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## **Trans people's experiences of mental health and gender identity services: A UK study**

Sonja J Ellis, Louis Bailey, & Jay McNeil

### **Abstract**

Drawing on survey data from a national (UK) study of trans people and mental health, the study presented here reports on the experiences of trans people in two health care settings: mental health services and gender identity clinics. An analysis of the (primarily qualitative) data indicates that in these settings practitioners tend to be poorly informed about trans issues and the realities of trans people's lives. The key observations of this study are that untreated gender dysphoria (due to delays or refusals of treatment), unnecessary and intrusive questioning/tests, prejudicial attitudes by service providers, and restrictive treatment pathways, all contribute to minority stress which is detrimental to the mental health and wellbeing of trans people.

### **Introduction**

The umbrella term 'trans' – and the definition adopted in this paper – refers to a wide range of people who find (or have found) their personal experience of gender is different from how gender is conventionally constructed. Therefore, those who would typically be considered trans include trans men (those assigned female at birth but who identify as male), trans women (those assigned male at birth but who identify as female), those who use alternative labels (e.g. 'bigender', 'androgynous', 'polygender') to describe their gender identity, and those who do not define their gender at all.

While much research has explored experiences of health care among lesbians, gay men, and bisexuals (e.g. Beehler, 2001; Eliason & Schope, 2001; Hinchliff, Gott & Galena, 2005), research on trans people's health care experiences is extremely limited. Often, trans people's experiences have been subsumed within studies of lesbian, gay, bisexual and trans (LGBT) people (e.g. Adams, Dickinson & Asiasiga, 2013; McCann et al., 2013). The notion of a collectivised experience among LGB and T people serves to conflate and consequently overlook the distinct needs and issues of trans people who, within this context, form a small minority within a minority. In the UK, the trans population is estimated to be in the region of 300,000; approximately 0.4% of the UK population

(see Reed et al., 2009); a large proportion of whom are relatively invisible being not obviously different in social appearance from cisgender<sup>1</sup> men and women.

In general, trans people are more reliant on health care services than LGB people. Like any cis-gender person, they do engage with health professionals for routine reasons (e.g. standard check-ups and routine medical care), and in relation to acute or chronic illness/conditions. However, trans people also engage with health professionals for reasons associated with their being trans – they may approach their General Practitioner (GP)<sup>2</sup> with questions about their gender identity or if they want a referral to a Gender Identity Clinic; and they may engage with mental health services for reasons related to transphobia. A number of studies (e.g. Pitts et al., 2009; Sanchez, Sanchez & Danoff, 2009; Taylor, 2013) have explored trans people's experiences of health care services generally. Commonly these studies – from a range of countries – have identified specific barriers to care which include lack of access to knowledgeable, competent, and trans-friendly providers (Sanchez et al., 2009; Taylor, 2013); fear of discrimination; lack of social support (Boyce et al., 2012), and inequality in accessing healthcare (Whittle et al., 2008). However, with the exception of Whittle et al 2008, such studies have tended to focus on the experiences of subgroups of the trans population such as male-to-female transgender persons (e.g. Boyce et al., 2001; Sanchez et al., 2009) or female-to-male transgender persons (e.g. Rachlin, Green & Lombardi, 2008; Taylor, 2013); and therefore do not encompass the breadth of the trans population as a whole.

In order to be eligible for treatment (e.g. hormone therapy; gender confirmation surgery) trans people must undergo a psychiatric assessment and be diagnosed with Gender Dysphoria (DSM-V). As such, a trans person wanting gender reassignment treatment through the UK National Health Service (NHS)<sup>3</sup> will come under the jurisdiction of mental health services. However, trans people may also utilise mental health services (public or private) if they require specific support related to their trans identity, gender transition, or for reasons which are not trans-related. Being trans or having a trans history places one outside of societal norms around gender, thus positioning one as 'different from the norm'. It is therefore common for trans people to experience 'minority stress' (Meyer, 1995); that is, psychological stress originating from marginalisation in the social environment which potentially contributes to mental health conditions (Huebner, Rebhook & Kegelez, 2004; Meyer, 1995). Many studies (e.g. Clements-Nolle et al., 2001; Hepp et al., 2005;

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<sup>1</sup> People who are not trans and do not have any trans history. That is, people whose gender identity and expression has always been typically associated with the sex they were assigned at birth.

<sup>2</sup> In the UK a GP is a professional who deals with everyday medical issues; commonly referred to as a 'doctor' outside the UK.

<sup>3</sup> The NHS is the state-funded health service which encompasses a wide range of medical services from health clinics through to hospitals. Private healthcare is relatively rare in the UK.

Nuttbrock et al., 2010) report higher levels of mental distress in their trans samples than in the population generally and claim that these are likely to arise from such stress. Furthermore, in a study of LGBT people's experiences of mental health services, Adams et al. (2013) found that cost, a lack of cultural safety (the ability to provide services that appropriately recognise diversity), and a lack of staff competence around LGBT issues to be substantive barriers to LGBT people accessing mental health services.

Trans people's relationship with Gender Identity Clinics (GICs) is primarily about exploring their gender identity and/or accessing gender confirmation treatment (e.g. hormone therapy and surgery options). To date, no study – that we are aware of – has explored trans people's experiences of this sector of health care. However, for trans people, interfacing successfully with GICs is a crucial step in the process of seeking gender confirmation; particularly in relation to medical intervention and surgery.

The study presented here is derived from the UK Trans Mental Health Study 2012 (McNeil et al., 2012) - the first comprehensive study of trans people's experiences of health care *and* the first study exploring the mental health experiences of trans people – specifically and separately – in the UK. Since trans people must access Gender Identity Clinics and mental health services if they want gender reassignment treatment (e.g. hormone therapy; gender confirmation surgery), this paper focuses on trans people's experiences of these services specifically. The purpose of this study was to gain a better understanding of the experiences of trans people as a whole; and to evaluate the above services in relation to trans clients.

## **Method**

### The survey

The survey from which these data were drawn was designed to comprehensively explore the mental health and well-being of trans people in the UK across a range of areas including life satisfaction, experiences of transphobia in daily life, current/past mental health, and social support. It also included a range of questions about access to and experiences of using gender related health services (i.e. Gender Identity Clinics) and mental health services. The present analysis is based on responses just to questions on the latter, encompassing questions on experiences of seeking assistance, satisfaction with services, and worries about accessing these services in the future. The

survey was of a mixed-methods design comprising standardised tests (not analysed for this paper), quantitative scales and fixed response questions, as well as open response qualitative questions.

### Procedure

The survey was compiled by the authors of this paper and developed through extensive engagement with the literature (both published and unpublished) around mental health and wellbeing in relation to trans people. This included national reports from Canada (i.e. the transPULSE project) and Australasia (i.e. the Transnation study; Couch et al., 2007). Key stakeholders, including an advisory group of trans community representatives as well as professionals working with trans people, were also consulted at various stages of survey development and their suggestions incorporated into the final version. Given that the research involved the recruitment of a (potentially) vulnerable population and contained potentially sensitive questions, full ethical clearance was sought from the Faculty Research Ethics Committee at Sheffield Hallam University prior to the commencement of data collection.

An overview of the study and a direct electronic link to the survey (hosted by Survey Monkey) was circulated via email to more than 70 organisations in the UK. Organisations targeted included those that were trans specific (e.g. Scottish Transgender Alliance; Mermaids; GIRES), those which included trans people but with a broader LGBT remit (e.g. The National LGB&T Partnership; Yorkshire MESMAC), LGBT-friendly organisations (e.g. Metropolitan Community Church), and organisations with more tangential links to the trans community (e.g. BPS Psychology of Sexualities Section). On the opening page of the survey a detailed briefing about the study was provided, including information about the purpose of the study, how the data will be used, and how anonymity will be ensured for participants. Respondents were asked to indicate their understanding and consent to participate by ticking a box – the survey could not be completed without this box being ticked.

Our request for participants generated over 1000 responses. However, the response set was edited prior to data analysis. Editing involved removing responses from participants who were too young to complete the survey (i.e. were under 18 years), had completed just the first few questions of the survey, and those based outside the UK. The final data set was imported from Survey Monkey into SPSS, at which point the responses were anonymised by the removal of IP addresses and other potentially identifying information (e.g. email addresses or names that respondents had included in their responses). During the analysis and presentation, the data was further anonymised to ensure

that any references to specific medical clinics and names of particular individuals (e.g. practitioners) were also removed from the data.

### Participants

The final sample comprised responses from 889 participants, although for the questions analysed here the response rate was somewhat lower. Questions on mental health services received a total of 621 participants (those from the complete sample who reported having used mental health services) whilst questions about Gender Identity Clinics received just 202 participants (those from the complete sample who reported having used Gender Identity Clinics). These samples represented trans people with a range of gender identities (i.e. those with a clear and constant gender identity as male/female; those with a non-binary gender identity; those with no gender identity) and at various stages of transition (i.e. not undergone transition; currently undergoing transition; already undergone transition).

A large number of respondents did not complete the demographic questions, so the participant profile of the sample is incomplete. However, based on those who did respond to this section (N=518), participants were predominantly white British/Northern Irish/Scottish/Welsh or English (86%) with fewer than 8% being from other white backgrounds, and less than 7% from other ethnic groups. The majority of respondents lived in England (around 84%), with the remainder living in Scotland (11%), Wales (4%), and Northern Ireland (less than 1%). Full details of the sample can be found in McNeil et al. (2012).

### Analysis

For the purposes of this paper, quantitative responses were analysed using descriptive statistics, while content analysis (Green & Thorogood, 2004; Hsieh & Shannon, 2005) was applied to the qualitative data. We adopted a critical realist approach to the data analysis, whereby respondents were treated as key informants about their experiences. Therefore, we have treated the qualitative data we have analysed as an account of participants' *actual* experiences (albeit told through the various subject positions they occupy). To analyse the data we collated responses to all questions relating to mental health services and GICs respectively, resulting in two sets of qualitative responses. Each set was then analysed inductively by reading through the responses and using coding to identify recurrent themes (Green & Thorogood, 2004). These themes have then been used to elucidate specific issues identified by the quantitative data.

## Results

### Mental Health Services

In total, 621 participants (66%) reported having used mental health services (through NHS, private, or voluntary-sector organisations) for reasons other than accessing gender reassignment medical assistance (e.g. hormones) – many prior to transitioning. This would seem to suggest that trans people are high users of mental health services. As indicated earlier, minority stress is an important factor in mental health and wellbeing so this is not entirely surprising. However, as the sample was self-selecting those with mental health issues may be overrepresented. Researching hard-to-reach groups such as the trans population necessitates non-representative sampling, so it is difficult to avoid this kind of bias. Never-the-less, it would seem likely that trans people are higher users of mental health services than the general population, but perhaps not as high as this percentage might suggest. In the main, respondents reported positively on their experiences of accessing and using mental health services. In particular, about two thirds (34.7% yes, sometimes; 29.9% yes, completely) were open with mental health professionals about being trans or having a trans history at least some of the time. However, around a third of respondents (32.6%) indicated that they had worries about accessing mental health services in the future because they are trans or have a trans history.

Most health services in the UK are run by the NHS, so where a person has been referred to mental health services by their GP, this will usually be to an NHS clinic/hospital. Of those reporting having used NHS mental health services (N=396), the majority (62.8%) reported being satisfied/very satisfied with those services. However, around a third (33.8%) indicated that they were dissatisfied or very dissatisfied with their experiences. This would seem to suggest that experiences for trans people within the NHS are quite varied. Some respondents had used both NHS and non-NHS (private or voluntary services) evaluating the latter much more favourably than their NHS experiences:

Most of the mental health services I have used have been unhelpful, the one magnificent exception to this was a private therapist who specialized in transgender care – she was a lifesaver.

I am overall dissatisfied with my experiences with the NHS and social services. I am however overall very satisfied with the mental health support I have received through the voluntary sector... mostly through the Terrence Higgins Trust.

One of the most commonly reported perceptions was that (NHS) mental health practitioners lack adequate experience or knowledge around trans issues (e.g. 'the services they provide do not meet the needs of trans people'; '...have little or no knowledge about trans issues and trivialise them'; 'a lot of people working in mental health services are ill-educated about trans issues'). Other studies have reported similar issues around the experience and knowledge of health practitioners in relation to trans issues (e.g. Adams et al., 2013; Pitts et al., 2009; Sanchez et al., 2009; Taylor, 2013).

For participants in our survey, practitioner perceptions of gender were also considered an important factor in positive experiences for trans people in mental health settings. However, the experiences that participants (N=411) reported varied somewhat. Twenty-nine per cent of respondents felt that their gender identity was not validated as genuine, instead being treated as a symptom of mental ill-health. Arising from this, many respondents expressed concerns that due to their perception of practitioners' lack of understanding about trans issues, they worried that mental health professionals would conflate their mental health issues and their being trans. For example, one respondent felt they 'might...be told that I am mentally ill BECAUSE I am trans without any understanding of the nuances'. This sentiment was echoed by a number of other respondents: 'If I decided to disclose my gender identity, I am worried that it would...be treated as either a symptom or the cause of my mental health issues', 'I worry they would blame everything on the fact I am trans', 'I worry that they will be preoccupied with me being trans and not explore the issues I bring forward', 'I have fears that my identity will be disrespected or denied because I have a mental health diagnosis' and 'anything that's wrong with me may be put down to my being trans when it might not have anything to do with it'. A fear/concern that being trans would be seen as the reason, symptom, or cause of their mental health issues was by far the most commonly reported worry about accessing mental health services.

### Gender Identity Clinics (GICs)

Of the total sample, 202 participants (22.7%) had used (and reported on their experiences of using) GICs. Experiences reported here were also problematic. For example, nearly half (46%) felt that they had experienced difficulties obtaining the treatment/assistance needed. As a result, overall satisfaction with GICs was somewhat variable (on a scale of 1-7 whereby 1 = very dissatisfied and 7 = very satisfied, mean = 4.4, SD=1.9). While there were multiple reasons for dissatisfaction, excessively long waiting times (around 32% waiting 1-3 years; and almost 10% waiting more than 3 years) were



frequently reported as an issue in this study. Long waiting times were also raised as a key theme in Hurtado, Gómez & Donat's (2007) Portuguese study.

In some cases the reported issues that led to dissatisfaction were much more complex. For example, one respondent reported having experienced problems with 'being misgendered, misnamed and mispronounced in all initial correspondence' and was asked questions which they felt were unnecessarily personal and overly invasive:

Questions were overly irrelevant, prying and sexual. My first doctor asked about masturbation repeatedly, which made me feel uncomfortable... I feel utterly powerless and infantilised in my dealings with them, entirely at the mercy of their restrictive, unpredictable, arrogant and incompetent service (Occurred after 2011).

Similarly, another respondent reported feeling very uncomfortable and exposed during an examination which required them to reveal their genitals:

When I finally got to see the locum doctor at the GIC he wanted to do an examination of my genitalia before providing me with my first prescription for hormones. However, this was not a physical exam - he made me stand in front of him wearing an unbuttoned shirt and stared at between my legs for 30 seconds. I didn't feel able to say no to this examination because I was concerned he would refuse me access to hormones... being stared at in that way left me feeling like I was some sort of freak show (occurred after 2008).

According to these self-reports, some trans people felt that clinical sessions ran counter to the preservation of their dignity and human rights. Instances such as these were not uncommon in our data; and indeed in other studies (e.g. Pitts et al., 2009) respondents also indicated a certain level of discomfort with examinations involving the exposure of genitals. While in these instances practitioners may have been undertaking legitimate examinations, these have been *experienced* in a very negative way by the trans client in each instance.

We also explored how truthful trans people felt that they could be during encounters with health practitioners in GICs. Of all who responded to the question 'have you ever withheld information from or lied to any clinician at an NHS GIC' (N=311), 30.9% reported having withheld information or lied about something. Predominantly, participants reported withholding information or lying about their mental health ('about my depression, feared it would prevent surgery'; 'afraid that if I discussed anxiety and depression that I would be withheld oestrogen'), sexuality ('that I'd been molested as a child or that BDSM is part of my sexuality'; 'about being bisexual'), and/or employment ('said I was working part-time, when in fact I was volunteering two hours per week');

‘said that I went full-time before I did’) on grounds that these issues might affect their access to treatment. Bearing in mind that participants had already reported long waiting times for access to GICs, it would seem that respondents feared that if they were seen as a complex case then their treatment might be stalled, interrupted or even potentially stopped altogether. As it is a current requirement that people be in full-time employment or education – which does not allow for unemployment (which is high anyway and comparatively higher within the trans population) – it is unsurprising that trans people might ostensibly lie about their employment status in order to access treatment. These findings are similar to those of other studies (e.g. Denny & Roberts, 1997; Walworth, 1997) which also report that clients had lied to therapists in order to meet guidelines for transitioning, especially where they thought that being honest would hinder access to treatment.

Respondents also commonly reported feeling that clinicians held outmoded views about gender and sexuality which were heteronormative in nature. Consequently, some trans people felt the need to ‘play it safe’ and pretend to be heterosexual even when they were not. For example, one participant stated ‘I lied that I had ever been interested in or had fallen in love with girls... I told the doctor I only liked boys’ because they had felt that admitting to being attracted to both males and females might be used to question their gender identity. While there is some evidence that historically (and in some cases, recently) GIC clinicians have been particularly heteronormative, this is also rhetoric which is repeated within the trans community and based on the sharing of bad experiences. Nevertheless, there were some reports of clinicians displaying heteronormative viewpoints:

“The GIC...seemed to have very rigid ideas of masculinity and femininity and seemed to be adhering to a now outmoded medical model...with one of my assessors asking me about sex positions, and how this “differed from heterosexual sex” (2012)

Respondents also reported withholding from clinicians any level of ambivalence or uncertainty about their gender. Fifty percent of participants who had attended GICs had felt uncertain of their gender at some point while attending a GIC. Of these, just over half (51.4%) felt unable to talk about this with a GIC practitioner. Overwhelmingly, this was explained by participants in terms of a fear that they would be denied treatment, their treatment would be delayed, or they would not be taken seriously. Reports of actual experiences in our data seems to support this: ‘I did once express how I was feeling confused about my gender... and they promptly withdrew my diagnosis’, ‘any sign of ambivalence is used as an excuse to delay your transition’, ‘the fact that I confidently voiced uncertainty about my gender with the doctor meant that he didn’t take my trans-ness seriously’. This particular issue was even more acute for those who did not define unequivocally as ‘male’ or

‘female’. These individuals felt that the imposition of narrowly defined – and exclusively binary – definitions of gender was problematic:

I feel I am primarily neutrois but also gender fluid, but I was expected to demonstrate a preference for a specific gender binary so I had to give the impression I wish to transition FtM (female to male) in order to get the treatment I need for how I really transition or else risk being denied treatment.

This issue has also been raised by others (e.g. Pitts et al., 2009; Taylor, 2013) in relation to health care settings more generally.

A sizeable minority of participants also reported feeling that they had been pressured into doing things that they didn’t want to do in order to ‘prove’ their gender to professionals in GICs. For example, some participants reported being pressured into changing their name (e.g. ‘had to change my name to obtain hormones’; ‘I was told I had to change my name’); dressing in a highly ‘feminine’ way (e.g. ‘I felt I had to change from my normal very casual types of clothes for a more feminine look to satisfy expectations of the gender specialists’; ‘I felt pressurised to... be more stereotypically feminine in my clothes so dresses and skirts instead of jeans and t-shirts’); or conforming to a conventional expectations of masculinity (‘I’m a punk rocker and I was asked by a counsellor to tone down my look, get a proper job and... short back and sides! I told her she was confusing fashion with gender’). Another problematic issue for participants was the pressure to *physically* conform to stereotypical notions of male/female including feeling pressured to undergo ‘sex reassignment surgery’<sup>4</sup> and/or other treatments.

It would seem then that although it was very important to respondents that their gender identity was validated, the constraints of the system and the gender frameworks to which they were expected to adhere to were a hindrance to reaching gender validation. This also appeared to be particularly problematic for those who self-defined their gender in a non-binary way. For example, one responded stated

I know from other people’s experience that I cannot have the treatment I want on the NHS without pandering to the binary gender and binary transition systems. I do not want testosterone and do not want to change my name and documents to male... but I have no intention of using my female reproductive parts and would like them gone (top and bottom) and would essentially like to be neutered... they are unwilling to meet my requirements and instead want me to fit theirs. It pisses me off that I can’t have ID and body to better match my identity.

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<sup>4</sup> We have used the term ‘Sex Reassignment Surgery’ here as this is the terminology used by our participants; however, our preferred term is ‘Gender Confirmation Surgery’.

For this individual, the protocols and procedures of GICs were felt to be a hindrance to the realisation of their gender identity. Similarly, this participant, who also identified in a non-binary way, felt that their identity had been erased by the pressure to conform to a narrow (and binary) definition of gender:

As a non-binary trans person I feel the pressure to present as binary and present myself in a fairly uncomplicated, predictable light to gain hormones. I feel ignored and erased as a non-binary trans person (and a cross-dressing, femme trans man) and quite angry that I can't have the personal autonomy to make my own decisions on what is necessary to do with my body without proving myself under someone else's gender standards.

The enforcement of such rigid constraints and a lack of sensitivity towards gender issues would therefore appear problematic for the mental well-being of trans people. As *people*, trans people are emotionally invested in their gender identity. While the level of investment in cis-gender individuals – including many practitioners – may be somewhat less, the importance of this for trans people living in a cis-gender-centric society should not be underestimated. As a result of rigid and strict procedures around gender presentation within GICs, many of our respondents found their experiences in these clinics quite traumatic. Just over half of participants (53%) reported having felt emotionally distressed or worried about their mental health while attending a GIC, and didn't feel that they could talk about this to practitioners.

## **Discussion**

The purpose of this study was to explore trans people's experiences of health care services in order to gain a better understanding of their experiences as a distinct group, and to evaluate mental health services and GICs in relation to trans clients experiences. As the health services that are in a position to assist trans people in gaining validation of their gender, it is imperative that these services meet the needs and reflect the lived experiences and situated lives of trans people.

The findings of our study show that on the whole, participants perceived mental health practitioners in particular to be poorly informed about trans issues and experiences. Given that mental health practitioners are gatekeepers to gender identity treatment (i.e. hormones; surgery) this is extremely problematic. Furthermore, for trans people accessing support for non-gender related reasons this does not make for a positive experience. In both instances, practitioners who are not adequately prepared for working with trans people could potentially impact on the quality of care and

assistance in ways that are detrimental to mental health and wellbeing. This would seem to suggest that (pre- or in- service) trans-awareness training is needed both to better educate practitioners, and to challenge prejudices which may leak out in practice settings. In particular, it is essential that some of the taken-for-granted assumptions about gender and also mental health are challenged. While some of Pitts and colleagues' (2009) participants viewed practitioners' inexperience as a mutual learning opportunity, like others of their participants, many of those in our study were clear that they did not see it as their role to educate practitioners: 'I Don't want to always have to explain myself'; 'shouldn't have to be about me teaching a counsellor a trans 101'. A perceived lack of competence and knowledge about trans issues on the part of health practitioners have also been widely reported in studies in the US (Sanchez et al., 2009), Canada (Taylor, 2013), and New Zealand (Adams et al., 2013) suggesting that the need for better education of practitioners about trans issues is not restricted to the UK context.

Related to this, the biggest issue for trans people was that their mental health issues would not be treated seriously in that these would be seen as the result of, or a symptom of, their being trans. In our study this was expressed primarily as a concern (although there were instances of this being reported as having happened). One way in which practitioners could help is through better communication with trans clients. Expressing their diagnoses in ways that make it clear that gender identity issues and mental health issues are not being conflated would help to alleviate some of these fears. However, there may also be a need to better monitor practitioner attitudes as conflating gender identity issues and mental health issues – where it occurs – may result in misdiagnosis. One of the problems here is that when seeking gender reassignment (through hormones and/or surgery) trans people are diagnosed with and treated for 'gender dysphoria' within a mental health framework (see also Barker & Wyllie, 2008). This is viewed as problematic for many trans people who see their being trans as a social variation or medical definition which does not fit within a psychiatric model of treatment. In addition, until very recently, diagnostic references listed trans as an identity disorder, a categorisation that many trans people feel uncomfortable with because there is actually no problem with their identity, but rather with the categorisation and constraints imposed on them by others. These potentially prejudicial/negative attitudes are encountered both inside and outside of a mental health setting.

In relation to GICs, access to services was seen by participants as problematic. While access to services has been highlighted as a problem in other studies (e.g. Adams et al., 2013; Pitts et al., 2009; Taylor, 2013) this has mainly been in relation to cost. Like Hurtado and colleagues (2007) rather than cost, waiting times were reported as the main issue in our study. In the case of our UK-based study,

this is largely attributable to the availability of gender services through the NHS. Timely access to hormones and surgery are critical to the mental health and wellbeing of trans people, so a review of waiting times (and support in the interim) is extremely important.

It was also evident in our data that trans people felt that many of the questions they were asked and/or physical examinations that were undertaken in clinical settings were unnecessarily intrusive. While there may be legitimate reasons for particular questions or tests, practitioners need to exercise a greater level of sensitivity towards their trans clients and communicate the reasons for asking what might appear as invasive questions – and to explain the need for particular physical examinations – to ensure that trans clients do not feel that they are simply an object of interest/curiosity. Situations which involve the exposure of genitals can be especially traumatic for trans people and should only occur when strictly necessary for medical purposes (e.g. see Ellis, McNeil and Bailey, 2014; Pitts et al., 2009). Where they do occur, they need to be dealt with sensitively with additional care paid to the communication and handling of such procedures.

Many of our respondents also felt that practitioners asserted narrow definitions and restricted understandings of gender with an expectation that clients would conform to these. The assertion of a binary system and stereotypical notions of what it means to be (and live as) 'male' or 'female' were extremely problematic for some trans people. Here, the problem lay in that they identified as neither male nor female so struggled to fit (and conform to) this gender framework. For others, the problem lay in that they wanted to 'be themselves' which meant clearly identifying either as male or female but embodying an appearance or behaviours which did not conform to the stereotyped image of these genders. The issue of problematic assumptions about gender on the part of practitioners has also been raised elsewhere. In particular, where resistance to non-binary complexities of gender identity and gender expression (Taylor, 2013) and the need for practitioners to develop a better understanding of the complexity and diversity of gender identities (Pitts et al., 2009) have been highlighted. There is therefore some work to be done in breaking down the barriers to affirming the trans person's gender by adopting a broader view of gender beyond a stereotypical binary model.

As indicated by Combs (2010) there is divergence between the diverse ways in which trans people experience their gender identities (i.e as non-pathological and inherent) and the current treatment approach which necessarily positions trans within a framework of pathology. The failure of the current framework to acknowledge and understand the complexity of gender identities within the trans population itself, let alone more sophisticated frameworks for understanding gender, throws

light on the limitations of using a medical model to respond to gender variation. As highlighted by Barker & Wyllie (2008) while clients are aware that health professionals are 'gatekeepers' to treatment, it difficult to establish an authentic relationship between practitioner and client. For this reason, many of our respondents felt unable to be open and honest about various aspects of their trans history, mental health, or other aspects of their lives for fear of being denied the treatments (interventions and/or surgery) that would make a positive difference to their lives. Similar findings have been reported by others (e.g. Denny & Roberts, 1997; Walworth, 1997). Trans people are reliant on medical practitioners at all stages of the transition process: from diagnosis with 'gender dysphoria', through to undergoing the real life experience, hormone therapy and (for many who choose to undergo it) gender confirmation surgeries. These fears are therefore understandable in that an inability to access support and treatment feeds into - and exacerbates - minority stress within this population. As indicated earlier, this is likely to *increase* mental health problems in the trans population rather than alleviate them (Huebner et al., 2004; Meyer, 1995).

Many of the problems highlighted in this paper arise from the pathologisation of trans people through clinical categorisation and the framework of treatment itself (i.e. psychiatry). First, the use of the diagnostic category 'gender dysphoria' is problematic in that it necessarily pathologises trans people as being mentally ill by virtue of being trans. Trans people wishing to transition, however, have no choice but to accept this category in order to access treatment (i.e. hormones); even if they do not plan to undergo gender confirmation surgery. Furthermore, current protocols also require that trans people (under the supervision of a mental health professional) undergo a mandatory period (typically, 1-2 years) living in their gender. This is known as 'the Real Life Experience' (RLE) and is usually tied to certain conditions (see Barker & Wyllie, 2008 for a detailed outline). For example, the protocol for one gender clinic (available at [www.nottinghamshirehealthcare.nhs.uk](http://www.nottinghamshirehealthcare.nhs.uk)) requires undergoing the RLE for a period of 'no less than two years'. In this document, expectations about role change during this period comprise 'a full adaptation to the chosen role' via paid employment, volunteer work or full-time study 'good adaptation within relationships with significant others', and 'documentary changes' (i.e. changes to name on drivers' licence, passport, etc). While it may be necessary to monitor an individual's progress through transition, this level of scrutiny is both unnecessary and potentially damaging. Such highly prescriptive requirements put barriers in the way of many trans people accessing gender reassignment treatment because they are not willing/able (for a whole host of reasons) to meet these stringent requirements. For example, requiring someone to hold down employment or full-time study is not only irrelevant with regards to demonstrating their gender, but is discriminatory against those not in work/study. For example, as highlighted by Barker & Wyllie (2008), this is particularly problematic for those who are not able to work due to

disability. Similarly, requiring someone to change their name is also problematic. A name in itself is not gendered, but rather it is the social meaning that society attaches to certain names that makes them gendered. To routinely ask trans people to change their name is to require conformity to relatively arbitrary social norms when to the trans person their name is a signifier of who they are. Furthermore, some of our participants felt that they wished to retain their given name as it had been specifically given to them by their parent(s) and therefore was an important part of who they are.

In summary, this paper highlights that there are a number of aspects around the health care of trans people that need evaluating and potentially reviewing. To do so would improve the mental health prospects of trans people within mental health services and gender identity clinics, and provide a better experience for trans people within these services. Adopting a flexible, patient-centred approach and utilising an informed model of consent would ensure that any changes were of a trans-affirmative nature. As highlighted by Adams and colleagues (2013) the involvement of specific client groups in decision-making around policy and practice is beneficial in ensuring that services best meet the needs of those client groups. Therefore involving trans people in decisions about their health care and treatment can only be beneficial to both practitioners and their clients.

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