Appendix V. Example of notes about positioning.

Positioned as against the medical colleagues
Participant positions himself far away from his medical colleagues who ‘mindlessly’ refer on to gender services. Positioning himself as against the practice of the medical colleagues by using humour to portray the ridiculousness of their suggestion (i.e. ‘magical clinic’).

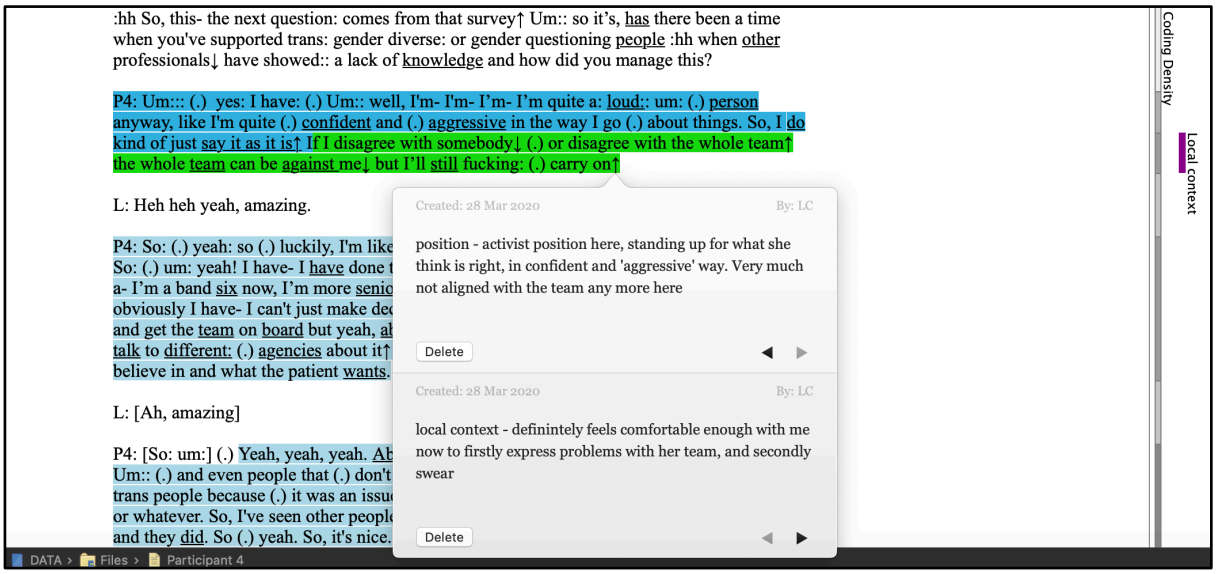
- To position himself as the expert (knows the medical terms but not on their side)

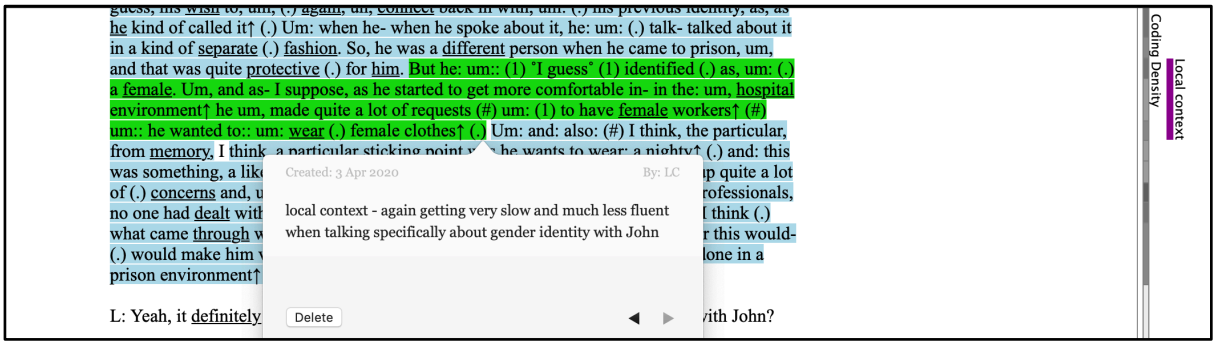
(goes with expert position) -because more knowledgeable, his knowledge claims are portrayed as elevated above traditional medical view

Positioning the other MH workers as inexperienced and unknowledgeable.
The term 'bless her' towards a student nurse, potentially patronising, also highlighting that she was early on in her career, painting a picture of someone inexperienced and without knowledge of trans issues.

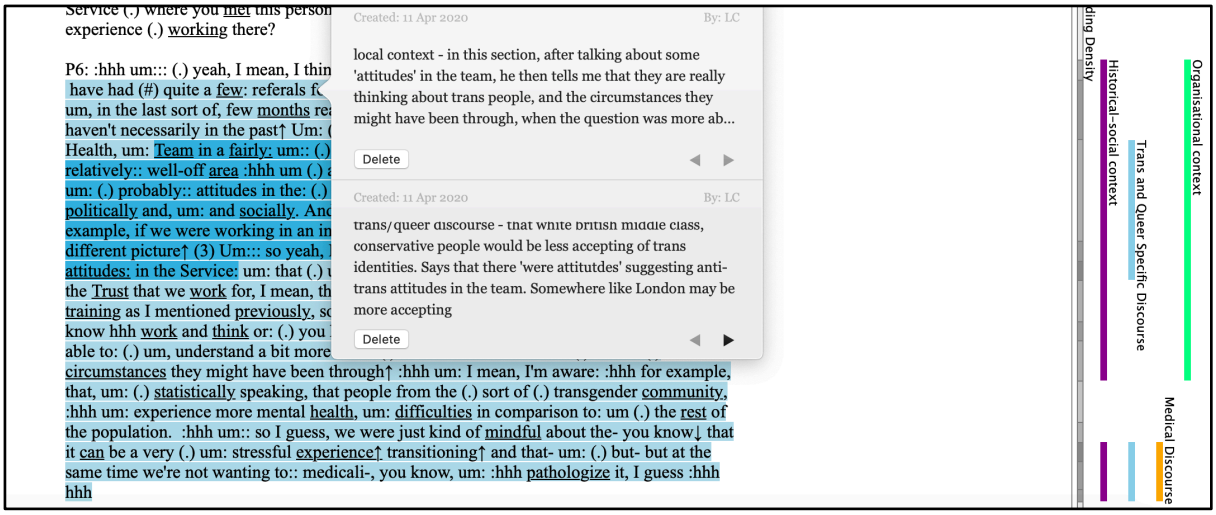
- To position himself as the expert (cluster with above)

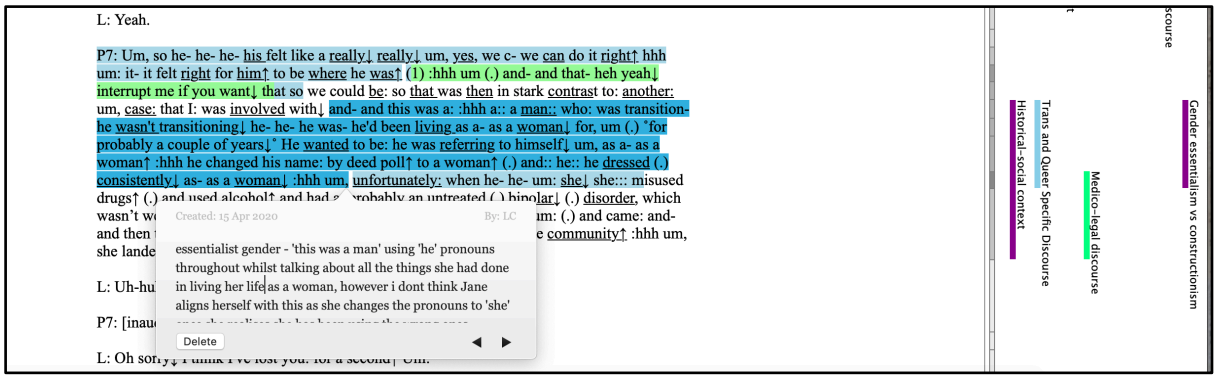
Appendix W. Examples of reading for local context





Appendix X. Examples of reading for historical and social context.





Appendix Y. Reflective journal entry during data analysis.

I get a strong feeling of unsatisfactoriness when I listen to the story of Jack, that the ending felt very unsatisfactory and unsettled, without closure. This is probably how Jack and Linda felt too.

I'm feeling sad hearing this story. Seems like a trans/gender questioning person losing their placement, and being forced to move to another secure unit because the wider organisational context isn't set up for him to 1) express his gender freely and 2) access specialist gender support in a timely way. Such a shame that disengagement, escalation, and placement breakdown are now part his medical history, as a result of this service inadequacy. Although this story is very sad, and further motivates me to complete this research, I don’t want the sadness to put me in a more critical and judgmental position of mental health professionals and their services, when analysing and discussing the data.

Appendix Z. Examples of identifying blind spots in analysis.

Discussions with my supervisors during the analysis phase helped identify my blind spots – positions, languages and contexts in the interviews which I had not previously noticed. For example, in one conversation, we noticed that Dave's reference to 'happy enough' had a sadness to it, that he didn't say that he was or could be entirely happy. We reflected on the historical and social contexts which may have set the scene for this sadness, and made it difficult for Dave to say he could be entirely happy. In another conversation, I was able to reflect on the ways my position, verbal and non-verbal feedback during the interviews may have opened up or closed down certain types of stories or positions from the participants, e.g. positions from a less affirmative perspective.

Appendix AA. Examples of changing direction.

In interview guide

After completing the pilot and first research interview, I noticed that the participants often gave a 'case presentation' for their response to the opening question, rather than telling a narrative story. I discussed this in a workshop, and one of my peers suggested adding a question immediately after the opening question, asking the participant how they *felt* about the work. This helped the participants move away from the 'objective' position of a mental health professional, speaking in generalisations, and more of their own personal narratives and experiences. During the interviews I also became more skilled in asking participants for specific examples when they might tend to move back to talking from a more generalised, 'objective' position.

During analysis

When I began the analysis, I labelled stories of clinicians working with gender diverse individuals as 'positive' or 'difficult', in line with the questions asked in the interview. However, after analysing a few interviews, I came to realise that this was too simplistic, and that the stories were a complex mixture of positive and difficult experiences. In addition, the client and practitioner may have had different ideas as to whether the stories were positive or difficult. Stories previously labelled as 'story of difficult work with a trans person' were further analysed along with other stories, and were given new labels such as 'story of separating out a person's 'parts'', 'story of other clinicians being less knowledgeable', 'story of conflict with other clinicians', 'story of risk from other men', and 'story of restrictive care'.

Appendix AB. Example of reflexive conversation.

A reflexive conversation with a supervisor prior to beginning data analysis helped me have clarity on my own position, how it may influence my analysis, and attempts I could make to think from different positions whilst analysing. For example, we spoke about having frustration towards high-powered clinicians who 'should know better'. We discussed the idea that dominant discourses are 'folded into' us. When people speak (from whatever position), they speak from a discourse which is outside of themselves. I thought it important to remember this when reading parts of the narratives which might have frustrated me, and think about where this frustration came from. We also had a conversation about audience, and feelings of apprehension about audiences to this research who might have a different view to me, or take a critical perspective of my work at a gender identity clinic. We had a conversation about the potential values held by these audiences, and shared values of empowerment, justice and compassion.

Appendix AC. Example of change of position

When I began this research, I felt frustrated that clinicians often felt they didn't have the skills to offer gender diverse people mental health support. I took the position that all clinicians had skills, and they could use these general skills to support anyone, including gender diverse individuals. However, through listening to the complex situations that participants found themselves in, I heard about specific knowledges that the clinicians had to learn in order to support their gender diverse clients appropriately, and safely. For example, Elena discussed several things she learned about safely and sensitively supporting gender diverse clients in an inpatient ward. I began to realise that I had taken for granted the understandings of queer identities which I had gained through my life experiences. My position moved to being in agreement with the participants who said there were specific 'facts' or skills they needed to learn through training, as well as discussions around how they can apply their general clinical skills when providing care for gender diverse individuals.

Appendix AD. Example of analysis changing with additional contextual knowledge

The majority of the research interviews took place before I began working at a gender identity service, whereas the data analysis took place once I had begun working there. This meant that some of my reflections and positions in regard to what the participants spoke about subtly changed between interview and analysis.

Through working at the gender identity service, I became aware of more perspectives for understanding gender identity, and was better able to notice how my position in the interview might have closed down stories or positions from perspectives different from mine. After having experience interfacing with local mental health services from a position of working from a gender service, I had a better idea of the kinds of mental healthcare that could be offered to individuals waiting to be seen by gender services, or waiting for physical interventions. I then felt differently about the clinicians who told stories about gender diverse individuals not being offered mental health treatment because their distress could only be managed at the gender service. I was also even more aware of the huge impact of a mental health professional's position on gender diverse individuals' care, and the power they wield in this regard. I was also aware of how much I aligned with the values of the gender clinic I was newly working at, and wondered whether I had begun reading the interviews from the perspective of the gender service, with this being the 'correct' one. I endeavoured to continue reading the interviews from a range of positions, and being open to feedback from supervisors.