A Qualitative Analysis of Transgender Women’s Lived Experiences of One-to-One Psychosocial Support in the Context of Presenting as Female

Thesis submitted in partial fulfilment for the degree of

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by

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Declaration

I confirm as the author, that this is my original work. It has been submitted for the partial fulfilment of the degree of Doctorate in Clinical Psychology to the University of Leicester and not part has not been submitted for any other qualification.

Emily Callan
Research Abstract

**Literature Review:** A systematic review was conducted to explore the psychological impact of surgical gender realignment procedures. The results appear suggestive of a better psychological adjustment for males-to-females regarding the functional outcomes of surgery, however more difficulty with integrating into society. Females-to-males report greater dissatisfaction with surgical outcomes but experience greater social integration, which in turn impacts positively on their psychological well-being. Contemporary studies appeared more inclusive of social and economic factors influencing successful gender transition. It is suggested that although there remains considerable psychological distress related to a range of factors, surgical intervention may help to alleviate psychological discomfort, though these results are taken as inferential rather than conclusive. A discussion of the clinical implications and future research discuss how research may further address the exploration of transgender psychological experience.

**Research Report:** The present study provides a qualitative exploration of the experiences of transgender individuals who sought one to one psychosocial support through the process of changing their physical appearance to reflect their internal experience of gender. The findings illustrate how internalisation of distal societal attitudes often led to marked psychological distress. The women sought to illustrate their experiences of self and others beyond the borders of their physical appearance, and bring to light both the psychosocial experiences they have been expected to tolerate, and the impact this had on them. The power of being listened to was a valuable source of support for the women. Clinical implications and future recommendations are discussed in relation to further research opportunities and enhancing understanding in a relatively unexplored area of clinical practice.

**Critical Appraisal:** A critical appraisal of the research process and learning outcomes of the researcher are described and discussed.
Acknowledgements

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PART ONE

LITERATURE REVIEW

A Systematic Review of the Psychological Impact of Surgical Interventions for Gender Related Distress
1. Abstract

Introduction

The concept of ‘transition’ represents a personal journey where they endeavour to physically alter their biological sex characteristics to become congruent with their experienced gender. This process may include taking on stereotyped looks, roles and responsibilities, as well as physically changing one's anatomical sex characteristics through medical interventions such as hormonal therapies and varying surgical interventions. With reported higher levels of psychological and social distress, suicidality and mental health problems pre and post transition, it is important to ascertain the diverse array of variables impacting on psychological and social well-being.

Method

Search terms were identified with reference to established transgender organisations. The final search terms and limits were entered into selected databases. Only papers that examined the psychological outcome of surgical procedures were included in the review.

Results

The results appear to be suggestive of a better psychological adjustment for males-to-females regarding the functional outcomes of surgery, however more difficulty with integrating into society. Females-to-males report greater dissatisfaction with surgical outcomes but experience greater social integration, which in turn impacts positively on their psychological well-being. Contemporary studies appeared more inclusive of social and economic factors influencing successful gender transition. Design and use of outcome measures remain problematic due to small sample sizes and non-population specific measures.

Discussion

The historic pathologisation of the transgender experience may have had great relevance to social constructions of gender variance, viewed by the self and by others. It is questionable whether such pathologisation allowed for a truly accurate representation of transgender mental health.

Conclusion

It is suggested that although there remains considerable psychological distress related to a range of factors, surgical intervention may help to alleviate psychological discomfort, though these results are taken as inferential rather than conclusive. Gender transitioning encompasses a complex interplay of bio-psychosocial variables which must be viewed holistically.
2. Introduction

2.1 Conceptualising Gender

Mainstream social constructions of gender demand individuals to conform to either a male or female identity (Wiseman and Davidson, 2012). Gender identity represents an intricate physical and psychosocial experience compounded by relational and societal expectations (Mascis, 2011). When one’s physical sex characteristics and gender expression co-emerge, this process is known as ‘cisgenderism’ (Bauer et al, 2009); For example, being born a biological male and developing masculinised gender expression.

The concept of ‘transition’ represents a personal journey where one endeavours to alter their biological sex characteristics to become congruent with their internal experiences of gender. This can involve changing social gender role and living as one’s preferred gender. This process may include taking on stereotyped looks, roles and responsibilities, as well as physically changing ones anatomical sex characteristics through medical interventions such as hormonal therapies and varying surgical interventions. Transitioning can be a socially visible process, highlighting the perceived importance of ‘passing’ as the other gender. Psychological distress may occur in instances where this process of passing is difficult.

2.2 Therapeutic Interventions for Gender Related Distress

The World Professional Association for Transgender Health (WPATH) is an internationally recognised multi-disciplinary professional organisation dedicated to promoting evidenced-based care, research, education and advocacy for all aspects of transgender health and social care. The fundamental aim of WPATH is to provide clinical guidance to professionals who are assisting transsexual, transgender and gender non-conforming people, with safe and effective pathways of care, to achieve psychosocial and physical comfort with their gendered selves (Coleman et al, 2011). The organisation have devised standards of care (SOC) for gender transitioning, designed to be flexible in order to meet the varying healthcare needs of all transsexual, transgender and gender non-conforming people. The guidelines outline a number of intervention options, varying in reversibility. The SOC value the roles of harm reducing approaches and do not advocate the necessity of any psychological, hormonal or surgical interventions (Coleman et al, 2011).
Currently, the Diagnostic and Statistical Manual of Mental Disorders V (DSM), states Gender Dysphoria (GD) to be a condition whereby persons experience persistent identification with the opposite gender. Marked by persistent and significant psychological distress this can lead to marked impairment in social, psychological, emotional and occupational well-being (American Psychiatric Association, 2013). A formal psychiatric diagnosis is required in the United Kingdom (UK) for those wishing to pursue hormonal and surgical interventions for gender related distress. Categorising gender expression with a functional diagnosis is problematic. A disorder as a collective description of symptoms with which a person may struggle is not a reflection of the person in context (Coleman et al, 2011). In May 2010, WPATH released a statement supporting de-pathologisation of gender non-conformity. The statement suggested that gender expression, which is not stereotypically associated with one’s biological sex, is a culturally diverse human phenomenon and should not be judged pathologically. Unfortunately, there remains much stigma attached to gender non-conformity across the world (WPATH Board of Directors, 2010).

The Gender Recognition Act 2004, allows those who experience ‘severe gender variance’, and have ‘medical treatment for the condition’, to apply for a Gender Recognition Certificate. This entitles the individual to recognition for the gender expressed on the certificate and, where the person was originally born in the UK, the certificate may be used to obtain a new birth certificate. Those seeking to change their gender status must provide evidence of a diagnosis of ‘persistent gender dysphoria’ (American Psychiatric Association, 2013), and must convince a panel of their intention to live in the new role permanently. Currently, this is a paper exercise, not requiring the applicant to appear in person. Detail of medical treatment is required. Genital surgery is not a requirement, although where it has taken place, applicants must supply details. This process places significant emphasis on a medical conceptualisation of gender variance, precluding the impact of the individual’s psychosocial experience.

2.3 Psychological Factors in Gender Related Distress

Studies using a range of methods identify elevated levels of psychological distress existing within the transgender population (Riley et al, 2011; McGuire et al, 2010; Dietert and Dentice, 2009; Mitchell et al, 2009; Whittle et al, 2007). Psychological
variables such as depression, anxiety and suicidal ideation are reported as higher for the transgender population (Clements-Nolle et al, 2006; Rotondi, 2011). In conjunction with this, eight psychosocial factors particularly contribute to higher rates of depression within the transgender community: discrimination, disclosure, identity support, substance misuse, hormones and sex reassignment surgeries, socio-demographics, socio-economic and access to health services (Rotondi, 2011). Stigmatisation may occur both pre and post-intervention and have a profound effect on the mental health, confidence and gender identity formation. Studies have been carried out in determining the levels and types of distress faced by the transgender community, and outlining the impact a lack of social support can have (Nemoto, 2011; Riley et al, 2011; Israel et al, 2008). With reported higher levels of psychological and social distress, it is important to understand the variables impacting on psychological and social well-being in order to formulate appropriate and relevant support mechanisms (Riley et al, 2011).

2.3.1 Previous Psychological Literature

One previous review was identified which looked at the psychosocial impact for those who had undergone surgical interventions for gender related distress. Abramowitz (1986) unsystematically reviewed studies conducted throughout the 1960’s and 1970’s. Psychosocial outcome was measured on an overall adjustment index arrived at by combining scores of legal complications, appropriateness of living arrangement, employment status, and psychiatric record. The main findings of the review indicated a 50-85% improvement rate of psychosocial function post surgery. Female-to-male transsexuals had lower rates of ‘serious complications’ post-operatively when compared with biological males. However, this finding was not amenable to statistical testing due to the large disparity of samples and the varying definitions of ‘serious complications’. Post-operative suicide attempts were rare, but attributed as a greater risk for biological males. Higher levels of social integration with communities following intervention were correlated with lower levels of depression. Female-to-male persons undergoing phalloplasty procedures reported a greater sense of disappointment in outcomes following surgery. Better outcomes were reported for all persons undergoing first time surgery than those who received follow-up procedures (Abramowitz, 1986). Despite the methodological implications of the review, it tentatively concluded that surgical intervention for gender related distress may have a positive impact on the alleviation of psychological discomfort.
The impact of hormone therapy on psychological well-being suggests a potential profound effect on mood and functioning (Rotondi, 2011; Murad et al, 2010; Slabbekorn et al, 2001). More recently, Murad et al, (2010) compiled a systematic review and meta-analysis of the psychological and social impact of receiving hormonal therapy. Psychosocial outcome was measured with regard to reported levels of depression, regret, well-being, satisfaction, adjustment, self-esteem, body image, suicide, health status, mental health status, sexual behaviour, and sexual dysfunction. It concluded hormonal therapies are effective at alleviating the symptoms of gender dysphoria and gender related distress, and are likely to improve quality of life and psychological functioning (Murad et al, 2010). Other key findings indicated that male-to-female transsexuals have poorer psychological outcomes than female-to-male persons. However, this link was made tentatively due to limited data.

2.4 Rationale and Aims of the Present Review

Identifying the variables impacting on mental health and well-being of the transgender population is complex due to the intricate interplay of the physical, psychological and emotional components of identity experience. Previous reviews have tentatively concluded that sex reassignment has a positive impact on the alleviation of gender related distress (Murad et al, 2010; Abramowitz, 1986). These reviews are now dated, or, have not included the impact of surgical intervention. This leaves more recent studies regarding the psychological and social impact following surgery unexplored. The present review will be put forward for publication in the International Journal of Transgenderism (Appendix A).

The present review aims to address the following research questions:

- What are the psychological and social factors which impact on levels of gender related distress following surgical intervention?
- How are these psychological and social constructs measured within the existing literature?
- What are the methodological issues of the research, specifically relating to research design?
3. Method

3.1 Development of Search Terms

Search terms were shaped through established transgender organisations including WPATH and Gender Identity Research and Education Society (GIRES) (GIRES, 2012). The exercise highlighted the wealth of medical literature within the subject area, which in turn helped shape the search terms further to ensure a psychosocial focus.

The final search terms included transgender or transsexual, surgery, sex reassignment or post-operative, psychological, psychosocial or mental health, impact or function.

3.2 Exclusion Criteria

A priori limits set to the search.

- Papers must be written in English.
- Lesbian, gay and bisexual (LGB) populations only. This was to ensure a complete focus on the experiences of the transgender population.
- Explicitly qualitative methods were omitted from the review. This was based on the limited availability of qualitative literature available to fit the requirements of a systematic review.
- Single case designs where omitted to increase homogeneity of the literature sample.
- Samples that have not undergone surgery. Recent literature has reviewed the psychological impact of medical (non-surgical) intervention on participants. The present review was to build on the previous literature and review post-surgical intervention.
- Summary papers and reviews. Only empirical papers reviewing outcome on the basis on intervention were used for the review.

3.3 Identification of Relevant Papers

The final search terms and limits were entered into Scopus, PsychInfo (including PsychArticles and PsychExtra) and Ovid Sp (including Medline and Embase). For reliability, the search procedure was replicated by an independent researcher, using the identified search terms and search procedure (Appendix B). Manual searches of The
Cochrane Library and the Public Library of Science were conducted to highlight existing reviews, and of grey literature, including Google Scholar, GIRES, and WPATH helped highlight papers which may not be identified through the mainstream search. Searches were conducted between 2nd and 25th August 2013.

3.4 Short listing of Papers

References identified were all examined by title. Explicitly irrelevant titles were removed. The remaining references were then exported to bibliographic software for collation and the removal of duplicate papers. Abstracts were retrieved for the remaining papers and read against the inclusion criteria. Any studies that did not meet the criteria were rejected from the review.

The full texts were retrieved for the highlighted studies and read thoroughly against the inclusion criteria again. At this point, manual searches of the reference lists of these papers also identified further studies for consideration.

Only papers that examined the psychosocial outcome of surgical procedures were included in this review. Samples which used LGB populations were also excluded. Papers which examined effectiveness or satisfaction of surgical technique (without acknowledging psychosocial impact) were not included, as were studies which studied the prevalence rates of specific conditions or behaviours (e.g. smoking or HIV rates). Intersex and biological sexual conditions were omitted from the present review. Surgical intervention cannot be reviewed in isolation to hormonal therapy, therefore acknowledgment is made that by proxy, all participants in the included studies have undergone hormonal therapy prior to surgical intervention.

3.5 Data Extraction and Synthesis

Identified papers were reviewed using the Strengthening and Reporting of Observational Studies in Epidemiology (STROBE). STROBE was developed to specifically provide recommendations for the reporting of observational studies lending itself to all designs of studies in the present review. Using a data extraction form (Appendix C), each paper was critiqued against the STROBE checklist (Vandenbroucke et al, 2007). The short listing process is detailed in Figure1.
Due to the heterogeneity of the samples and follow-up times; meta-analysis was not possible. A narrative discussion addressing the thematic findings, samples, methodologies, and measures follows.
Figure 1: Process of Short listing Papers

1. Initial scoping exercises and shaping of search terms
2. Initial search from databases using identified search terms, N=441
3. Application of Exclusion Criteria (LGBT, medical, reviews, intersex, Qualitative, specific behaviours), N=64
4. Exported to RefWorks
5. Removal of Duplicates, N=61
6. Abstracts read against Inclusion criteria, N=8
7. Manual search of grey literature and reference lists, N=5 (additional)
8. Full text retrieval, read against inclusion
9. Final Selection for review, N=13
10. Data extraction and quality appraisal (STROBE) applied
4. Results

Thirteen papers were selected for review. A brief summary of each study will be outlined before a narrative discussion of the main findings in relation to the review research questions. Study design and specific outcome measures can be found in Appendix D. Diagnostic terms such as ‘transsexual’ reflect the terminology used in the paper under review.

4.1 Outline of Papers

Dhejne et al. (2011) retrospectively analysed the data from the National Registers of Sweden, between 1973 and 2003. The study identified all those who had undergone surgical interventions for gender related distress. The sample (N=324) was matched with randomly assigned population based controls (10:1). Controls were matched by birth year, sex at birth and final (reassigned) sex. The results indicate that mortality for sex reassigned individuals was higher during follow-up than for controls. This was particularly high with regard to suicide. The transgender population also had a higher rate of attempted suicide and inpatient psychiatric care. Females-to-males had a higher risk for criminal conviction following surgical interventions. The study concluded that whilst surgical intervention may be effective in alleviating the psychological symptoms of gender dysphoria, the transgender population have significantly higher risk of mortality, including suicide, and need for psychiatric care than the general population. It recommends further psychiatric and somatic care following transition.

Lawrence (2003) examined the factors associated with satisfaction or regret following surgical intervention in 232 male-to-female transgender women. The sample all had surgery from 1994-2000 and was all a minimum of twelve months post-operative. Through questionnaires, the participants reported an increase in their quality of life as defined by psychological, physical and social well-being. None of the participants reported continuing regret following surgery, though some expressed occasional regret. Compliance with minimum standards of eligibility with WPATH standards was associated with better post-operative quality of life outcome.

Smith et al. (2005) prospectively considered the outcomes of surgical sex reassignment. Using a between-groups design, the sample (N=325) included adolescents and adults at various stages of transition. Results of the study indicate that psychological distress was
reduced as a result of the intervention. Two participants expressed regret following intervention. Females-to-males are reported less psychological distress than male-to-females. The study concluded that sex reassignment interventions in its varying forms are effective at relieving gender related distress. Males-to-females with ‘unfavourable psychological functioning’, such as inconsistent gender dysphoria, may be a risk factor for attrition and poor post-surgical psychological well-being.

Rehmen et al. (1999) collected data from those who had undergone surgical interventions for gender related distress from 1980-1994. The final sample (N=28) were a minimum of three years post-operative. Questionnaire results supplemented by qualitative interviews with a smaller proportion of the sample (N=11). Physical functioning post-operatively was reported to be good by the sample. Vocational and social relationships were reported to be satisfactory. A significant result for the study was the recommendation of post-operative psychotherapy. Participants reported some disappointment in adjusting to personal relationships with male partners and general integration in society as women. From this, the study advocates a period of post-operative psychotherapy to facilitate both psychological and social identity adjustment.

Lobato et al. (2006) retrospectively analysed a cohort of 19 Brazilian transgender patients who received surgical intervention between 2000 and 2003. Participants were a minimum of twelve months post-surgery. The objective was to describe the psychosocial impact of surgical interventions for gender related distress in relation to sexual experience, romantic relationships and relationships with families. All participants had been enrolled on The Gender Identity Disorder Program which provided diagnostic evaluation as well as medical, psychological, social and clinical support to all those enrolled. Outcome was measured using a self-report questionnaire designed by the multi-disciplinary team working in the program. The results indicate that there was no regret experienced by the cohort regarding surgery. In addition, 64.7% maintained initiating and maintaining relationships had become easier. Overall, the study concludes that for the present cohort, the psychological impact of surgical intervention was positive.

Hunt and Hampson (1980) retrospectively analysed 17 biological males who had received surgical intervention. The mean follow-up period was 8.2 years. The sample had all applied for gender reassignment surgery between 1968 and 1972 and was treated
for ‘Transsexualism’ at an American gender identity service. Data collected revealed there were no changes in levels of psychopathology following surgery. Modest gains were seen in economic functioning and interpersonal relationships. Greater positive gains were recognised in sexual satisfaction and acceptance by family members. The study concludes that surgical interventions may have a positive impact, alleviating gender related distress. They also go on to suggest that an individual’s ability to adjust and cope with the social and psychological impact of gender related distress prior to surgery as an indicator of their ability to adjust following surgery.

De Cuypere et al. (2006) wanted to establish how patients of a multidisciplinary gender team in Ghent were functioning psychologically, socially, and professionally after a longer follow-up. From 107 patients who had received surgery between 1986 and 2001, the sample (N=62) completed a number of outcome measures followed by a qualitative interview. The findings suggest that females-to-males scored higher (better) on global assessment of functioning compared with males-to-females. There was no difference in psychological functioning between the cohort and the general population, however, those participants with pre-existing psychopathology where found to have retained more psychological difficulties. The findings report an overall positive change in social and family relationships. There were no reports of regret relating to surgery. In conclusion, the study advocates the use of surgical interventions as a ‘treatment’ for gender related distress, however acknowledges psychosocial intervention may be necessary.

Udeze et al. (2008) prospectively studied forty male-to-female participants with a diagnosis of gender dysphoria. The UK based study used pre and post measures to determine if there was an improvement on the self-reported measures following gender reassignment surgery. Participants were randomly selected to complete the measure, and were again asked to complete the measure when six months post-surgery. The results of the study suggested that surgical intervention for gender related distress had no significant effect on participant’s psychological functions as determined by the outcome measure subscales, within six months of the intervention. The authors recognise the limitations of a small follow-up period and the advantages of replicating the study with a greater sample size and a wider range of psychological measures in order to elucidate on the effectiveness of surgical interventions for gender related.
Budge, Adelson and Howard (2013), undertook a cross-sectional survey of 351 transgender men and women to examine the coping styles as mediators between distress and transition status, social support and loss. The results indicated that the prevalence of depression and anxiety in transgender men and women surpasses that found in the general population. The study concludes that practitioners need to focus on interventions that facilitate less avoidant coping styles and increase social support. Greater levels of social support were correlated with lower levels of depression and anxiety. They also discuss how the psychosocial needs of those undergoing transition changes over the course of their transition and those interventions need to adapt to the psychosocial needs of the individual at each stage of transition.

Beatrice (1985) used a between-groups design to assess the psychological functioning of heterosexual males, transvestites, pre-operative transsexuals and post-operative transsexuals. The four groups represented ‘a gradient of progressive feminisation which showed progressive levels of psychological dysfunction’ (Beatrice, 1985). Beatrice found transsexuals to score significantly higher than other groups on clinical scales of schizophrenia and paranoia. Post-operative transsexuals scored significantly higher on a measure suggestive of psychotic functioning. Beatrice concluded that transsexuals represented a group that were characterised by profound psychological dysfunction. To substantiate this finding further, psychological testing in conjunction with psychiatric evaluation should be used.

Parola et al. (2010) aimed to provide a retrospective analysis of the impact of surgical interventions on the participant quality of life. The sample (N=38) were a minimum of 2 years post-operative, and completed a self-reported questionnaire relating to quality of life, such as perceived physical health, social life and relationships and mental health. A smaller sample of the original (N=30) were reselected for a qualitative interview to complement the quantitative findings. The results suggest that surgical reassignment improves quality of life, particularly with reference to sexual and social functioning. The findings also suggest that females-to-males have better quality of life than males-to-females on the domains of social and professional life.

Barrett (1998) assessed the psychological and social impact of genital surgery on female-to-male participants. The design involved two groups of participants, one had been accepted for surgery (N=23) which was compared to a sample (N=40) who had
undergone surgical intervention between six and 160 months previous to the study. Quantitative measures were used to assess psychological and social function of each group and compare the results. The results indicate that rates of depression were significantly higher for the post-operative group. Satisfaction with relationships also fell following surgery, however this finding was non-significant. The study suggests that whilst changing the physical appearance of the external genitalia may serve to reduce distress, there is no direct psychological benefit following completion of surgical procedures and that greater alleviation of psychological distress can be achieved by facilitating social gender role transition.

Mate-Kole, Freschi and Robin (1990) prospectively analysed the data from two groups of twenty demographically similar patients accepted for surgical interventions. One group was offered treatment as usual (TAU), whilst the second group was offered surgical intervention early. At the two year follow-up period, the latter group had received the surgery, whilst the control group were still waiting to receive it. During routine examination by a psychiatrist at the beginning of the referral process, a psychologist administered a test battery of outcome measures, which were repeated at the two year follow-up period. Follow-up data suggests that the operated group where more socially active and had improved rates of employment compared with the TAU group. Patients who had received surgical intervention also reported reduction in neurotic symptoms.

4.2 Main Findings

Psychological Impact

Six studies concluded that surgical intervention directly reduced individual psychological discomfort (Dhejne et al, 2011; De Cuypere et al, 2006; Lobato et al, 2006; Smith et al, 2005; Mate-Kole, Freschi and Robin, 1990; Hunt and Hampson, 1980). Rehman et al. (1999) reported that whilst the majority of participants remained ‘psychological stable’ following surgical interventions, some participants experienced emotional difficulties. Udeze et al. (2008) reported no significant psychological change following intervention, however, an increase in anger and hostility was observed post-surgery. Pre-existing psychological difficulty was felt to impact on post-surgical ability to adjust psychologically and socially (De Cuypere et al, 2006; Hunt and Hampson, 1980). Beatrice (1980) represents one of the earlier papers included in the review and
may reflect a degree of pathologisation prominent in earlier conceptualisations of Transgenderism. It reported there were higher levels of paranoia and schizophrenia compared with heterosexual males, indicative of that ‘which showed progressive levels of psychological dysfunction’.

Psychological distress can be greatly alleviated through changing social gender role than through surgical procedures alone for female-to-males (Barrett, 1998). Whilst, Parola et al. (2010) and Budge et al. (2013) report surgical intervention having a positive impact on relationships for female-to-male participants; Budge et al. (2013) also reports there to be greater ‘psychopathology’ post-operatively for female-to-male transsexuals. However, these findings are not statistically significant. It cannot be concluded that phalloplasty is of direct psychological benefit to female-to-males participants (Barrett, 1998). This may be due to the lesser functional outcome of genitals following surgery. Males-to-females are noted to have fewer complications following surgery which may partly explain the disparity in findings (Parola et al, 2006). Female-to-male participants had better mental health than male-to-female (95% confidence interval) and surgical gender reassignment is seen to have a more positive effect for female-to-male in terms of psychological factors (Parola et al, 2006; Smith et al, 2005). Conversely, De Cuypere et al. (2006) could not substantiate these findings and reported no significant difference in the psychological impact across their sample.

Three studies reported all participants expressed no regret following surgery (Lobato et al, 2006; Rehman et al, 1999; Hunt and Hampson, 1980). Post-operatively, fewer surgical complications and a greater functional outcome of new genitals were also correlated with less regret (Lawrence, 2003). Earlier intervention for ‘gender dysphoric symptoms’ was correlated with better post-operative psychological outcome (De Cuypere et al, 2006).

There was little indication given in any of the studies of a raised concern for suicidal ideation or participant attempts on taking their own lives following surgery. However, Dhejne et al. (2011) indicated that the transgender population are three times greater risk of mortality from all causes, including suicide, over general population controls. Males-to-females are at increased risk of suicide against all controls, whereas females-to-males rates are increased only against biological male controls. On the contrary, De
Cuypere et al. (2006) stated that post-operatively, participants are at less risk of suicide compared with the general population. Males-to-females are said to experience higher levels of gender related distress regarding adjustment post-operatively than female-to-males which is supported by Budge et al. (2013). Budge et al. (2013) and Parola et al. (2010) suggest that both adverse social and psychological effects of surgery are more prominent for male-to-female participants.

Thematically, the results of the studies appear to suggest that a progression through the transitioning process initiates a gradual alleviation of psychological distress experienced by individuals. As biological sex characteristics align with preferred social gender, individuals begin to experience less psychological distress and engage in less avoidant coping styles (Budge et al, 2013). In the earlier stages of the transition process, participants may engage in more avoidant coping styles due to a sense of inadequate social support. Less social support is associated with elevated levels of anxiety and depression (Budge et al, 2013).

**Social Impact**

The social impact of surgical interventions was largely discussed with regard to adjustments in family relationships, financial factors and occupational status. Overall, studies reported surgical intervention to improve social quality of life of participants (Udeze et al, 2008; Lobato et al, 2006; De Cuypere et al, 2006; Smith et al, 2005; Lawrence, 2003; Rehman et al, 1999; Mate-Kole, 1990). Regret was largely associated with social factors such as diminished family relationships (Lobato et al, 2006). Those who had undergone surgery had become more socially outgoing with family and friends, as well as engaging in more social and group activities. Employment status was variable and highlighted a particular difficulty for post-surgical people (Hunt and Hampson, 1980).

Difficulties relating to social integration following surgery were predominantly recognised by a lack of social support, acceptance and ridicule by society (Lawrence, 2003; Smith et al., 2005). Familial relationships were recognised as important social factors in several of the studies. Largely, these reports were of positive maintenance and gains in this area (Parola et al, 2010; Lobato, 2006; Hunt and Hampson, 1980).
Social adjustment for female-to-male participants was less problematic than for male-to-female (Budge et al, 2013; Parola et al, 2010; De Cuypere et al, 2006; Smith et al, 2005). However, female-to-males were more likely to feel distress due to their physical appearance and emotional state (Parola et al, 2010). Males-to-females arguably face more visible ridicule and relationship concerns as a result of transitioning. This creates a greater sense of loss in ability to pass as female. Specific losses such as occupation and financial may be less prominent for female-to-males due to increased social support and expectations of biological women, during pre-transition (Budge et al, 2013).

De Cuypere et al. (2006), Rehman et al. (1999) and Hunt and Hampson (1980) all reported participant satisfaction with employment. Eighty per-cent of female-to-males had maintained or acquired employment, whilst rates of employment hadn’t changed in males-to-females (De Cuypere et al, 2006). Having a meaningful occupation provided a sense of stability and offered the opportunity to be self-supporting (Rehman et al, 1999). The rates of post-operative unemployment were above the general population norms (De Cuypere et al, 2006) with 20% of males-to-females and 11% of female-to-males losing their jobs during their reassignment process. High post-surgical expectations of social integration proved problematic for some participants (Hunt and Hampson, 1980).

Dhejne et al. (2011) suggests that transsexuals were at a greater risk of conviction post-operatively; however, these results were only significant for those who had undergone surgery before 1989. For males-to-females surgical intervention did not impact on risk of criminality, however females-to-males demonstrate an increased ‘proneness’ to criminality. This appears contradictory to previous findings suggesting that following surgical intervention, individuals engage less in anti-social behaviours such as drug abuse and criminal activity (Rehman et al, 1999). This is not to suggest that the original findings of Dhejne et al. (2011) are not valid. It may be important to consider that the study will reflect the psychiatric treatment of transsexualism provided in context to the social norms of the 1970’s and 1980’s. As understanding of gender related distress has evolved, intervention options have become more refined. A wider acknowledgment of psychosocial care may impact on findings explaining why results for those undergoing surgery after 1989 were no longer significant (Dhejne et al, 2011).
4.3 Methodological Issues

4.3.1 Design

Three studies used a prospective design. A potential limitation to this approach is that not all psychosocial theory is amenable to formulation and deterministic predictions that may be tested over time (Bitektine, 2008). Conceptualising transgender experience within research terms is still in its infancy. Inferring deterministic predictions on a relatively unexplored phenomenon may have implications on the validity of the findings due to the heterogeneity of the research sample. For example, comparisons between pre and post-operative groups in Beatrice (1985) and Barrett (1998) may be problematic due to separate samples being used in each condition. Whilst similarities in certain participant demographics can be met, the psychosocial experience of each person and the evolution of their experience cannot be encapsulated through this process. Between-subjects validity also relies on larger sample sizes to generate valid data, increasing the chances of false conclusions being made if samples do not reach statistical power. This is inherently problematic to the validity of any quantitative analysis of transgender experiences as sample sizes are often recruited due to limited accessibility of participants. This is particularly well documented in Barrett (2008).

The amenability of social phenomena to quantification through robust methodological design is problematic. Seven studies used retrospective analysis. Retrospective design may be well suited to transgender research studies as it allows for the study of relatively rare presentations to be observed without necessitating large sample sizes as these can be difficult to attain. This is particularly evident in the earlier studies, before the advent of internet and computer based recruitment. However, accuracy of any pre-existing data within retrospective designs may be problematic, particularly if it has not been collected for the reasons it is being analysed. Hunt and Hampson (1980) used existing clinic data to judge the course of post-operative functioning of its participants. This may have implications on the validity of the findings as the results of the study were known at the formulation of the hypotheses. In these instances, studies cannot be free from the researcher’s retrospective rationalisations and biases (Bitektine, 2008).
4.3.2 Samples

Sample sizes ranged from 17-351 (Budge et al, 2013; Hunt and Hampson, 1980). Small sample sizes impacted on power for many studies particularly the earlier studies where access to participants may have been compromised by restricted recruitment methods. Few details were given regarding socio-cultural and economic information of participants and the biases this may introduce. Although, Beatrice (1985) claimed to have excluded participants on the basis of ethnicity and economic factors, the study does not detail the exact exclusion criteria. Budge et al. (2013) gave great detail on the cultural background of participants. Heterogeneity across the samples makes comparison and conclusions difficult. Sample characteristics may have introduced inherent bias’ which may impact on the validity of the conclusions drawn. Participants selected adhered to clearly defined exclusion criteria, which excluded pre-existing psychiatric diagnoses. The perceived psychological resilience of the selected participants may contribute to a skew in findings. Dhejne et al. (2011) identified participants from the national registers based on disparities in their birth sex and current sex and by psychiatric diagnosis. This encompasses only those who had legally changed their gender. Participants were not identified by surgical procedure as surgical intervention for gender related distress does not have a diagnostic code that can be recognised on the registers.

Wide age ranges make it difficult to discern the psychological impact of surgery on younger and older participants. Lobato et al. (2006) claimed to have studied the impact of surgical intervention on both male-to-female and female-to-male participants. However, on closer examination, the number of female-to-male participants was reported to be one. Applicability of the findings from this yields similar difficulties as single case design studies. There were a disproportionate number of male-to-female participants within the reviewed papers. Similarly, disproportions in the reported follow-up times across the studies do not allow for conclusions to be made regarding a consensus on average time allowed for adequate psychosocial adjustment.

4.3.3 Outcome Measures

It is questionable whether generic mental health measures are appropriate for the transgender population. In the absence of such population specific measures, only two studies devised measures designed specifically for transgender populations (Lawrence,
2003; Rehman, 1999); however these have not been validated with the population. Budge et al. (2013) was the only study to use exploratory factor analysis on the outcome measures used within the study to determine their reliability within the transgender community.

Historical perceptions of gender contribute to a binary conception of gender excluding and constructing transgender experience as inherently pathological. This may increase the likelihood of internalisation of distressing perceptions of the self. Self report measures contend with the propensity of participants to engage with social desirability bias. This may be a more prominent feature in the retrospective studies, particularly where a significant time period has lapsed since gender transition was completed. Participant’s responses may also be significantly affected by both their feelings at the time of completion of the measures used and their psychosocial experience throughout transition. This contextual and potentially highly emotive individual experience provides a rich detailed context to the development of the participants current understanding and framing of their current circumstances. This depth of data is often missed by quantifiable measures. The agenda of the researcher and their perception of the transgender population may have bearing on their interpretation of information presented to them in any supplementary qualitative information. Individual and historical contexts may serve to support existing social ideologies such as heteronormative expectations and pathologisation of socially occurring phenomena, rather than be objective accounts of participant psychosocial experiences (Dhejne, et al, 2011).
5. Discussion

The current paper reviewed research into the psychological and social impact of surgical gender realignment interventions. The results indicate a role of surgical interventions in relieving individual psychological distress. However, there are many inconsistencies in the reported results with regard to other psychosocial variables.

5.1 Summary of Findings

Consistent with the previous literature, (Murad et al, 2010; Abramowitz, 1986), aspects of psychosocial adjustment following surgical intervention appear more difficult for males-to-females. The results appear to be suggestive of a better psychological adjustment for males-to-females regarding the functional outcomes of surgery, however more difficulty with integrating into society (Budge et al, 2013; Parola, et al, 2010). Females-to-males report greater dissatisfaction with surgical outcomes but experience greater social integration, which in turn impacts positively on their psychological well-being. As reported by Barrett (1998), greater psychosocial change can be achieved through changing social gender role e.g. appearance, for females-to-males, than can be achieved through surgical realignment of biological sex characteristics. This supports the holistic approach advocated by WPATH, and that gender realignment consists of an integrative psychosocial experience that has implications on mental health and well-being, beyond surgical and chemical intervention.

Variable results in the rates of post-operative suicide to not allow for definitive conclusions to be drawn, however, in line with Abramowitz (1986), higher rates were attributable more to male-to-female persons than biological males (De Cuypere et al, 2006). It is important to consider this in conjunction with the reported social well-being of males-to-females being potentially more difficult following transition. It has also been noted that negative affect following surgery may be attributable to social factors such as social and familial relationships (Lobato, 2006; Barrett, 1998). The social experience of all transgender persons cannot be overlooked. It represents a significant factor in the psychological experience had by those who transition, arguably, way beyond the physical presence of genitalia.

The contemporary studies appeared more inclusive of social and economic factors influencing successful gender transition. This may be a reflection of the evolving
perception of gender transitioning as a holistic process involved in all psychological, social and emotional facets of the individuals life. The influence of the WAPTH standards of care (WPATH, 2011) may have particular bearing on this evolution. However, there remains a heavy reliance on people to self-identify to existing psychiatric and socially constructed labels in order to access intervention pathways. No study included in the review made reference to the potential psychological effect of adhering to diagnostic labels. The historic pathologisation of the transgender experience may have had great relevance to social constructions of gender variance, viewed by the self and by others. It is questionable whether such pathologisation allowed for a truly accurate representation of transgender mental health.

5.2 Quality Appraisal

Quality appraisal primarily examined the structure of the research design, sample size used, and the outcome measures used. Gender realignment research precludes the use of more scientifically rigorous methodologies such as randomised controlled trials and blinding. As the evidence advocating the use of quality appraisal measures for evaluation is limited (De Costa et al, 2011), the STROBE tool was used as a guide to appraise the quality of included papers and not as a rigid scoring system. The variability in research designs means that a meta-analysis wasn’t possible. This variability also prevents rigorous statistical testing, meaning results are not easily generalised. On reflection, this may be a positive. Developing understanding of what it is to transition ones gender suggests an ever evolving continuum of experience. The growing recognition of a contextual experience greatly reduces the prospect of controlling for all psychosocial experiences (variables) which impact on the course of the person’s journey. To quantify this experience will always present substantial flaws in both design and process. Gender realignment is a unique psychosocial and possibly medical journey in which no two experiences are ever truly the same. In this instance, there will always be unavoidable biases in sampling, design and interpretation.

Sampling bias is particularly evident in the studies, inherent in their methodological design and rigid exclusion criteria. Rates of attrition were most prominent in the cohort studies. Whilst it may be beneficial for researchers to allow a longer follow-up period for assessing psychosocial well-being, this also offers a greater likelihood of attrition due to disengagement from services (De Cuypere et al, 2006). This presents a
continuing and often unavoidable bias in samples. Another potential reason for attrition may be a disproportionate focus on the surgical experience as the ultimate goal of transitioning. Once this is achieved, there is a marked ‘distancing’ of individuals from gender services, recognised worldwide (Lobato et al, 2006). This makes psychotherapeutic follow-up difficult both on an individual and service level. Without a recognition and perceived need for such services, developments cannot be made to ensure their provision. Individuals may want or need such services but not in a medical context. Surgery is only part of the process of transitioning, however, at this time, gender related services are predominantly within a medical context. As a result, disengagement from services will continue and an accurate representation of transgender psychosocial experiences may never be fully understood.

A lack of validated population specific outcome measures is problematic to transgender research. In the instance that the study devised a population specific measure, clinical relevance increased however reliability was compromised, increasing bias and margin for errors. Only one study attempted to verify the validity of the measures being used (Budge et al, 2013).

5.3 Further Investigation and Clinical Implications

The results provide some evidence for the efficacy of surgical interventions in relieving psychological discomfort resulting from gender related distress. However, this is not a treatment which can be advocated for everyone. There is evidence to suggest that passing socially may be important in managing distress, indicated by the perceived higher levels of psychological well-being female-to-males. The psychological and social impact should be considered for all intervention options, not just those related to surgery and functional genital outcome. There are many psychosocial factors which influence the transition experience which, during a time of significant medical intervention, may often be over looked. Surgical intervention for gender related distress places significant expectations on the individual. These expectations, such as managing the emotional impact of a significant and permanent identity change, far surpass those of other purely cosmetic procedures. If left unmanaged, these expectations can pose significant psychological and social challenges for the individual. Post-surgical therapeutic services, such as psychotherapy, have been advocated to manage this (De Cuypere et al, 2006; Rehman et al, 1999). Consideration into what may be helpful and
unhelpful in these therapeutic instances will help in shaping appropriate services for those who wish to engage with them. Further research may help to identify factors within the social, psychological and emotional experiences of those who seek gender services.

5.4 Limitations of the Present Review

Surgical procedures cannot be evaluated in isolation to other interventions. It is acknowledged that all the participants undertaking surgical intervention have undergone a range of other interventions and experiences prior to surgery. The impact of these must be considered when interpreting findings.

The systematic methodology was seen as a strength of the review, however the process can never be fully objective. Due to the exclusion criteria, relevant literature may have been overlooked. Only including papers which were written in English could have prevented the inclusion of non-westernised cultures. The current review has sought to synthesise the findings from a body of quantitative literature. Through suggesting that studies of gender realignment procedures preclude rigorous scientific methodologies, analysis of available qualitative literature as well as unpublished material (and that currently in press) may complement a more comprehensive evaluation of the available literature.

5.5 Conclusions

The current review presents variable findings relating to the psychosocial experiences of those who have undergone surgical intervention for gender related distress. It is suggested that although there remains considerable psychological distress related to a range of factors, surgical intervention may help to alleviate psychological discomfort, though these results are taken as inferential rather than conclusive. Gender transitioning encompasses a complex interplay of bio-psychosocial variables which must be viewed holistically. To apply the findings of any study definitively may be considered inaccurate and unethical.
References


PART TWO

RESEARCH REPORT

A Qualitative Analysis of Transgender Women’s Lived Experiences of One-to-one Psychosocial Support within the Context of Presenting as Female
1. Abstract

Introduction

Mainstream social constructions of gender demand individuals to conform to either a male or female identity (Wiseman & Davidson, 2012). Transphobia has been defined with research as an “emotional disgust towards individuals who do not conform to society’s gender expectations” (Hill, 2002). This study explores the experiences of transgender individuals who sought psychosocial support through the process of changing their physical appearance to reflect their internal experience of gender.

Methodology

Six participants were recruited for the study. All interviews were conducted by the author at locations identified by the participants as accessible and suitable. The data was transcribed verbatim by the researcher and analysed using an Interpretive Phenomenological Analysis.

Findings

The findings illustrate how internalisation of distal societal attitudes often led to marked psychological distress. The women sought to illustrate their experiences of self and others beyond the borders of their physical appearance, and bring to light both the psychosocial experiences they have been expected to tolerate, and the impact this had on them. The power of being listened to was a valuable source of support for the women.

Summary of Findings

The need to be listened to and understood on a contextual level was important for all the participants. Following this, a demonstration of the professional to engage with the presenting difficulties of the client, reducing the propensity of assumptions on their experience was a significant positive factor for participants. A perceived need for a greater provision of individual support and information on how to access services for gender related distress was found as important to the participants of the study.
2. Introduction

2.1 Constructing Gender

A person’s gender identity represents an intricate psychosocial experience compounded by relational, cultural and societal expectations (Mascis, 2011). Co-emergence of one’s physical sex characteristics and gender is known as ‘cisgenderism’ (Bauer et al, 2009); for example, being born a biological male and developing masculinised gender expression. Conventional ideologies surrounding gender role and appearance often demand that individuals conform to a binary identity of either a male or female (Bettcher, 2014; Wiseman and Davidson, 2012).

Heteronormativity suggests a binary system of gender, by which only two sexes are ‘accepted’ (Johnson, 2013). As part of this, one’s gender identity should show congruence with one’s external genitalia, through this, displaying heterosexual preference (Kitzinger, 2005). Heteronormativity forms an interpretive framework used to describe the taken-for-granted presumptions of sex and gender role (Jagose, 1996). Through socialisation seemingly insignificant inequalities and micro-stressors can present in everyday action and discourse (Peel, 2012; Robinson, 2005), the cumulative effects of which can have significant psychological impact on individuals if internalised (Szymanki and Kashubeck-West, 2008).

Complexities regarding gender identity conceptualisations have led to the emergence of both theoretical and political stances opposing identity-based categories, signalling a strong opposition for heteronormative assumptions (Bettcher, 2014). Informed through the work of Foucault, and Derrida, Queer theory was developed during the 1990’s through the work of Judith Butler and Eve Kosofsky Sedgwick (Bettcher, 2014). The theory helps establish a form of self identification for those that do not subscribe to the traditional binary divisions between man and woman, male and female, and masculine and feminine (Bettcher, 2014). Historically, feminist perspectives surrounding trans issues were marked by hostility, however an evolution of theory and debate has seen the emergence of a productive interaction between feminist, queer and trans politics.

The concept of ‘transition’ represents a personal journey where one endeavours to alter their biological sex characteristics to become congruent with their internal experiences of gender (Johnson, 2013). The term ‘transgender’, developed to resist the
pathologisation of trans people, has been used to describe those who do not conform to prevailing expectations of socially constructed gender expectations (Bettcher, 2014). This can involve changing social gender role and living as one’s preferred gender. This process may include taking on stereotyped looks, roles and responsibilities, as well as physically changing ones anatomical sex characteristics through medical interventions such as hormonal therapies and varying surgical interventions. Transitioning can be a socially visible process, highlighting the perceived importance of ‘passing’ as the other gender. Psychological distress may occur in instances where this process of passing is problematic due to normative discourses constructing gender role transgression as inferior or in some cases, deviant (Johnson, 2013).

2.2 Psychological Impact of Prejudice

Many forms of prejudice involve people categorising others in ways that are contrary to their own self identity (Bettcher, 2014). Research has suggested that older white heterosexual males, who do not know sexual minority persons personally, are significantly more ‘homophobic’ in their attitudes towards homosexuals than any other ethnicity (Kite & Whitley, 1998; Logan, 1996; Van de Ven, 1996; Herek, 1994) due to sex role rigidity and expected gender conformity of males posed as much greater than in females. As the male gender role rigidity is perceived as greater, deviance is more defined (Hort, Fagot and Leinbach, 1990). Social constructionist ideas suggest that ‘prejudice’ is a flexible concept which incurs different meanings to different people at different times. A small number of researchers into prejudice have been informed by the ideas of queer theory in thinking of sexual and gender ideologies as heteronormative, proscribing heterosexual identities (Shaw et al., 2012).

Transphobia has been defined with research as an “emotional disgust towards individuals who do not conform to society’s gender expectations” (Hill, 2002), similar to established definitions of homophobia posed by Weinberg (1972). Sugano et al. (2006) later added “social discrimination and stigma of individuals who do not conform to traditional norms of sex and gender”. Transphobia surpasses homophobia to include fear of a continuum of gender expression including transgender men and women, transvestites, feminine men and masculine women (Nagoshi et al, 2008).

Reports have suggested transgender populations experience harassment at much higher levels than their LGB peers (McGuire et al, 2010). Often, their sexuality is questioned
as a result of their gender identity, despite many transgender individuals identifying as heterosexual (McGuire et al., 2010). A key assumption of the stigma model suggests that mental health difficulties and potential physical ill health follow from individual experiences of prejudice rather than any inherent pathology (Shaw et al., 2012). Family stressors including the fear of rejection and disapproval of their emerging identity, coupled with the social stigma surrounding lesbian, gay, bisexual and transgender (LGBT) orientation may perpetuate internalisation of homophobic and transphobic ideas (Marshal et al., 2011; Zubernis, 2008). This may lead to a negative impact on mental health and well-being (Williamson, 2000). Individuals may become socially isolated or begin to engage in ‘risk behaviours’ such as substance misuse, self-harm or suicide to escape the internal distress caused by rejection from society as a result of disclosing their identity (Zubernis, 2008). These risk factors can compromise the psychosocial well-being of the individual, leading to psychological and emotional distress (Marshall et al., 2011). It is due to these multiple stressors and the development of unhelpful coping strategies as a means of escape, which may put LGBT populations at greater risk of depression (Marshall et al., 2011; Zubernis, 2008; Morrow, 2004). Unhelpful coping mechanisms such as substance misuse may emerge in an attempt to manage stress (Wilson et al., 2002). The sustained invalidation of feelings and identity restricts LGBT population’s safe access to social support networks such as family and friends. In this case, LGBT youth are have few other choices than to attempt to manage their distress on their own, which can lead to unhelpful coping strategies.

2.3 The Role of Individual Psychosocial Support

Psychotherapeutic intervention has been suggested as beneficial to those who self-identify and transgender as a means of managing some of the co-occurring difficulties they may have alongside gender related distress. This may include feelings of low mood, anxiety, internalised guilt and shame and coping strategies for endured prejudice. This is irrespective of their consideration for surgical interventions (Riley, Wong & Sitharthan, 2011). Psychosocial support has historically been considered most useful for those who have been denied surgical interventions for gender related distress, however, in more recent years, consideration has been given to developing services appropriate for the continuum of experiences lived by the transgender community (Riley, Wong & Sitharthan, 2011).
Psychotherapy services have historically developed against a background of pathology for gender and sexual minority persons. Little has been evidenced to establish the effectiveness of psychotherapies for LGBT individuals (King et al., 2007). More recent ideas have suggested that affirming therapies and the normalisation of experiences had positive implications on people by enabling them to process and counteract their earlier negative developmental experiences (Riley, Wong & Sitharthan, 2011; King et al., 2007). The findings also indicate that individual therapy is largely a positive experience when the therapist engaged in the presenting issues of the client rather than instinctively assuming their gender or sexual identity was the cause of any distress (Riley, Wong & Sitharthan, 2011; King et al., 2007).

2.4 The current study: Exploring experiences of psychosocial support

A review of the current literature highlighted implications of gender related distress on mental health and well-being. Minimal literature has effectively detailed the processes of individual psychological support currently available or examined the utility of current systems of practice for transgender individuals. In consideration of the suggestion that psychotherapeutic services are developing in context to a continuum of transitional experience, (Riley, Wong & Sitharthan, 2011), the present study aims to explore the experiences of transgender individuals who sought one-to-one psychosocial support in context to changing their physical appearance to reflect their internal experience of gender. Specifically, the study draws on the literature suggesting the significant psychosocial impact social transitioning can have and therefore focuses on the experiences of those who have socially transitioned and are now living as permanently as their preferred gender. In this instance, all participants conceptualised their identity as female. Psychosocial support has been defined as a form of support or talking therapy provided on an individual basis with a counsellor, psychotherapist or psychologist, provided in the context of the person presenting as female. This includes NHS or non NHS services. Participants were not recruited on the basis of their experiences of support groups or peer support alone.

The goal is to inform psychological approaches to working with the transgender population and to have a better understanding of the psychological impact this process has on individual experiences of self. The focus of the study is to inform psychological practice in the earlier stages of transitioning, prior to surgical interventions being
sought. The objectives of the current study aim to address the following research questions:

- What psychosocial experiences lead to the participants seeking of individual psychological support?
- How has one-to-one psychosocial support proved helpful and/or unhelpful for those individuals in relation to mental health and psychosocial well-being in the context of presenting as female prior to surgical interventions?
- What impact did the involvement of one-to-one psychosocial support have for the participants of this study as they began living as their preferred gender?
3. Method

3.1 Researchers Position

The present study was approached from a critical realist position. A detailed description of the author’s position can be found in Appendix E.

3.1 Design

A recent systematic review of the literature found no published research on the experiences of one-to-one psychosocial support during gender realignment (Callan et al., 2014). Due to the lack of established theory, an exploratory qualitative approach into the experiences of individual psychosocial support is suggested. This method of inquiry was also consistent with concerns of established and clinically valid quantitative report measures, and concerns of reaching appropriate sample sizes for the transgender population (Callan et al., 2014). A flow diagram of the research process can be found in Appendix G.

3.2 Ethics

Ethical proposal was considered by Derbyshire Research Ethical Committee, and a favourable opinion was granted in February 2013 (Appendix F). Approval by Research Governance was obtained from the sponsor (Leicestershire Partnership Trust).

An amendment to Derbyshire Research Ethics Committee was made in August 2013 to expand the inclusion criteria of participants to those who have not yet undergone genital surgery, but who have socially transitioned and are living full time as their preferred gender. The amendment was granted favourable by the committee in August 2013 (Appendix G).

3.3 Selection of Methodology

An ability to encapsulate and acknowledge the uniqueness of the subject matter, and an ability to be sensitive to process was felt central to the methodology chosen. The methodology was chosen to reflect the existentialist view of the self in an evolving state of ‘becoming’ (Smith et al, 2009). A methodology which could offer a reflection on such processes felt fitting to the exploration of identity formation intrinsic to the posed research question. The specific phenomenon under investigation in the study was the
participants lived experiences of one-to-one psychosocial support provided in the context of them presenting as female. The methodology was also recognised as compatible with the researcher’s epistemological position. Critical realism understands there are stable and enduring features of reality that exist independently of human conceptualisation (Fade, 2004). Recognised differences in the meanings individuals attach to their experiences are considered possible because they experience different parts of reality (Fade, 2004). Through the social cognition paradigm is founded on the hypothesis that human speech and behaviour reflect these differences in meaning either directly or indirectly. Analysis of interview data is considered to be a reasonable method of accessing and developing an understanding of these differences (Fade, 2004).

Grounded Theory (Glaser and Strauss, 1967) offered the potential as an established method of systematically approaching the analysis. This ultimately could have lead to the development of a theoretical account of the experience. The fundamental limitation to this approach was felt to be the absence of acknowledgement for the individuality of experience which arguably constitutes significant importance in the study of relatively rare social occurring phenomenon.

Examination of the existing literature has suggested that accessibility to sufficient quantities of data for such an approach may be problematic. The research questions ask about the construction and function of experience, therefore narrative, discursive or methods focusing on theory development are not appropriate as the conflict with the nature of the research questions posed for this study.

3.3.1 Development of interview schedule

The interview schedule (Appendix H) was devised in consultation with existing researchers and clinicians. By drawing on the expertise of experienced people within the area, the researcher aimed to increase the validity of the data collected in the interviews to ensure that both a breadth and depth of information could be collected. The structure of the questions was designed to allow participants space to reflect on their life as a whole and discuss meaningful experiences to them which may not have been encapsulated through specific questioning. The interview began with participants being asked about their lives growing up to add context to the narratives as well as introduce the participants to the interview process. Participants were then asked about their more
specific areas of their experiences of support services. Non-directive or leading prompts were used to encourage participants to expand on points of interest. At the end of the interview the participants were asked if they had any further points that they would like to share that had not been covered by the researcher’s questions.

For the purposes of the study, a semi-structured interview format was considered most appropriate. This allows for a rich account of data (Smith, 2008) and allows the participant space to explore their experiences in a way that is meaningful to them and avoids closed questions leading to restricted answers. The researcher was able to gain a depth of understanding to the participants reflections of their experiences and also pursue specific lines of inquiry they may feel beneficial to the research study. By using this semi-structure, the author was able to allow the participant to construct their own narrative of experience by beginning with more open ended questions contextualising the participant’s narrative whilst offering them opportunity to explore specific areas at a more analytical level should they so wish. This structure was felt to facilitate a comfortable introduction and interaction to the interview process, with opportunity for more detailed analysis as it progressed (Smith et al, 2009).

3.4 Procedure

3.4.1 Recruitment

Voluntary sector agencies and support services such as UK transgender support groups and LGBT services were initially contacted by email by the author to discuss the possibility of supporting with recruitment. These services were identified from previous consultation with the transgender community, as well as online searches for social and support groups. The specific names of these organisations are not detailed as to protect the confidentiality of the participants. Where the agencies were able to offer assistance with recruitment, initial study information (Appendix I) was forwarded to the agency for dissemination to prospective participants. The support organisations highlighted the opportunity to potential participants to take part in the study using their existing mailing lists, notice boards and online forums. Potential participants for the study responded to advertising for the study by email. Participants wishing to be part of the study were then sent further detailed information about the specific requirements of participation (Appendix J). Appointments were made with the participants via email correspondence. At the arranged appointment the researcher provided a written consent form for the
participant to sign (Appendix K). This recruitment procedure was initially started following first ethical approval in February 2013. Due to limited number of recruited participants, the inclusion criteria were widened in August 2013 to include those who had not specifically undergone surgical intervention. The same procedure was repeated with the same organisations, highlighting the change from the original criteria. In addition to the participant information, snowballing techniques were used inviting prospective participants to consider if they knew anyone else who may be willing to participate.

3.4.2 Interview Process

All interviews were conducted by the author at locations identified by the participants as accessible and suitable. This included community centres, LGBT centres and transgender community services. Each interview lasted for approximately 60 minutes and was audio recorded. Upon meeting the researcher introduced herself and her role within the research process. Participants were asked to read the participant information sheet and the researcher provided any relevant clarification. Following this, the participant was asked to sign the written consent form. At this point audio recording began with the first question of the schedule. Following the completion of the interview, participants were thanked for their time and encouraged to contact the researcher if they had any further questions regarding the use of data.

3.5 Sample

Six participants were recruited for the study. This was considered enough to establish the core elements of experience across the narratives. This was also supported by the recommendations of Smith et al. (2009). The participants were healthy volunteers recruited through charities and voluntary sector agencies.

The author acknowledged the potential heterogeneity of the client group under investigation and that the participants were all at varying stages of their transition. For the purposes of the study, there was a reliance on participant self-identification to prescript social and diagnostic labels around gender identity. In order to ensure suitable homogeneity for the analysis, the research sample inclusion criteria required participants who
• Were UK citizens born biologically males and are now living as females.
• All participants identified themselves as women and were undergoing gender transitioning in UK services.
• All received 1:1 talking therapy with a UK registered therapist
• All participants had legally changed their gender to female and were receiving hormonal therapy in a UK gender service.

The initial proposal for the study recommended participants must have undergone genital surgery. Due to limitations in recruitment availability under the initial proposal, and the practicalities of completing the project, the recruitment inclusion criteria were widened in February 2013 to include those who had not undergone surgical intervention. Due to the phenomena under investigation being the experiences of therapy in the context of presenting as female, specifically prior to any surgical intervention, this widening of criteria was not felt to compromise the validity of the analysis or the homogeneity of the sample. All participants were reflecting on experiences they had undergone prior to consideration or implementation of surgical procedures. The researcher acknowledges a period of immediate physical and psychological adjustment following surgical procedures; therefore participants who had received surgery were both a minimum of twelve months post-surgery. The final sample comprised of two women who had undergone genital surgery in the UK, two women who were due to receive surgery within a twelve month period, and two women who would be considering surgery within a twelve to eighteen month period.

All participants have sought and received some form of one-to-one psychosocial support during the process of their gender transition. The sample was recruited on the basis that they have all received 1:1 talking therapy with a counsellor, psychotherapist or psychologist within the UK, in context to their experiences of gender. The phenomenon under investigation for the study is the experience of one-to-one psychological or counselling support in context to presenting as female. The focus of the study was the lived experiences of this support prior to surgical specific interventions. All of the participants had had this experience.

The definition of psychosocial support was defined in this way and remained static throughout the recruitment. However, when interviewing, some participants discussed
the role of other support such as the trans community and support groups. This was in addition to their one-to-one experiences.

Existing literature researching this minority population has primarily recruited white Caucasian male-to-female participants for data analysis. The sexuality of the client group, whilst a recognised variable, is considered by the researcher as a fluid concept dependent on individual differences and personal identification (Markowe, 2002). This variable is thus considered too complicated to control for within the study due to its natural fluctuations for many people over time. It again may prove too restrictive for an existing minority sample. In collecting the sample demographic information, all six participants identified as heterosexual women. Those with atypical features relating to their biological sex or gender identity were not included within the study for example, intersex conditions.

A summary of the self-reported demographical information provided by the participants is detailed in Table 1. This information is offered in summary form only to protect the anonymity of the participants.
### Table 1. Participant Demographic Information

<table>
<thead>
<tr>
<th>Demographical Information</th>
<th>Number of Participants</th>
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<tr>
<td><strong>Age</strong></td>
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<td>30-39</td>
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<tr>
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<td>White Other</td>
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<tr>
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<tr>
<td>In a Relationship (As Female)</td>
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<tr>
<td>Divorced</td>
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<tr>
<td><strong>Number of Children</strong></td>
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<td>3</td>
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<td>1</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Duration of one-to-one psychosocial support</strong></td>
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</tr>
<tr>
<td>1-6 (one hour) sessions</td>
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</tr>
<tr>
<td>7-12</td>
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<tr>
<td>13-18</td>
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<td>18+</td>
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<td><strong>Professional Involvement (in context to presenting as female)</strong></td>
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<td><strong>Additional therapy accessed</strong></td>
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<td>Psychologist</td>
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</tr>
<tr>
<td>Psychotherapist</td>
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</table>
3.7 Data Analysis

3.7.1 Transcription

Consistent with the recommendations of IPA methodology, the researcher transcribed all six interviews verbatim. Within this included a note of semantic interactions such as pauses, sighs and laughter to contextualise the verbal communication. The researcher used the transcription process as opportunity to become immersed in the data and begin the process of becoming familiar with the material.

3.7.2 The Interpretive Process

The initial stages of the analysis allowed the author to become immersed in the data. This was achieved through reading and re-reading the transcripts and listening to the original audio recordings to begin to develop a sense of each participant’s individuality. The aim of the process was to become immersed in the psychological experience of the participants, not to quantify or prioritise aspects of their narrative. Instinctive recollections, thoughts and feelings in relation to the narratives were noted separately at this stage of analysis.

Following this initial stage, the author engaged in a process of initial noting on the transcript (Appendix L). This process is designed to examine the semantic content of the language on an initially very exploratory level. Whilst continuing a growing familiarity with the transcripts, it offers the opportunity to note specific ways in which the participant talks about an issue, as well as how they might think and understand that issue (Smith et al, 2009). Whilst endeavouring to stay close to the participants explicit meanings, the author made initial descriptive notes focussing on the content of what the participant said; linguistic comments, which explored the specific use of language used; and conceptual comments which engaged with the data on a more conceptual level. Through this process, the author became aware of instances of similarities and differences, echoes, amplifications and contradictions within the content of the participants narrative (Smith et al, 2009).

Through the use of this exploratory commenting, the next stage of the analysis was to develop the emergent themes (Appendix M). At this stage, the author endeavoured to reduce the volume of detail whilst maintaining the complexity of the data. This began a
process of mapping the interrelations, connections and patterns within the original notes (Smith et al, 2009). The primary aim of this process is for the emergent themes to begin a reflection of understanding about what was said by each participant and the meanings they communicated about their experiences.

The later stages of analysis involved the clustering of themes into super-ordinate categories. This was viewed as a dynamic process by which the author continued to reflect on the data to enrich the interpretations she made. Through this process, the author made preliminary links and connections between issues and concepts apparent within the data. Throughout the process, the author aimed to be aware of the verbal responses of the participant, but also how and why they spoke about the content of the interview. By this, a more meaningful interpretation of phenomenological experience could be obtained.

3.7.3 Quality Checks

The quality assessment of qualitative research can be assessed by four broad principles put forward by Yardley (2000). The author considered these principles to be helpful when considering the research data due to their complementary relationship with IPA. An avoidance of simplistic and prescriptive procedures enables the principles to reflect the subtleties in the interpretive process (Smith et al, 2009). The author endeavoured to adhere to the following principles:

Sensitivity to context: mindfully conducting the analysis with acknowledgement for existing literature and research in the area, the researcher’s personal and professional approach to the material, and the context in which participants accounted their experiences.

Commitment and rigour: the author was committed to the research and the analysis, in that ethically she believed the data should be examined with care and due attention paid to the meanings inferred by those who had taken part. Supervision was sought at each stage, in order to support and enrich this process.

Transparency and coherence: the researcher has attempted to carefully describe each stage of the study, in terms of rationale for what occurred and how it was executed.
**Impact and importance:** in the context of little existing research literature, the study was considered to be of practical utility, making a valuable contribution to a developing area of knowledge.

In addition to this, transcripts were independently analysed by the researcher’s field supervisor in order to establish a greater sense of validity in the reported themes. This was considered particularly important as due to time constraints, individual respondent validation was not possible at this stage of the research project. Other modes of validation were sought through conversation and consultation with published researchers within the subject area. In consideration for any future publishing of the data, individual respondent validation will be sought prior to publicising the results, in order to verify the validity of the data further.
4. Results and Analysis

The following section provides a narrative account of the findings of the analysis. The findings represent a detailed analysis of the interpretations made of the data. These interpretations are then illustrated using extracts from the transcripts. For the purposes of confidentiality, participants have been identified using a pseudonym. Any identifiable details have been omitted from the extract and appear as (deleted) within the extract. The extracts are referenced by line number to the original transcript. The accounts of the participants are structured by the super-ordinate themes which were supported in the data.

4.1 Evidencing Themes

4.1.2 Psychological Experiences of Self

It was important for the participants to feel able to retell their experiences in their own words. By facilitating this, the participants were able to contextualise their experiences of individual support, enhancing the depth of understanding which led to them engaging with it. This was important in allowing them to reflect on helpful experiences of individual support in a wider context, which may not have been encapsulated through more structured questioning.

*Something Different*

Most participants reported feeling or knowing there was ‘something different’ about their internal experiences of gender compared to how they perceived others experienced it. Across all stories, the physical placing of this description within the narrative was indicative of the importance this construct had for the participants in understanding their inner experiences of self. This description was found at the beginning of all the stories, which took place at the start of all the interviews. For five participants, this corresponded to early childhood recollections of their lives growing up and experiences of gender:

“...growing up I had to be one of the boys but, you know, I didn’t know, I wasn’t sure what is was but I knew there was something different about me” (Christine, 6-8).
The use of ‘had’ and ‘those’ suggests that what Christine did know was that it was ‘not me’ that she was expected to ‘be’, although at the time, as a child, she didn’t know what was different about her experience. Within this narrative of ‘something different’ was a construction that there was something ‘wrong’ with how the participants experienced their gender:

“I knew there was something wrong with my gender about three or four years old...cuz I always wanted to dress as a girl” (Mary-Jane, 24-26).

The construction of something ‘wrong’ with the participants’ inner experiences of gender was linked to the description of ‘internal pressure’ they described experiencing. The two illustrations were interpreted as descriptions of internal experiences of self. The ‘self’ can also be discerned through the ownership Mary-Jane suggests by ‘my gender’ and ‘me’. Descriptions of ‘internal pressure’ readily followed descriptions of ‘something different’ within the stories.

**Pressure**

Five participants spoke of an increasing sense of ‘pressure’ as their understanding of ‘something different’ increased. This pressure was constructed as the result of something intrinsic to the participants, and that they were responsible for putting that pressure on themselves:

“So imagine most of it is like an internal pressure that I put on myself.” (Joanne, 55-56).

In her account, Anna illustrates how the culmination of feeling like ‘the odd one out’ and an increasing sense of pressure ultimately lead to her taking time from work. Being overwhelmed by the feelings she experienced, illustrated through her use of ‘meltdown’, Anna described the emotional impact that this pressure had on her:

“The pressure from that, the pressure from burning the candle at both ends, being unhappy, never having relationships, I always felt like the odd one out, had a bit of a meltdown and had to take three weeks off work.” (Anna, 136-140).

A developing sense of pressure was described frequently across all six stories indicative of the strong emotional impact this feeling had on the participants and a central feature in understanding their psychological experiences.
Moral Self

Three participants retold of growing up in strict Roman Catholic families. In this context, religion and morality were closely linked, and served to function as a method of restricting the expression of participant’s experiences of gender. Christine describes her mother’s reaction to discovering she had made an item of female clothing as a child:

“She told me I was the devil’s child and god was watching me” (Christine, 18-19).

This suggestion of ‘being watched’ was linked to the participant’s sense of pressure that the participants described and how this went on to impact on their emotional experience. Joanne described the emotional impact of managing her internal narrative that she was ‘evil’:

“Sorry I’m going to start crying in a minute (pause)... I just kept telling myself it was really bad, it was really evil, although I may think that I am thing, I always knew I was, at the same time trying to solve, telling myself, you know it is bad.” (Joanne, 66-72).

The dichotomy between right and wrong, good and bad was as a struggle was described explicitly by Joanne throughout her narrative. During the interview process with Joanne, at point where she became upset, her posture and demeanour became more closed, and she also withdrew her eye contact. Her experiences of ‘trying to solve’ were linked to the participant’s descriptions of their internal experiences of gender being constructed as problematic. This is discussed further later in the analysis.

Joanne’s use of ‘evil’ to describe a social perception of herself parallels with the descriptions of those who discussed religion. This may evidence the perceived link with one’s inner experiences and a social undesirability that must remain hidden. This parallel was further evidenced by Mary-Jane’s narrative of a possible social perversity that should not be expressed. Central to her account was the implication of sex offending being an assumed part of transgender experience:
“...all the books, the serious ones, said that all the people that did this were deviants or... maybe they maybe even paedophiles or sex offender and it was all very very negative so again you tended to suppress it.” (Mary-Jane, 106-109).

Mary-Jane’s accounts illustrates a need to ‘suppress’ her experiences which constructs a sense of shame around them. Through this suppression, Mary-Jane enters into a social performance whereby her she is expected to conform to normative gender ideology.

4.1.3 Performing Self

Performance was described in relation adhering to an expected social gender role. This was illustrated most strongly through engagement in intimate relationships. A process of self-acceptance was reported by participants as an initial stage in acknowledging and affirming their internal experiences of gender. They describe how communicating their experiences with others had led to both positive and negative experiences, all of which impacted on their emotional experience of themselves.

*Relationships*

Forming relationships with females in an attempt to manage social expectations and assert an identity was mentioned by five participants. Having a relationship with a female partner was constructed by the participants as what they felt they were ‘supposed to do’. Anna describes her attempts at engaging in a heterosexual relationship as a means of establishing her identity. Her use of ‘it might be that I’m making it all up’ was reflective of the internal experiences of the self, suggesting a continuing experience of ‘becoming’:

“I was so desperate not to be trans you know, cuz I’d tried to be gay you know and that's not working so I thought I’d try to be straight cuz it might just be that I’m making it all up in my head about being trans and this might be the thing that is gonna knock me into shape. So I ended up going out with this girl.” (Anna, 279-284).

Anna’s use of ‘knock me into shape’ was linked to the expression of the moral self and the expectation of the participants to regulate their internal experiences. Mary-Jane told of expectation put on her by others to have a relationship and family, as a means of being the *answer* to her feelings of being transgender:
“I was told your answer was to get married, have a family and this will all go away. Oh and by the way, if you do find someone to marry, don’t tell them because once you’ve got married it’ll go and it might put them off, so...no need to worry about telling them. Course, when you get married it’s exactly the opposite (laughs)” (Mary-Jane, 110-116).

The characterisation of marriage as an ‘answer’ constructed the participant’s internal experiences of gender as a problem to be solved. Although it was not clarified with Mary-Jane the use of the words ‘your answer’ may serve to reinforce the notion that Mary-Jane’s internal experiences of gender are problematic, and also her problem. This was linked to earlier thoughts of participants having to manage a sense of internal pressure and the responsibility of containing their internal experiences of gender. Christine described the emotional impact of continuing with what she felt she was ‘supposed to do’:

“...it was difficult and I just sort of carried on and carried on and um, and eventually I sort of followed the line that you’re supposed to and found a girl and got married. And that doesn’t help. Because now you’re in a house full of clothes. It’s really, stressful you know.” (Christine, 25-29).

Conforming to social expectations was a powerful theme through all the narratives. This was predominantly discussed with the expectation being with the participant. However, Mary-Jane describes a sense of performance in which both her and her wife ‘played’ to their expected roles. Central to her account is the inference that this could not be sustained indefinitely. This is best illustrated by her use of ‘for a while’:

“It was a game we played for a while” (Mary-Jane, 167).

Being Accepted

Throughout the data there was a strong sense of value attached to the need for the acceptance of others. The frequency of its appraisal within the narratives indicated its importance in shaping participant’s emotional experience and sense of self. Acceptance was discussed predominantly through absence of intolerance, prejudice and abuse. Consistent to these accounts was the indication that men were seemingly less accepting than women. This was reflected in both social and professional contexts.
Acceptance of internal experiences of gender being different from physical sex was viewed as positive for five participants. Rosa’s account illustrated an ongoing internal conflict of trying to conform to her male self. The consequences of this had significant implications on Rosa’s emotional well-being:

“I felt depressed over a long period of time. But when I finally gave up fighting against trying to be male and all that right, it was a lot better” (Rosa, 78-80).

Reflection on the process leading up to a sense of acceptance for their experienced gender, Christine recalls a feeling of ‘living a lie’. Christine described the impact of her own self-acceptance and how this initially caused her further emotional distress:

“And I began to realise, I was, I, I, I was living a lie. I was living a lie and I couldn’t, it got harder and harder. You know, we have this saying in the transgender community, once you let the person out of the box it’s very difficult to put her back in again. And, I didn’t want her to go back in. And every time I went somewhere and had to get changed to go home I was distraught.” (Christine, 40-45).

Paradoxical to Christine, Joanne’s account illustrates an internal struggle and resistance to align herself with the transgender community. However, both women’s accounts illustrate an underlying struggle with managing their internal experiences of gender:

“But like in the past I’ve always been reluctant to, I really hated being around other transgender people, I hated other transgender people, cuz I saw them and thought it meant something quite horrific, and that’s what I really didn’t like” (Joanne, 40-43).

Joanne’s use of ‘been reluctant’ followed by ‘really hated’ demonstrated an escalation in emotion for what she was describing as her narrative continued to unfold. Joanne’s emotional connection with the retelling of her story in some way amplified her intensity of feeling as she continued to talk. The intensity of her emotional language through terms such as ‘hated’ and ‘horrific’ interpreted as very powerful in illustrating the intensity of the feelings resonating with Joanne. This escalation in emotion was linked back to the theme of pressure and how this developing sense of having to tolerate difficult internal experiences impacted on the women’s psychological and emotional well-being. These feelings of hatred may represent an internalised perception of herself
that Joanne feared others may think of her if she was to align herself with this socially marginalised community. Evident throughout Joanne’s story is her struggle to understand her experiences and construct a narrative around it to explain it:

“I’ve realised what, what I am, I don’t know, I still can’t explain what it is I am cuz I don’t know” (Joanne, 38-39).

“If I had to meet myself as well, I’d probably be frightened of myself (pause) cuz I don’t like it.” (Joanne, 163-164).

The evident muddling of tenses throughout Joanne’s story seems to confirm that at times, Joanne has felt at times she has been able to make sense of her experiences; but that this is something that she maybe feels she has lost at the present time. This mixing represents a fundamental core of Joanne’s dichotomy between her psychological experiences and social expectations, as her sense of internal experience of identity has been ravaged by her experiences of social expectation. It further highlights the role of acceptance as a process. Anna was the only other participant to describe a sense of struggle with accepting her internal experiences of gender:

“I'm about as stable as I can be and there's still a part of me, oh god, it sounds terrible but there's still a part of me that wishes they would tell me something different, but they won’t, they won’t.” (Anna, 433-436).

Anna’s choice of language in describing her experiences suggests a lack of absolutes. It reflects the fluidity in her experiences which have been and may be subject again to future change. This sense of fluidity represented something important for Anna and integral to her understanding of her experiences, evidenced by ‘stable as I can be’. This infers an idea of a fluctuating acceptance process rather than a compartmentalised experience.

Oppositional relationships were identified within Joanne’s narrative illustrating some contradictory feelings relating to the process of acceptance by others. Whilst a need for social acceptance was sought by all of the participants, Joanne’s account describes uncomfortable feelings at receiving positive social acceptance. This conflict was not noted in any of the other participant’s stories:
“They're really good, they're wonderful, and they're really good with me. They kinda accept me for who I am but they, they don’t think it’s odd, they accept, I think maybe the generation nowadays, maybe they just treat people different now I don’t know. Maybe it’s just I’ve bought my children up to be lovely, but they're just really sweet, they accept it completely, they might not like it, but they accept it.” (Joanne, 90-96).

“No one has taught me how to be something you’re not, and accept the fact someone is being nice to you as well. I really didn’t know how to deal with it so I felt really awkward and really strange” (Joanne, 232-234).

**Total Intolerance**

Lack of social acceptance was characterised by the presence of abusive behaviours and prejudice by half of the participants, however the expectation that these behaviours will feature in the future narratives of these women was described by all six. The power of this theme was noted in the repetitive use of ‘I’ by Rosa, conveying a strong sense of personal attack:

“I get verbal abuse by the hour as soon as I'm outside my own home. And I get other types of abuse as well every day. Um, I get threats of violence at least daily, sometimes more times. All sorts of other things. Total intolerance.” (Rosa, 277-280).

Consistent to four of the stories was the belief that women were more tolerant towards the participants than men. This was described in both social contexts, and in the context of healthcare professionals, which impacted on their choice of GP which they saw to first discuss their experiences. In this description, Rosa illustrates the emerging gender bias in social acceptance. She describes how the presence of females can disperse the extent of abusive behaviours she is subjected to; however, her description is also indicative of female perpetrators:

“I have noticed, that usually the people that cause me grief, err, typically is a group of men usually in their mid twenties, and there's usually around two three four of them. Err, yeah, that's a usual typical situation. If there was one female in the group it’d be less of a problem, if they're only women it's less of a problem.” (Rosa, 309-313).
All six of the women constructed a narrative around social acceptance in relation to ‘passing’. Suggested by her use of repetition, this account by Christine illustrated the importance attached to ‘passing’. Constructed within this narrative through use of ‘too quickly’ is the inference that passing is not a static event that once achieved is completed.

“It’s all about passing really. It’s all about passing, not outing yourself too quickly“ (Christine, 446-447).

4.1.4 A need for support

The perceived need for individual psychosocial support was contextualised by the participants in relation to other temporal life events. The need for emotional support was constructed through the narratives by describing the impact of gender realignment on the psychological experiences of the women. The construction of ‘the dark place’ was illustrated through all narratives. This was abstracted alongside a theme of ‘unlocking an emotional experience’ and the beginning of a processing of the ‘internal experiences of self’.

The Dark Place

The constructed narrative of the ‘dark place’ was explicitly used by two of the participants; however a narrative of distressing psychological experiences in relation to gender transitioning was described as a core experience for five of the participants:

“The dark place by the way is what every transsexual, as soon as you say it, knows. Now, I don’t know if you’ve heard about this or whatever, this dark place, mentally. It’s blacker than black” (Paula, 494-497).

Descriptions of the emerging narrative surrounding the dark place were evident earlier in Paula’s story. The frequency of her description and detail in her story was indicative of the physical and emotional impact this period of time had on her:

“...they are some of the most dark days to get over and you're in a hell of a lot of pain” (Paula, 378-380).

“You're just running on pure despair, emotional despair, and it’s frightening.” (Paula, 510-511).
These descriptions were linked back to the previous ideas the women made when noticing ‘something different’ about their internal experiences of gender and the impact this had on their emotional experiences. The description of ‘running on pure despair’ illustrated the expectation of the participants in continuing with their lives with limited resources, despite their internal emotional distress. This was linked to the ‘internal pressure’ described earlier by the women and the expectation that they will tolerate their psychological distress alone.

Unlocking an emotional experience

A sense of threat was described in several of the participant’s stories with regard to their emotional experiences within individual support services. This was particularly strong with reference to therapeutic services accessed through mainstream NHS gender services. Five participants described support services as ‘gatekeepers’ to their required ‘care’. The frequency of this theme was indicative of the emotional resonance it had with the women:

“I’ve said it to them to their faces, people are frightened to death that you’re gonna take something off them if they say something wrong. We want to tell you what you want to hear” (Paula, 290-292).

“...if I tell you too much you're going to withdraw all the care from me. So the person who is meant to be there to help you the most, the person that says they are there to help you through it, and says they're working in partnership with you, you know they're not” (Joanne, 670-674).

Hiding emotional experiences were related back to the theme of performance and how a need to tolerate discomfort for fear of rejection was reminiscent of historical expectation on the women. A perceived mistrust of others was also related back to the theme of ‘total intolerance’ whereby participants fearing abusive or rejecting behaviours from society was mirrored in their fear to disclose their actual emotional experiences in a supposedly therapeutic setting.

Constructed within the narratives was a process of ‘unpacking’ the psychological experiences of the participants. Linked to this were the ideas of validation of internal experiences and how this process of validation through individual support mirrored that of the processes of ‘acceptance’ for previously described by the participants. Reflected
in her account, Joanne describes a sense of previous compartmentalisation of her identity experience which had been ‘packed away’. Joanne describes the process by which she began this process with her counsellor:

“And like, explaining it and going through it with him was a really weird situation, and I my experience was like, um, like I’d packed loads of boxes up, in my head, and they're like stored away somewhere like in an attic in my mind and he like kind of let me, while I was transitioning, cuz I was talking to my mum at about the same time I think, I was unpacking it, it felt like I was unpacking all these boxes that I had packed away years and years ago and it was really nice as I was beginning to unpack them.” (Joanne, 249-256).

Previous themes of performance by expectation of tolerating internal experiences of distress were further described by Paula. She describes how a perceived expectation to manage her internal experiences on her own has impacted on her ability to communicate how she feels. These ideas were linked to previous ideas of anticipated rejection by others:

“...I've dealt with this on my own now for so long that when my fiancé sees me like that he doesn’t know what to do, and I just will not, I'm just starting to learn now to go into his arms and be hugged and this that and the other, but it has taken a long time” (Paula, 255.258).

Unlocking an emotional experience highlighted the emotional impact of the process of making sense of the participant’s internal experiences. The psychological impact of the ‘dark place’ was thematic across all narratives. Here, Paula succinctly illustrates the emotional impact of and the perceived need for emotional support:

“I'm here to be put right, cuz I'm damaged” (Paula, 117-118).

4.1.5 Individual Therapeutic Support Services

Five Participants spoke of experiences of accepting individual therapeutic support as part of their experiences of transitioning. These narratives were constructed around experiences of helpful attributes within the therapeutic relationship and difficulties experienced as part of engaging with services.
Prepared to listen

Being ‘prepared to listen’ facilitated a positive experience of individual support evidenced to across all six interviews. It’s simple but detailed description within each narrative reflected the importance participants placed on having a space where they could ‘unpack’ their emotional experiences and feel listened to. Mary-Jane describes the significance of listening in this therapeutic process. Her use of ‘just listen’ is central to her account in illustrating the simplicity of the most effective tool when providing emotional support:

“And I learnt a long long time ago that listening is a very powerful therapy, if you’re just prepared to listen to people, you know, just the occasional ‘mmm’ and ‘yes’ and ‘I understand’, ‘oh yes we’ve seen that before’, is what people want...” (Mary-Jane, 774-778).

Validation of emotional experience was eminent throughout four narratives as valuable. Through this validation, a process of ‘normalisation’ allowed the participants to access ‘human’ responses to emotionally challenging times in their lives, and not have their distress pathologised against the backdrop of their assumed experiences of gender. In her account, Joanne described her needs of support from her counsellor. Her account was allied with the constructs of the ‘dark place’. Her sense of ‘void’ was reflective of emotional experiences ‘locked away’ which she had described struggling to access:

“All I want from the person who sits opposite me is to try and help me through this quagmire or black darkness or whatever it is, this void, I think it’s more like a void.” (Joanne, 761-764).

Positive experiences of counselling were also linked to the theme of being accepted. In this instance, Joanne describes an interaction with her counsellors in which she did not feel judged. Highlighted here is the effectiveness of perceived acceptance of her therapists, combined with a willingness to listen, in facilitating a positive connection enabling Joanne to begin the process of ‘unpacking’ her psychological experiences:

“...they just didn’t judge me, asked really simple questions, shut up most of the time, when I needed prompting he prompted me but never ever judged me and wanted to hear. He really gave me the impression that he wanted to hear.” (Joanne, 335-338).
Fear of being honest about their emotional experiences was illustrated in three of the participant’s narratives. In overcoming her anxiety about discussing her experiences, Paula described how beneficial she found honest communication in facilitating her emotional support. Focal to her story was the perceived sense of flexibility this gave her within a structured support service:

“And unfortunately, they've got to work within certain guidelines and if you don’t fit into those guidelines, you don’t get nowhere. But if you have the nonce to actually say, like I was saying, then they've got some kind of room to manoeuvre on them rigid rules, and that's what I was giving them. Even though I couldn't meet none of them rigid rules, we could manoeuvre.” (Paula, 192-198).

Concern that existing individual support services such as counselling and individual therapy relied heavily on ‘guidelines’ and that a more fluid approach to the contextual experiences of the individual led to a positive experience of therapy, were explicitly discussed in half the narratives. Paula’s ability to communicate her emotional experiences described a process of validation and acceptance which facilitated a ‘manoeuvring’ on prescriptive packages of care. Therapeutic support led by the individual needs of the participant was conducive to positive experiences of support.

*External validation of internal experience*

Managing the assumption of professionals, that the participant’s external self was validation of their psychological experiences was described by most participants. Christine explains how her physical appearance was taken as validation of her internal experience. Central to her account was the assumption that her physical appearance and demeanour within appointments was somehow indicative of her internal experiences of the process. Christine wonders if there was something about how she ‘came across’ which suggests her psychological and social experiences were aligned:

“I showed her some paperwork I had like a copy of my passport and stuff and she just said yeah ok, thanks for coming and they'll get me another appointment with a psychiatrist. Now, she had no idea what I was thinking inside. I don’t know if there was something about how I came across to her and she thought yeah you are, but they don’t treat everybody in the same way. Or the right way you know” (Christine, 573-579).
Christine experiences being validated in a way that she states that others aren’t – that she has been accepted by the gender service and passed through a hurdle. It is physical ‘passing’ and congruence to an unknown ideal that has been validated.

Participants described an assumption by healthcare professionals that their distress was inherent to their gendered self, and therefore providing individual psychosocial support required specialist skills or training. In the context of the therapeutic relationship, this assumption stifled therapists’ empathy, curiosity and understanding. This is illustrated in Joanne’s description of her counselling where she had to ‘get used to’ her counsellor and tolerate these difficulties before she was able to feel she could be helped by him:

“...a counsellor I had recently, it took me an awfully long time to get used to him, because the starting point was, ‘I don’t know if I can counsel you because I don’t have any experience in this area’, and throughout my whole time of being transitioned I’ve had that time and time again with GPs or whoever, in the health service they’ve always said, it’s a specialist area, I can’t help you. It’s like...It’s like ‘fuck off’. Of course you can help me. And you think I know about what’s happening in my mind? You think I can help myself? You think I, by the way this is all new to me as well! It’s not just new to you or difficult for you, by the way, it’s difficult for me as well!” (Joanne, 316-329).

This is a core experience of the women interviewed, evidenced by reference in all of the narratives. This demonstrated how much the women had to know about themselves and their experiences, trust in others, as well as their ability to tolerate their feelings and the discomfort and inexperience of health professionals to receive support.

Joanne described how the assumptions of her counsellor caused further emotional impact. Central to her account, Joanne went to describe that the need for specialist training of the therapist was unnecessary; that she wanted help ‘being me’:

“So, at counselling, I had to say to him um, ok, you don’t know anything about transitioning, I actually don’t want you to help me out with transitioning, I can help myself. I can see who I need to see, I just want you to help me deal with being me. I want you to help me deal with being this person, being stressed at work and what I'm doing to myself, just help me in the way you would help anyone else.” (Joanne, 329-335).
There was a strong sense across the accounts that to provide support to the participants required specialist knowledge in some way. This leads to a sense of frustration for Joanne whereby she is conflicted whether to pursue with the therapeutic relationship. Although not clarified with Joanne at the time of the interview, Joanne’s perceived need to explicitly tell her counsellor her needs for support, was reflective of a pervasive sense of being objectified by her diagnosis, and her need to move away from this, to be viewed as a person. Her description of being ‘stressed at work’ functions to construct her distress as the same ‘anyone else’ that may come into therapy. By conveying a sense of ‘ordinariness’ in her experiences, Joanne was able to set aside the assumptions of her therapist and allow the therapeutic relationship to continue. This was linked to the willingness of support services to ‘listen’ to the needs of the participants when providing support.

4.1.6 Contextual Factors in support

Access to support and Information

Mary-Jane described the problems in accessing information around individual support services available to the transgender community. She described how she felt that often, the problems related to GPs not knowing what services were available, but also feeling at times that professionals were purposefully obstructive in providing access:

“I think one of the most difficult things is a, people finding their way into counselling, so quite often the GPs are either unsure or are obstructive or in some cases just won’t treat people.” (Mary-Jane, 654-656).

Descriptions of obstruction were illustrated in all six narratives. This was linked to the ‘hard work’ that the women described in negotiating with healthcare professionals in accessing medical and psychosocial services. A lack of knowledge was not constructed negatively for all participants. Paula described feeling the same with regard to her GP being unaware of how to access support services, but constructed within her account she reports how this made her feel confident in affirming her own knowledge and understanding:

“You go to your GP and they haven’t got a clue ... So you’re basically having to tell them what to do and that really makes you feel confident, you know.” (Paula, 405-412).
This was related back to the expectations described by the participants about knowing and understanding their experiences and having to cope with them ‘on their own’. Previously the impact of this expectation had been constructed around distressing psychological experiences, however for Paula in this instance, it provided her with a confidence in herself she had previously not experienced.

“I've had to be proactive in getting the help for myself and I think it needs to be made easier for people to get. It’s a bit of a lottery” (Anna, 660-662).

Psychosocial support was constructed within the narratives as a positive experience for all participants. Within this construction, further avenues of support were contextual to each individual. Four women discussed the value attributed to the contextual support they received from transgender support groups:

“You know, they rely on the support groups to tell them what they need to know and that shouldn’t be the case. The third sector shouldn’t be the place to be feeding that information. It should be coming from the health boards and the well-being boards you know“ (Christine, 539-542).

Christine’s description created a conflict within her story between the value of support and information and the avenue that the support came from. This conflict was described in four of the participant’s accounts and illustrates how different sectors may view their responsibility in providing support. Consistently described within all the narratives was the expectation that health providers should make available a better and accessible package of holistic care, inclusive of psychosocial support.

**Alternative Avenues of Support**

The value attached to receiving individual support for their psychosocial well-being was described throughout all six participants’ stories. Four participants described their proactive nature in wanting to offer something back to these services. Mary-Jane describes how she felt those who have been through gender services could help to support the existing transgender community through their journey:

“I really feel the community has a part to play. And how the support groups can help in both support and in education.” (Mary-Jane, 719-721).
This sense of ‘responsibility’ was further supported by Christine. In her account, Christine describes her sense of personal responsibility in helping those who are currently, and who will be entering gender services:

*I think um, transgender support groups are the way forward. Because, you know, a lot of trans girls get their surgery and everything, and then they go into stealth mode. Where, I don’t think that’s fair. Coz, the people that came before them, showed them the way, and helped them and supported them. And I feel personally, that it’s my job to carry that on to the next generation’* (Christine, 347-352).

A strong sense of gratification for the support they received was illustrated in four of the participant’s narratives signifying the deep emotional importance the experiences held for the participants, illustrated in Anna’s concluding remarks:

“*I mean all I’d say is the therapy that I’ve had has been good for me and definitely kept me alive.*” (Anna, 656-658).

The value of support received by the participants was discussed by all the women in relation to life experiences of managing stress:

“*Transitioning can be such a stressful time, anything that can make it easier is good.*” (Joanne, 1049-1050).

This was related back to descriptions of ‘internal pressure’ constructed by the participants in ‘unpacking’ their psychological experiences of self.
5. Discussion

The aim of the present study was to explore the lived experiences of individual psychosocial support from the perspective of those who have transitioned from male to female. The design of the study explored the experiences of six participants, who were recruited through third sector agencies for their experiences of therapeutic services in the form of psychotherapy, psychology or counselling services. All six participants were living full-time as females, two had undergone genital surgery, and four had not. All of the interviews were transcribed verbatim, and analysed using IPA.

5.1 Summary of Findings

The findings illustrated how relationships with others impacted continually on participant psychological experiences of themselves. The internalisation of distal societal attitudes of difference and disgust often led to marked psychological distress for the women. Despite a pervasive sense of difficulty, the participants described a continual drive to move forward in their journeys in the hope of becoming their preferred self and be accepted by others.

The women sought to illustrate their experiences of self and others beyond the borders of their physical sex, and bring to light both the psychosocial experiences they had been expected to tolerate, the impact this had on them and how this lead to the perceived need for therapeutic support. The power of normalisation and feeling listened to was a valuable source of support for the women and important in helping them to process their emotional experiences beyond the backdrop of any pathology (King et al., 2007).

Participants evidenced a strong sense of needing to be accepted which was echoed in many domains of their life, including acceptance of themselves, with family, socially and as part of the healthcare system designed to support them, including acceptance by their therapist. This sense of acceptance was linked readily to their psychological experiences of self. The need to be listened to and understood on a contextual level by their therapist was important for all the women interviewed. A desire to ensure that others receive better support in the future through education of professionals and communication with the transgender community about effective support was also important. Fear of being denied medical intervention often lead to a marked fear of disclosing emotional difficulties for the women. A perceived need for a greater
provision of individual support and information in context to presenting as female was found as important to the participants of the study.

5.2 The results in relation to existing literature

Conceptualising Gender

Whilst the focus of the study was the discussion of experiences of therapy, it is worthy of note the continuous use of binary language used by the participants in conceptualising their gender identity. All participants subscribed to the labels of female or woman and heterosexual. Consideration in how the cultural expectations of being female placed on the participants influenced their sense of self and their need to ‘fit in’ (Johnson, 2013) highlights the importance of alternative theoretical frameworks, such as Queer and Feminist theory in conceptualising gender experiences beyond heteronormative expectation (Bettcher, 2014).

Influential Factors in Seeking Support

Throughout the interviews there was a strong sense that contextualising the participant’s experiences was fundamental in understanding their experiences of self and how this lead to them seeking individual support services. Participants spoke of both their personal perspectives, but also a strong sense of importance was put on social dimensions and how this impacted on them. This expectation may have demonstrated a social intolerance to minority human experiences in society. It was evidenced in the narratives that in both social and professional domains, biological females were more accepting of minority difference than males. The researcher considered the further interpretation that males may react more strongly to this transgression from gender role due to anxieties of gender being emblematic of sexuality (Devor, 2009) and a fear that sexual association with transgendered women may be indicative of a slight on their heterosexuality (Schilt and Westbrook, 2009).

The process of internalisation of homophobic prejudice may help in understanding of the psychological effects of social discrimination faced by the transgender community (Nemoto et al., 2011; Nagoshi et al, 2008). Parallels with the internalisation process of homophobia (Williamson, 2000) and the narratives presented within the present study suggested a profound psychological impact that acknowledging ones experiences of gender may have if not congruent with expected social norms. The behaviours described
by the participants in the present study mirrored both the extroverted reactions (forming heteronormative relationships with women and adhering to binary gender expectations) and the introverted reactions of self-denigration (constructing inner experiences of gender as ‘evil’ and ‘wrong’ and avoiding association with other trans people) suggested by Allport’s (1954) conceptualisation of stigma and prejudice. The internalisation process is evident where participants have attempted to identify (albeit temporarily) with the beliefs of the heteronormative majority. Further psychological indicators of low mood, anxiety and anger, as well as behavioural indictors such as alcohol use, drugs and suicide expressed by some participants may also give validation to this process.

**Feeling listened to**

Kagan (2008) concluded that feeling listened to correlates positively with health and quality of life. To measure the extent and value of this intervention would prove inaccurate as it requires a person-centred approach which provides meaning to the individual in the context they wish to discuss it. Participants within the present study spoke of desiring a system of recognition for their internal psychological experiences where they felt able to freely express themselves free of judgement and expectation, in a way that may in part normalise and value their experiences, in spite of an ever present threat of rejection. This concept highlights the ‘human’ experience endured by the participants which is often overlooked in expectation that validation of their external selves represented their internal experiences. In support of previous findings, space to discuss these experiences separate from existing gender pathology was invaluable to providing holistic and meaningful psychological care (Riley, Wong & Sitharthan, 2011; King et al, 2007).

**Continuum of Support Provision**

Studies using a range of methods identify elevated levels of psychological distress existing within the transgender population (Riley et al., 2011; McGuire et al., 2010; Dietert and Dentice, 2009; Mitchell et al., 2009; Whittle et al., 2007). Stigmatisation may occur both pre and post-intervention and have a profound effect on the mental health, confidence and gender identity formation. With reported higher levels of psychological and social distress, it is important to continue to develop an understanding of the variables impacting on psychological and social well-being in
order to formulate appropriate and relevant support mechanisms (Riley et al., 2011). Highlighted in the present study, effective lines of communication between sectors of care become imperative in providing a meaningful and holistic package of care inclusive of all needs of the service user across their transition.

The suggestion that future service users undergoing surgery need to be given better provision of information regarding psychological expectations following surgery was supposed during the study by the two participants who had undergone surgery. They posed that future patients need to be aware of the emotional impact of identity reformation and those feelings of disappointment, depression and stress may follow. Managing participant’s post-surgical expectations of both functional ability and psychological well-being is discussed sparingly in the current literature. What is available currently highlights the incongruent nature of expectation and reality that faces many transgender individuals (De Cuypere, 2005). Whilst this discussion could not be incorporated into the analysis for the present study, this has been highlighted as a consideration in other literature (Bohane, 2010).

5.3 Methodological Issues

The limited external validity of the present study impacts on the application of the findings to wider contexts and populations. Widening the recruitment to include a broader range of people would have enhanced the external validity; however this would have been incompatible with the chosen method of analysis.

The sample was White, predominantly British (one participant was European, now living in the UK) which has further implications on the external validity of the findings. The researcher considered the need for an in depth exploration of personal experience as a valuable. Similarly, the researcher considered the idea that the study may also have benefitted from a smaller sample size whereby allowing a greater depth of analysis of the transcripts.

The design methodology does not allow generalisation of the findings to the wider transgender population. However, to avoid false conclusions, and acknowledging the complexity of experience described by participants, cautious consideration should be given when implementing un-validated quantitative measures without further
explorative research with other non-normative gender presentations. The varying positions of the participants throughout their transitional process may have impacted on their reflections given. Other variables such as experiences of relationships and services which have shaped participants experiences of themselves may also serve to influence the reflections made by the participants and how they perceived their psychosocial support. Further research may wish to consider separate research for those at varying transitional periods, however careful thought must be sought not to inadvertently reinforce binary heteronormative ideologies by compartmentalising transitional experiences, from a cisgender perspective.

A semi-structured interview encapsulated the experiences of each participant and developed a narrative. A disadvantage of the interview process meant that it is possible that the process was biased by the researcher’s agenda and therefore may have missed important aspects of the participant’s lives which they would have otherwise told. This is particularly evidenced by a number of the participants asking the researcher how she would like them to answer the question presented to them. Debatably, refinement of the researchers interview skills though supervision and practice may have helped reduce this possibility, ensuring that all lines of enquiry were recognised and given the space to develop. One way to address this would be to facilitate the study using focus groups or unstructured interviews. On reflection, the researcher thinks this would compromise the sensitivity of the research. Further studies may also like to explore the use of other data collection methods including written narratives. However, a strong reliance on participants to complete diaries or notebooks which may impact on the nature of the data collected. Prospective use of written data may influence the data recorded by the participant to match the expectations of the researcher, whereas retrospective analysis relies of the collection of data potentially used not for the purposes it was collected.

The researcher remained aware that the analysis process was conducted individually and that this invites the possibility that the reflections made about the data may have been different should it have been examined within a team. To address this, the researcher engaged in regular supervision as a space to reflect on her interpretations and develop new ideas based on the transcripts. Regular time was set aside in advance to ensure that as much of this process could be conducted through personal meeting, however this process also continued through emails and telephone contact.
During the research process, individual respondent validation could not be sought due to practical limitations. In response to this, the researcher was able to ensure that alternative means of validation was sought through consultation and networking with members of the transgender community and academic researchers. This was sought through visiting agencies involved with transgender communities such as social groups and LGBT agencies. On contacting these organisations, the researcher was invited to attend the groups to informally discuss the subject of psychosocial support. The researcher also met with several academics who had recently published literature within the subject area, and informally discussed their research findings and experience. These opportunities allowed for genuine and valuable insight into the lived experiences of the transgender community and ‘unofficial’ validation to the findings. Specific consultation for the current data will be sought with participants prior to further publication of the results.

5.4 Clinical Implications and Future Research

The key purpose of the present study was an exploration of helpful and unhelpful components of individual psychosocial care throughout gender realignment. The utility will be to inform service providers for people experiencing gender related distress about some of the potential contextual factors influencing experience and how these present in clinical practice. The functions of the findings extend to all levels of service provision, including primary care (GP’s) through to specialist gender services. Clinical Psychologists who work within services where gender difficulties may be presented in practice may use the findings of the present study to inform their knowledge and practice.

Fundamental to understanding the individual differences and the impact of gender related distress on the individual is the ability to view transitioning holistically and as a continuing process. The tendency to compartmentalise experience has been suggested as unhelpful and the importance of allowing a space for service users to explore their psychological experiences and the impact these may have is essential at all stages of care.

Participants suggested a desire to feel more able to speak openly about their psychological and emotional experiences. Highlighted within the findings were suggested improvements to access to individual psychosocial support following surgery.
The psychological impact of social transition discussed by the participants indicates a greater need for a larger provision of information surrounding the undertaking of these processes. A move away from prescriptive forms of therapy and the development of a space whereby service users feel able to freely discuss their psychological and emotional well-being without fear of being judged is suggested as instrumental in their journeys. Accessing this support may endeavour to help service users manage their expectations of social and emotional transitioning. The findings also highlights a need for establishing a more open narrative about accessing support without fear of being judged or denied intervention.

In consideration for further research, and in recognition of the continuum of gender experience (Bettcher, 2014), repetition of the current study with other non-binary gender presentations may prove valuable in developing understanding in experiences. Many gender differences have been postulated and in particular, a measure of female to male participants, and other cultural groups may provide a valuable starting contribution to the present findings. Further thought to the methodology may consider the use of Grounded Theory (Glaser and Strauss, 1967) in providing a systematic generation of theoretical understanding in this area using a wider sample. Individual respondent validation for the findings of each interview would prove valuable in affirming the validity of the data interpretations should the research process be repeated in the future. Consideration may also be paid to the systemic context, including family members, healthcare professionals and social groups. Positive experiences of trans identity led to peer support and knowledge, including teaching opportunities described by participants within this study. An understanding of how gender is both constructed and expressed by wider populations may further contextualise academic and clinical understanding of the difficulties and opportunities experienced by transgender communities.

5.5 Conclusions

The current research provides an exploration of the lived experiences of people who have received individual psychosocial support in context to them presenting as their preferred gender and how the process of therapy proved helpful or unhelpful. Six participants were interviewed for the study. Transcripts were analysed using IPA. The findings illustrate how social and professional relationships with others impacted on
participant’s experiences of helpful therapy. A sense of acceptance was linked readily to participant’s psychological experiences of self both socially and professionally. Contextual understanding of their experiences was important for all the women interviewed. A desire to ensure that others receive support in the future was also important. A perceived need for a greater provision of support and information in context to all facets of transitioning, including surgical procedures was evidenced as important to the participants of the study. Individual support had been constructed as a positive experience for all participants in allowing them space to consider their ‘human responses’ to their social and psychological worlds.

The utility of the present finding may help to inform specialist gender services of the psychosocial experiences endured by the transgender community and the processes that can be utilised in therapeutic support to manage these in a helpful way. Further research may wish to develop the current findings by broadening the sample criteria to encompass other diverse gender presentations.


Nemoto, T., Bodeker, B. & Iwamoto, M. (2011). Social Support, Exposure to Violence and Transphobia, and Correlates of Depression Among Male-To-Female


PART THREE

CRITICAL APPRAISAL
Choosing a Project

I spent considerable thinking time about why I had chosen this study. I wondered what the topic may say about me, how it may be received by others and how I may be viewed by others for conducting it. My initial thoughts came from my only other experience of academic research. My undergraduate dissertation was a qualitative exploration of heterosexism and homophobia from a heterosexual perspective. Whilst this paper was explicitly related to sexuality, it ignited my interest in gender roles, social conformity and the experiences of those who transgress socially constructed gender norms. During my first year of training I conducted a literature review which examined the experiences of psychological distress faced by Lesbian, Gay, Bisexual and Transgender (LGBT) youth. My conclusions led me to the understanding that experiences of distress by transgender communities may be qualitatively different to those experiencing distress related to their sexuality. This was something that I had not considered before and further exploration of the literature revealed there was little empirical research dedicated to the psychological experiences of gender related distress. My original aim for the study was to recruit participants who had undergone surgical genital intervention. This was based on reading some unpublished empirical data suggesting an increase in psychological distress following surgery (Bohane, 2010).

I chose to approach my study from a social constructionist perspective. I understand that human experience are subject to context and can be shaped by many processes, beliefs and events. In this sense, I understand there can often be multiple interpretations which can be made of the same phenomenon. Each individual will have their own constructions of an experience. Through the interpretation of the language of experience, IPA allows for this to be explored. Both the participants and my own constructions are unique to us both respectively. The double hermeneutic cycle in IPA allowed for both the participant to make sense of their experience and also the researcher to make sense of the participants experience. Though I do not have access to my participant’s reality, this process occurs through interpretation of their language. I understand gender as a social construction of the self that can be shaped and reshaped. Gender expression resides on a continuum of experience (Cobb et al., 2009) and it is not quantifiable and therefore cannot be accurately measured (Pedersen, 2010). My position towards the subject matter was process-oriented as I sought to explore the
meaning of experiences. My position was one of exploration rather than explanation and was concerned with the process of an evolving experience rather than an explicit focus on outcome.

In understanding how individual experiences are constructed and understood, ideas around impartiality and objectivity were thought to be unobtainable (Smith et al, 2009). Reflecting on my epistemological position, Interpretive Phenomenological Analysis (IPA) felt most appropriate to use as I was not seeking to establish an objective ‘truth’, but explore how my participants had come to understand their experiences. Being both reflective and discursive, the approach subscribes to social constructivism (Smith et al, 2009). IPA allowed me to explore in depth the experiences of the participants, as well as reflect on my own involvement with the subject matter.

**Expectations and Uncertainties**

At times I felt out of my depth when contemplating the scale of the project. Knowledge of the limited literature available in the research area left me with both a sense of anxiety and excitement. I was anxious that through publication of my findings my work would be in the public domain and I feared that my attempts to encapsulate and interpret my participants stories might not in some way be ‘good enough’. Despite this, I was also excited that my study appeared to contribute something previously unexplored in the current literature and that my epistemological position and my qualitative methodology allowed me to explore these experiences in depth. I feel my own limited knowledge on the subject matter allowed me to curiously explore the experiences of my participants without a significant expectation of what I would find. My position as a researcher has allowed me to theoretically explore the literature, but also my position as a clinician has allowed me to develop ideas regarding clinical utility of my findings beyond the present study.

Initiating the interview process often left me with a sense of anxiety of the expectations of my participants about both myself and the interview process. In attempting to make sense of this anxiety, I wondered whether my feelings might reflect that of the participants. I wondered if they too may be anxious about the expectations of what the interview process may involve, and how I, as a researcher, would respond to the information they gave me.
At times throughout the interview process, I felt unexpectedly frustrated by the
tendency of the participants to deviate from the interview questions. For example, when
asked about experiences of therapeutic support, participants often discussed experiences
of charitable groups and peer support they had experienced at varying stages of their
transition. I wondered if my experiences of frustration may reflect those experienced by
the participants; were they frustrated by my prescriptive expectations of what I thought
signified psychosocial support? Through this process I developed my skills in
understanding the meaning of support for my participants. I acknowledged my
prescriptive ideas about psychosocial support could be detrimental to my understanding
and interpretation of my data. Reflections made during supervision enabled me to
to consider the wider context of experience that my data was representing, as well as
learning to consider the value of support spoken about in absence.

**Practicalities**

Recruitment for the study required a lesson in patience and diplomacy. I was aware that
the nature of my research involved disclosure of any potential participant’s most inner
personal experiences of themselves and others. As well as this, recruitment proved time
consuming as my process, and ethical guidelines required that I did not approach
individuals personally, and so I became reliant on the goodwill of the organisations that
I contacted to advertise my study for me.

Time spent waiting for responses from advertisement proved to be both anxiety
provoking and frustrating. Following completion of two of interviews, I received no
contacts for a further four months. Containing this anxiety was a learning curve for me
and required me to make conscious decisions about timing further contact with the
organisations in order to enhance recruitment. Due to a continued absence of responses,
consultation in supervision led to the decision to widen the search criteria to those who
hadn’t undergone genital surgery, but had still received psychosocial support. The
decision was made on the basis of my investigation looking into mechanisms of support
and not specific gender realignment procedures. Upon reflection, I feel that widening
my participant inclusion criteria functioned also to enhance my data by allowing me to
draw upon the experiences of a wider group without compromising my analysis. I also
wondered if it would fit better with how the transgender community may view
‘transitioning’ as not necessarily being surgical.
I was also aware that in conjunction with the restrictions on my sample due to my chosen analysis, my recruitment procedure also may have impacted on my final participants to the study. Whilst a voluntary participation was chosen for my project, I was aware that this may produce a sample bias towards those who may have a vested interest in the specific subject area I was examining, which may ultimately exclude those without this interest.

**Supervision**

Supervision offered a safe space to constructively discuss my concerns and anxieties about the research process and it offered direction at times when I felt my own to be wavering. It also offered reflective discussion on my analysis process by challenging whether my interpretation was from my data or a theoretical or psychodynamic reflection from myself. This enhanced my analysis by allowing to critically consider my process and keep my results as close to my original transcripts as possible.

As the process evolved, supervision was a beneficial space for checking the validity of the analysis process that I was engaging in. Regular supervision meetings were scheduled throughout the analysis stages and forward thinking was given to the use of each session in order to manage expectations and ensure meaningful use of time. Regular email and telephone contact also proved valuable in managing unexpected or important discussions that could not be held in the interim.

**Thinking about Gender**

Even within gender research studies committed to the study of oppression and power differentials, binary sex and gender terms are used (Dow & Wood, 2006). This can perpetuate thinking about sexuality and gender in compartmentalised ways. Throughout the research project I remained aware of my own gender identity and how this may be constructed by others as a privilege (Johnson, 2013). I considered how my taken for granted assumptions of my own cisgendered experience may be viewed by others and how this impacted on my relationship with my participants, and ultimately, on their willingness to share their stories with me. I wondered if my participants viewed my own gender experience as my ‘unearned privilege’ (Johnson, 2013). Thoughts of my cisgender privilege where balanced against my position as a female researcher as possibly enhancing the openness of my participants. Throughout the narratives they
described a sense of greater acceptance by females than males. Specifically, I wondered if a perceived greater acceptance by females felt by the participants allowed for them to recall more open and detailed accounts of their lives without increased anxiety of being rejected or abused.

I spent a lot of time prior to starting my interviews visiting groups, organisations, researchers and clinicians in order to formulate a better understanding of my own and others construction of gender. In consideration of cisgender experience, I reflected on the concept of my participant’s gender identity having never shifted, but that it was their bodies that have changed to align with their ‘selfhood’ (Johnson, 2013). Critiquing the innate assumptions related to cisgender experience I felt that my own gender identity was constructed as an assumed stable centre of myself. I found myself uncomfortable with this assumption and felt that gender and indeed sexuality are processes constructed, explored by everyone. With this in mind, the disparity between both mine and my participant’s experiences of our gendered selves became less polarised and I felt more able to manage my anxieties about exploring this unfamiliar area. The widening of my inclusion criteria allowed me to consider how my initial inclusion criteria may have served to enforce binary conceptualisations of gender and heteronormative assumptions equating gender with biological sex. It was important for me to reflect on my initial ideas of recruiting participants on the basis of them having undergone physical intervention. On reflection, this was not necessary to the present study and I considered how my original ideas compartmentalised my participants. Surgical intervention was not necessary for my participants to consider themselves female.

Throughout my study I endeavoured to respect the language each of my participants used to construct their identities. I reflected on my experiences with my participants and considered their use of language in describing conceptualising their gender identities. I was struck by the significant use of binary language and the need for all to be recognised as women and female. I wondered if this, in part, may be influenced by the demographics of my participants. All of my participants were representative of white, working class western culture. Arguably a culture saturated with heteronormative ideology and gender role expectation, I wonder if, as well as these normative expectations forcing these ladies to realise they did not ‘fit’ with a male identity, that it also forced them to aspire to a female ideology rather than an identity comfortable to
them. I wondered how this impacted on their psychosocial well-being in terms of managing expectations about transitioning. I also felt that these ideas encouraged me to consider my own understanding of gender and how my understanding continued to develop throughout the course of this research.

Collaborations with Professionals and Services

My experience of contacting existing support services was largely a positive one. The willingness of all the agencies I approached to help with recruiting in detailing my project on their websites, mailing lists and social networking pages far surpassed my expectations. I wondered if this could be attributed to the perceived value of my study by existing support networks. For me, this highlighted a positive need for effective communication between healthcare services and the third sector, and how greater appreciation for psychosocial and emotional well-being may be addressed for those undergoing intervention for gender related distress. This said, I was also aware of sensitive issues that came out of my findings, including criticisms of professional groups and historical unhelpful practice. An ability to remain ‘true’ to my participant’s stories had to be balanced against a backdrop of diplomacy within my findings.

My training in Clinical Psychology has enabled me to develop a system of understanding presenting difficulties through formulation. This allows me to develop a curiosity within my clinical work and establish a sense of meaningful therapeutic engagement with my clients. As part of my study I had to contend with frustration at the description of my participant’s compartmentalised experiences and my belief of the overt ‘medicalisation’ of healthcare services. In developing an understanding of my feelings I felt my position as a professional strengthen and I feel passionate about promoting a psychological perspective in this clinical area. My position as both a researcher and clinician has been greatly impacted by the process of the research, of which I feel a value.

Suppressing my Inner Clinician

Reflecting on my experiences of each interview I thought about my sense of feeling uncomfortable at times throughout each one. The skills I have learned as part of my training in clinical psychology sometimes proved difficult to suppress when engaging in my role as a researcher. I found these feelings to be particularly stronger in my first
interviews, and at times when my participants were upset by their stories. With practice, I felt an increasing control over these feelings and I learned the importance of separating my role as a clinician from a researcher.

I quickly became aware of the complexity of my participants lives and how as an outsider to their experience, a seemingly minor event may have had a significant impact on their sense of self. I found myself balancing an increasing sense of curiosity for my participant’s lives with an unexpected sense of guilt that at times when I felt the interview was losing focus, I would redirect it back to a point of conversation consistent with my own agenda.

**Safe Uncertainties**

As I explored my chosen methodology further I soon realised my anxieties of being an inexperienced researcher using an interpretive analysis. At times I found myself overwhelmed by the volume of data I had received from my participants and was fearful of managing a balance of the IPA process. I wanted to ensure my analysis extended beyond mere description; however I became aware of my anxiety in engaging deeply with the data in recognition of imparting myself on my participant’s stories.

My first lesson learned during the write up of my project centred on trusting the process of analysis. I soon realised the magnitude of the task before me and at times, found difficulty containing my anxiety. In trying to make sense of my experience, I realised it focussed on my perception of time passing and knowing I had not got a written account of my analysis. I was able to discuss the process within supervision and reflected on the importance if the analysis as a process. Reflecting on this experience, I learned that my data analysis could not be compartmentalised. The interpretation of my data extended well beyond my initial expectation, through the formulation of my themes, and continued throughout my write up. Through this I learned that labelling my themes and interpretations too early could impact to the detriment of my work, but by allowing myself to become ‘lost’ in my data ultimately allowed me to produce a more exhaustive analysis and hopefully a more thorough account of my participants stories.
Work Life (im) balance

My expectations of the magnitude of my project were quickly surpassed and I began to realise that despite effective time management strategies, my project was going to become a significant feature of my daily life. At times, I felt frustrated, overwhelmed by the task set before me and worn out by the ever present position in my mind. To help manage this, I found value to agreeing deadlines within supervision and the structure and containment offered by this. Use of a research diary proved invaluable in both the research process and for the unexpected thoughts and curiosities which came to mind during unconnected activities.

On Learning from my Participants

On commencing my project and as part of my ethical considerations I was aware on some level of the sensitive nature of my topic however on reflection I realise I could not prepare for the moving accounts that I was privileged to hear. Through a strong narrative of struggle and rejection I was struck by the strength and resilience of my participants and their continuing positive outlook on their futures. I quickly became aware of my own feeling of gratitude towards the women in sharing some of their most personal experiences with me.

As I reflected on my themes evidenced within the data, particularly those around listening and acceptance, I wondered how this impacted on my performance within the interviews. I recalled in a number of the interviews participants commenting positively on my verbal and non-verbal communication with them and how this facilitated them wanting to talk to me. I felt that this positive feedback was valuable in facilitating a helpful experience during the interview process, but also a skill which I can continue to develop throughout my clinical career.

Working with Endings

As my project comes to an end I have reflected on my journey through it and the various roles that those involved have played. I thought about how my experiences doing my project had impacted on me as a person. At times, feeling very lost in an unfamiliar process it was sometimes easy to lose sight of where my project was heading. In learning a new process of analysis, and wanting to do this well, it was
sometimes difficult to see the project as a whole, and I was sometimes left with a sense of feeling stuck. Though as the process came to a close, I experienced a great sense of pride in feeling I had achieved something I once felt unachievable. As I felt I regained some clarity and direction from this ‘stuckness’, I unexpectedly noticed some feelings of guilt for losing sight of the stories as real life accounts by my participants.

Particularly through the interpretation process and learning the meaning and impact my participant’s experiences had on them, I felt a great sense of honour that they had allowed me into their worlds and shared their stories with me. A number of times since the interviews I have found myself wondering about the ladies and how their lives are continuing to unfold. Certainly, I had been moved by my participant’s accounts and hoped that the finding of my research will spur future research into the provision of support for others facing similar difficulties. I still remain unclear about when my project will fully come to a close and when my relationships with my participants will finally come to an end. I wondered how this ambiguity about the end was reflective of my participant’s feelings of their own journeys.

I feel my confidence as a researcher has significantly developed and knowledge of the process has left me with a continuing curiosity to explore future research. I am aware of the limitations of my research design and that generalisations to the wider transgender population are not possible. However, my study has illustrated the complexity of gender experience that I feel can only be truly encapsulated through a qualitative analysis. I enjoyed meeting and talking with Joanne, Rosa, Mary-Jane, Paula, Christine and Anna and recognise without their willingness to openly share their stories, my project would not have been possible.
References


Appendices

Appendix A - Guidelines for Authors Submission

“The International Journal of Transgenderism is committed to the advancement of knowledge in the areas of: transgender identity and sexuality; the health of transsexual, transgender, and gender nonconforming people, their families and communities; the medical and psychological treatment of gender dysphoria; social acceptance and legal recognition of changes in gender role; transgender rights; and the professional and public education on gender diversity and the phenomenon of transgenderism. The International Journal of Transgenderism, together with its partner organization the World Professional Association for Transgender Health (WPATH), provides an intellectual forum that stimulates new ways of thinking and understanding various aspects of sex, gender identity, and gender expression.”

Instructions for authors

Manuscript Submission

The International Journal of Transgenderism receives all manuscript submissions electronically via their ScholarOne Manuscripts website located at: http://mc.manuscriptcentral.com/wijt. ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, as well as facilitating the review process and internal communication between authors, editors and reviewers via a web-based platform. ScholarOne Manuscripts technical support can be accessed via http://scholarone.com/services/support/. If you have any other requests please contact Walter Bockting, the journal’s editor, at wb2273@columbia.edu.

Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. All accepted manuscripts, artwork, and photographs become the property of the publisher. All parts of the manuscript should be typewritten, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in an abstract of not more than 250 words and include 3-5 keywords. Please consult our guidance on keywords here. Avoid abbreviations, diagrams, and reference to the text in the abstract.

References

References, citations, and general style of manuscripts should be prepared in accordance with the APA Publication Manual, 4th ed. Cite in the text by author and date (Smith, 1983) and include an alphabetical list at the end of the article. Examples:

Illustrations

Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- Sized to fit on journal page
- EPS, TIFF, or PSD format only
- Submitted as separate files, not embedded in text files

Color Illustrations

Color art will be reproduced in the online production at no additional cost to the author. Color illustrations will also be considered for the print publication; however, the author will bear the full cost involved in color art reproduction. Please note that color reprints can only be ordered if the print reproduction costs are paid. Print Rates: $900 for the first page of color; $450 for the next 3 pages of color. A custom quote will be provided for authors with more than 4 pages of color. Art not supplied at a minimum of 300 dpi will not be considered for print.

Tables and Figures

Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

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### Appendix B - Search terms and search procedure

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### Appendix C - Data Extraction Form

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#### Aims:

#### Sampling / Participants: *(Total number of participants? Age range, who was studied, how was the sample recruited? Response rate?)*

#### Study Type / Design: *(Randomized allocation? Is a control group used?)*

#### Outcomes and Measures: *(What outcomes are being measured? What measurements are used? Are measures validated? At what time points are measures completed self-report or clinician-rated?)*

#### Intervention: *(Type of intervention? Control group comparable? Format of the intervention? Staff delivering it?)*

#### Analysis: *(What statistical methods were used? Was power calculated? Intention-to-treat?)*

#### Findings:

#### Controls/ Validity / Reliability:

#### Conclusions: *(What do the findings mean? Generalisability? Implications & Recommendations?)*

#### Additional Comments:
### Appendix D - Included study design and specific outcome measures

<table>
<thead>
<tr>
<th>Study ID</th>
<th>Author/ Date / Location</th>
<th>Design Features</th>
<th>Sample</th>
<th>Outcome Measures</th>
<th>Key Results</th>
</tr>
</thead>
</table>
| 1        | Dhejne et al. (2011)    | Population based matched cohort design | • Exposed sample, Total N=324  
• Male-to-female N=191  
• Female-to-Male N=133  
• No socio-cultural demographics given  
• Identified from National Register of psychiatric diagnoses from 1973-2003  
• Random selection of 10 unexposed controls for each exposed participant | • National Registers:  
• Cause of Death Registry  
• The Hospital Discharge Register  
• Total Population Register  
• The Medical Birth Registry  
• Register of Education  
• The Crime Register | • SRS alleviates gender dysphoria but more support is needed for follow-up  
• Transsexuals are increased risk of conviction post-operatively. Only statistically significant in those operated on pre 1989  
• Transsexuals are four times more likely to have psychiatric admission pre operatively than controls  
• Transsexuals of both genders are three times more risk of mortality of all causes than controls  
• Mortality from suicide is greater in post-operative group even after adjusting for previous mental health issues |
| 2        | Lawrence (2003) USA     | Retrospective cohort study | • N=232 post-operative male-to-female transsexuals.  
• Mean age of SRS was 44 (SD 9) (range 18-70)  
• Mean age at time of survey 47 (SD 9) | Devised for the purposes of the research. Five categories devised to assess  
• Preoperative predictor variables related to transsexual typology  
• Compliance with established treatment | • Less surgical complications were indicative of lower levels of regret.  
• Higher levels of childhood femininity and an earlier age of wishing to transition was also correlated with less regret  
• Regret was associated with |
| 3 | Smith et al. (2005) | Large-scale prospective follow-up study | N=365 adults and adolescents  
N=222 (N=146 males-to-females, N=76 females-to-males) hormonal treatment  
N=188 (N=117 males-to-females, N=71 females-to-males) Completed surgery. | Biographical data  
The Gender Identity Disorder in Childhood Scale  
The social Support Scale  
Utrecht Gender Dysphoria Scale  
Body Image Scale  
Appraisal of Appearance Inventory | Surgery alleviates gender dysphoria  
Good psychological, social and sexual function post-operatively  
Post-operatively, female-to-male homosexuals functioned better than male-to-female non homosexual  
Male-to-females with more psychopathology and and cross-gender symptoms in social factors such as diminished family relationships  
Surgery improves quality of life |

- Duration of pre-operative hormone therapy (months) = 44 (SD 43) (range 0-324)
- Amount of pre-operative psychotherapy (months) = 75 (SD 118) (range 0-1000)
- Amount of post-operative psychotherapy (months) = 8.5 (SD 23) (range 0-240)
- Received surgery between May 1994 and March 2000
- Minimum of one year post-operative regimens
- Relevant mental and physical health and social factors
- Postoperative predictor variables
- Postoperative variables related to regret and satisfaction
<p>|   | Rehman et al. (1999) | Retrospective | Surgery performed between 1980 and December 1994. Follow-up time up to three years. Sample, N=28 respondents. All males-to-females. Lived as females for 12 months minimum. All aged over 21 at the time of surgery. Single, N=18. Married, N=1. Divorced, N=8. Widowed, N=1. Pre Surgery psychotherapy for 1 to 2 years (or 15 sessions) with a. | Devised by the authors. Investigated: the kind and degree of satisfaction following Surgery. an evaluation of the emotional and psychological issues experienced as part of living in society as female. evaluation of self-perception as living as female with genetic females in society. the impact of surgery on quality of life. adjustment in employment. degree of importance | Quality of life reported as high post-operatively. No regret was experienced by anyone. Marked decreased in suicide attempts, criminal activity and drug use post-operatively. Little difficulty in maintaining close friendships. Identify the need for proper preparation of patient for Surgery, this includes post-operative psychotherapy. childhood were more likely to drop out of treatment. |</p>
<table>
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<th>No.</th>
<th>Author(s)</th>
<th>Study Type</th>
<th>Details</th>
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| 5   | Lobato et al. (2006) Brazil      | Long-term follow-up cohort study   | Enrolled onto the Gender Identity Disorder Program N=116  
Received surgery April 2000-2003, N=30  
Final sample for inclusion in study, N=19  
Male-to-female N=18  
Female-to-male N=1  
Mean age 26.1 (range 18-47)  
Post-operative follow-up time ranged from 1-2.5 years  
‘Type I transsexuals’ (desire to transition came early in developmental life)  
Excluded if intersex, |
|     |                                  |                                   | Un-validated questionnaire designed by the multi-disciplinary team within the Gender Identity Disorder Program team (consisting of social worker, nurse, psychologist, psychiatrist, bioethicist and urologic surgeon). |
|     |                                  |                                   | Surgery had a positive effect on the three aspects of the participant’s lives under review.  
No regret of surgical intervention post-operatively  
Non-statistically significant increase in number of relationships maintained or initiated |
suffering co-morbid psychiatric disorder or addictions.

- Initially only homosexuals considered for Surgery

<table>
<thead>
<tr>
<th>Study</th>
<th>Authors and Year</th>
<th>Design</th>
<th>Sample</th>
<th>Methods</th>
<th>Findings</th>
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</table>
| 6     | Hunt and Hampson (1980) USA | Follow-up study Retrospective Pre and post evaluation | N=17 male-to female
Surgery between 1968 and 1972
psychiatric diagnosis
‘Convincing Physical demeanour’
Intelligence test showing participant Is 'sufficient enough to understand process’.
Minnesota Multiphasic Personality Inventory
Qualitative interviews | Surgery as an extremely beneficial procedure
No change in psychopathology since surgery
60-70% improved functioning or stayed at a high level of functioning |
| 7     | De Cuypere et al. (2006) Belgium | Retrospective Mixed methods | N=107
Male-to-females, N=63
Females-to-males, N=44
Surgery completed between 1986 and 2001
Post-operative delay of 1 year minimum.
For interview, N=56
Males-to-female, N=33 | Biographical data
The Utrecht Gender Scale
The Global Assessment of Functioning Scale
Symptom Checklist-90, Dutch version
Semi-Structured interview on treatment outcome | Socially subjects experienced positive change
Slightly more males-to-females were happy with results of surgery than female-to-males
Suicide rate dropped significantly though was still above the norms of the general population
Females-to-males scored significantly higher on the Global Assessment of |
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<td></td>
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<td>The mean follow-up period was longer for males-to-females (P=0.117)</td>
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- Functioning Scale

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<th>N=40 randomly selected male-to-females</th>
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<td>Mean time lapse between first assessment and Surgery was 14 months (range 2-24 months)</td>
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<td>Follow-up time, 6 months</td>
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<td>Mean age, 47.33 years (SD: 13.26, range 25-80 years)</td>
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</table>

- Symptom Checklist-90 Revised

- There were no significant changes on the Symptom Checklist-90 Revised scales post-surgery
- A slight reported trend in anger and hostility
- No psychiatric diagnoses
- No relationship between Symptom Checklist-90 Revised score and time on waiting list

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<td>Female-to-Male N=125</td>
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<td>Mean age 40.28, SD 12.85</td>
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- Demographic questions – open ended questions on gender identity and position in transition status.
- Multidimensional Scale of Social Support
- Ways of Coping – Revised

- Depression and anxiety in both trans men and women far surpass that of the general population.
- Depression:
  - Trans men 48.3%
  - Trans women 51.4%
- Anxiety
  - Trans men 47.5%
  - Trans women 40.4%
- Avoidant coping served as a
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<td></td>
<td>7.4% biracial (N=26)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Range of sexual orientations</td>
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<tr>
<td></td>
<td>Recruited through social networking sites and LGBT services.</td>
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<tr>
<td></td>
<td>Explicitly excludes genderqueer and cross dressers.</td>
<td></td>
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</tr>
<tr>
<td>10</td>
<td>Beatrice (1985) USA</td>
<td>Between groups design Comparing four groups</td>
<td>Tennessee Self Concept Scale (TSCS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Minnesota Multiphasic Personality InventoryRevised</td>
</tr>
<tr>
<td></td>
<td>Total sample, N=40</td>
<td></td>
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<tr>
<td></td>
<td>Recruited through gender identity clinics at 2 medical schools, university based.</td>
<td></td>
<td>TSCS analysis of variance produced no significant differences across groups.</td>
</tr>
<tr>
<td></td>
<td>Self identified heterosexual men (N=10)</td>
<td></td>
<td>Minnesota Multiphasic Personality Inventory analysis of variance produced significant differences across some scales.</td>
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<tr>
<td></td>
<td>Transvestites (N=10)</td>
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<td></td>
<td>Pre operative</td>
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<td></td>
<td>Transsexuals (N=10)</td>
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<td></td>
<td>Post</td>
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<td></td>
<td>Parola et al. (2010)</td>
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<tr>
<td></td>
<td>France</td>
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<tr>
<td></td>
<td>N=38 for quantitative measures</td>
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<tr>
<td></td>
<td>N=30 for qualitative measures (N=15 MtF, N=15 FtM)</td>
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<tr>
<td></td>
<td>There was no inclusion criteria noted for the selection of participants for qualitative measures.</td>
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<td></td>
<td>Age range 32-65</td>
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<td></td>
<td>All had undergone hormonal and SRS over a period of at least two years</td>
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<td></td>
<td>Short Form-36, health related Quality of life questionnaire.</td>
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<tr>
<td></td>
<td>Covers: physical activity, limits to physical activity, physical pain, perceived health, energy levels, social life and relationships, mental health, limits due to mental health.</td>
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<tr>
<td></td>
<td>Eysenck Personality Inventory</td>
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<td></td>
<td>Quality of life for surgically reassigned participants was improved.</td>
<td></td>
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<tr>
<td></td>
<td>No significant change in social and family relationships</td>
<td></td>
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<tr>
<td></td>
<td>Female-to-male participants reported better social and professional lives as well as better friendships and psychological well-being, than male-to-female.</td>
<td></td>
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</tbody>
</table>
| 12 | Barrett (1998) | UK | Cross sectional Between groups design | • Exclusively female-to-male participants, N=53  
• NHS patients  
• Pre-operative group N=23  
• Mean age 35 (range 17-51)  
• Post-operative group N=31  
• Mean age 40 (range 24-72)  
• Pre-operative groups recruited from Charring Cross Gender clinic or through urological surgery waiting list  
• Diagnosed as female-to-male transsexuals  
• No demographic differences between pre and post-operative | • General Health Questionnaire (GHQ), total score and sub-scores  
• Symptom Checklist-90, global severity index score  
• Social Role Performance Schedule  
• Demographic information: -rate of employment -mean income -use of alcohol -use of cigarettes -satisfaction of genital appearance -sexual function -urinary function -relationships | • GHQ produced no significant differences between populations with all sub scales except depression.  
• Depression was higher in post-operative participants  
• Post-operative group report more androgynous sex role characteristics  
• Changing physical appearance of genital reduces distress  
• No evidence that phalloplasty has a direct psychological benefit |
| 13   | Mate-Kole et al., (1990)                              | Between groups (treatment)                           | • Total N=40  
  • 20 self identified male transsexuals :treatment as usual.  
  • 20 demographically matched self identified male transsexuals receiving early surgery.  
  • Mean age 32.5  
  • Age range 21-53 | • Crown Crisp Experimental Index 
  • Bem Sex Role Inventory | • Patients who received surgery, showed a significant increase in social functioning  
  • Group A also had higher incidences of employment.  
  • Significant differences were also seen between groups at follow-up stage for social activity. |
Appendix E - Statement of Epistemological Position

The current research project was conducted from a critical realist perspective. Critical realism simultaneously challenges the central concerns of both natural and social sciences. This makes critical realism of particular interest in the study of human experience which bears significant relevance to natural science (due to their physical presence in the natural world) and social science (due to their applications in deeply human contexts) (Fade, 2004). Critical realism distinguishes between the “real”, the “actual”, and the “empirical” (Bhaskar 1975). This stratified ontology is what differentiates critical realism from empirical realism allowing critical realism to acknowledge the world cannot merely consist of atomistic objects (or events) easily observed and without any hidden characteristics. Even though critical realism accepts that there is one “real” world it does not follow that we, as researchers, have immediate access to it or that we are able to observe its every aspect (Fade, 2004).

Critical realists consider instead of looking for “social laws” we should be looking for causal mechanisms and how they work. Consistencies are only likely to take place under particular circumstances within “closed systems”. However, “open systems”, like the social world, are too complex, therefore the same causal influence can produce diverse outcomes. Given continuous change in society, one can expect a lack of regular relations between causes and effects. Akin to interpretivism, critical realism shares the view that social phenomena are concept-dependent and need interpretive understanding. Conversely, unlike interpretivism, it does not exclude causal explanation (Sayer 2000).

Critical realism maintains a strong emphasis on ontology, existing independently of what is thought about it. Crucially, this forces us to accept the fallibility of human knowledge and the possibility of getting things wrong. Bhaskar (1998) distinguishes between the transitive and intransitive objects of knowledge. Intransitive objects of knowledge are the ones that don’t depend on human activity (knowledge of things which are not invented by humans e.g. gravity, death etc), whereas transitive phenomenon’s are “artificial objects fashioned into items of knowledge by the science of the day” (Zachariadis, Scott and Barrett, 2010). These ‘items of knowledge’ can be established facts, theories, paradigms, models, methods and techniques of study that are used by a particular researcher.
Sayer (2000) argues that “observability may make us more confident about what we think exists, but existence itself is not dependent on it”. However, critical realists recognise that there is a causal criterion too (Collier 1994). This means observable events that are being causally generated from multifaceted interactions can give some information on the existence of these unobservable entities, thus making it possible to understand how things would have been different, for example, if those interactions did not combine the way they did.

Interpretive Phenomenological Analysis (IPA) was deemed most suited to both the author’s epistemological position and the focus of the research question (Fade, 2004). It suggests that human beings are shaped by pre-existing cultural forces, however, there is possibility to ‘rework the constitutive material through symbolic or cognitive activity in developing further as an individual’ (Smith et al, 2009; Fade, 2004). Informed by hermeneutics (the theory of interpretation), IPA analysis allows for exploration of experience as well as the participants attempts at making sense of that experience (Smith et al, 2009). In this sense, self-identity is not distinctive and possessed by the individual; rather the self comes to be reflexively understood by the individual in terms of their biography (Giddens, 1991). Whilst identity is assumed as continuous through time and space, self-identity in this instance is such continuity as reflexively interpreted by the individual (Giddens, 1991). This method of enquiry lends itself to the exploration of the previously unexplored processes, rather than attempting to explain them. Through a process of double hermeneutics, the researcher is also able to engage with her own process of making sense of the participant making sense of their experiences. The researcher engages with both the parallel processes of the participant on a shared ‘human’ level, however the researcher engages in second order sense making, in that her engagement remains more conscious and systematic (Smith et al, 2009). IPA invites the use of smaller sample sizes to account for the complexity of human experience (Smith et al, 2009) and invite a detailed examination of the data on an individual level.
References


Appendix F - Flow diagram of research process.

- Initial meeting with supervisors to discuss interest in potential topics.
- Decision on topic made.

- Final decision on topic made.
- Formulation and refinement of research question.

- First Draft Research proposal submitted to University of Leicester.

- Research proposal redrafted for peer review at University of Leicester.
- Peer review. Amendments made.

- Preparation for submission to NHS ethics.

- Final submission to NHS ethics.

- REC Meeting held by Derbyshire RREC committee.
- NHS ethical approval granted.

- Ongoing data collection and transcription.

- First draft literature review started

- First draft literature review submitted

- Second draft literature review submitted

- Major amendment submitted to ethics to widen search criteria.
- Third draft literature review submitted

- Final literature review submitted
- Final transcription of interviews

- Data analysis

- First draft empirical paper submitted.
- Amended. Second draft submitted.
- Critical Appraisal. Abstract written

- Submission of thesis to University of Leicester
Appendix G - Approval Letter from NHS Ethics

Health Research Authority

NRES Committee East Midlands - Derby
Research Ethics Office
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8439438
Facsimile: 0115 8436294

18 March 2013

Miss Emily Callan
School of Psychology
104 Regent Road
Leicester
LE1 7LT

Dear Miss Callan

Study title: The Lived Experiences of Transgender Male to Females in Psychosocial Intervention throughout Gender Reassignment Surgery

REC reference: 13/EM/0098
IRAS project ID: 121092

The Research Ethics Committee reviewed the above application at the meeting held on 07 March 2013. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Mrs Carol Martin, nrescommittee.eastmidlands-derby@nhs.net.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).
Conditions of the favourable opinion

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

1. Please ensure the Participant Information Sheet is sent to the participant prior to the consent being obtained so they have the opportunity to read through this thoroughly
2. Please include contact details in the Participant Information Sheet for a complaints procedure
3. Please amend the Consent Form, currently it is too complicated and sections are repeated, please refer to the template on the NRES website

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

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

Sponsors are not required to notify the Committee of approvals from host organisations

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.
Approved documents

The documents reviewed and approved at the meeting were:

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<th>Version</th>
<th>Date</th>
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<tr>
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<td>Letter from Emily Callan</td>
<td>19 February 2013</td>
</tr>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td>2</td>
<td>15 January 2013</td>
</tr>
<tr>
<td>Investigator CV</td>
<td>Emily Callan</td>
<td>19 February 2013</td>
</tr>
<tr>
<td>Letter of invitation to participant</td>
<td>2</td>
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</tr>
<tr>
<td>Other: CV</td>
<td>Marilyn Christie</td>
<td>19 February 2013</td>
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<td>Other: Demographics Form</td>
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<td>Participant Consent Form</td>
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<td>01 February 2013</td>
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<td>Participant Information Sheet</td>
<td>2</td>
<td>01 February 2013</td>
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<tr>
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<td>REC application</td>
<td>121092/4130 72/1/857</td>
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Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.
Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/EM/0098 Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members’ training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee’s best wishes for the success of this project.

Yours sincerely

Mr Peter Korczak
Chair

Email: nrescommittee.eastmidlands-derby@nhs.net

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments
“After ethical review – guidance for researchers”

Copy to: Mr David Clarke, Leicestershire Partnership Trust
Appendix H - Notification of Ethical Amendment

05 November 2013
Miss Emily Callan
School of Psychology
104 Regent Road
Leicester
LE1 7LT

Dear Miss Callan

Study title: The Lived Experiences of Transgender Male to Females in Psychosocial Intervention throughout Gender Reassignment Surgery

REC reference: 13/EM/0098
Amendment number: Version 2 08.10.2013
Amendment date: 08 October 2013
IRAS project ID: 121032

The above amendment was reviewed 17 October 2013 by the Sub-Committee in correspondence.

Ethical opinion
The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents
The documents reviewed and approved at the meeting were:

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<tr>
<td>Protocol</td>
<td>2</td>
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</table>
Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/.

| 13/EM/0036: | Please quote this number on all correspondence |

Yours sincerely

Mr C. Hallamell

Mr Peter Korczak (Chair)

E-mail: NRESCommittee.EastMidlands-Derby@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to: Mr David Clarke, Leicestershire Partnership Trust
Appendix I - Interview Schedule

**Semi Structured Interview Schedule**

1. Can you tell me about life prior to your gender reassignment?
   *Prompt:* Relationships, family life, social life, work life…
   What kind of person were you?

2. Can you briefly tell me about the process of your gender reassignment?
   *Prompt:* Timescales, Environments, Services, Attitudes of professionals

3. Can you tell me about your experiences of psychological/psychosocial support through your transition?
   *Prompt:* Who suggested/referred you for support?
   Why did you attend therapy?
   Timescales, Feelings, Thoughts, Impact on you...

4. How would you describe yourself as a person now?
   *Prompt:* What kind of person are you?
   What are the most important things to know about you?
   How do you see yourself?

5. Has having psychological intervention affected how you see yourself and if so how?
   *Prompt:* How would you say you have changed?
   How would you have seen yourself had you not had psychological support?

6. Can you tell me about your life currently?
   *Prompt:* Relationships, family life, social life, work life…

7. How would you describe the impact on you whilst receiving psychological/psychosocial intervention?
   *Prompt:* Are there any positive aspects to therapy?
   Are there any negative aspects to therapy?

8. Can you tell me about how you see your life in the future?
   *Prompt:* Relationships, family life, social life, work life…
Appendix J - Initial Information

Information Sheet

Experiences of Psychological Intervention during Gender Reassignment Surgery

You are being invited to take part in a research study. Before you decide whether or not you wish to participate, it is important for you to understand why the study is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Thank you for reading this.

What is the purpose of the study?

This study will objectively look at how psychosocial support proved helpful and/or unhelpful for those individuals who have undergone surgical transition, relating to their mental health and psychological and emotional well-being. The goal is to inform psychological approaches to working with the transgender population and also to have a better understanding of the emotional and psychological impact such a process has on their social and emotional well-being and identity. The study will focus in those who received formal psychosocial intervention from services (NHS or non NHS). This study aims to inform clinicians about helpful ways of working with this transgender men and women, and understanding their needs during the transition process.

What will happen to me if I take part?

The interview should take no longer than an hour. Only one interview is required. If it is not possible to complete the interview in one appointment then the researcher will be happy to arrange to meet you again.

There will be an opportunity after the interview to discuss with the researcher any questions you may have or any concerns or distress caused. The information will be gathered to look at individual experiences of psychological interventions during gender reassignment surgery.

What do I have to do?

Taking part in this study means that you will be interviewed. You do not have to do anything else. Your regular activities and day-to-day routines will not be affected as much as possible.

If you are interested in taking part in this study or for further information, please contact:

Emily Callan,
Email
Appendix K - Participant Information

Patient Information Sheet

Experiences of Psychological Intervention during Gender Reassignment Surgery

You are being invited to take part in a research study. Before you decide whether or not you wish to participate, it is important for you to understand why the study is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Thank you for reading this.

What is the purpose of the study?

This study will objectively look at how psychosocial support proved helpful and/or unhelpful for those individuals who have undergone surgical transition, relating to their mental health and psychological and emotional well-being. The goal is to inform psychological approaches to working with the transpopulation and also to have a better understanding of the emotional and psychological impact this process has on social and emotional well-being and identity. The study will focus on those who received structured psychosocial intervention from services (NHS or non NHS). This study aims to identify the lived experiences of trans men and women in order to inform clinicians about helpful ways of working.

Why have I been chosen?

Participants for the study were identified from a range of Transgender support organisations. Participants for this study have undergone surgical gender reassignment or are currently undergoing hormonal treatment and have undergone counselling or psychosocial support relating to their gender reassignment.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to give your written consent. If you decide to take part you are still free to withdraw at any time without giving a reason. Any information or responses you may have already given will be destroyed.

General advice about participating in a research study can be sought from the patient experience lead or National UK Clinical Research Network.

What will happen to me if I take part?

Once you have agreed to take part in the study a researcher will arrange to come to see you at a convenient place. The interview should take no longer than an hour. You will be asked to give written consent for the interview to be audio recorded. Only one interview is required. If it is not possible to complete the interview in one appointment then the researcher will be happy to arrange to meet you again. Breaks can also be taken at any time throughout the interview.

There will be an opportunity after the interview to discuss with the researcher any questions you may have or any concerns or distress caused. The information will be gathered to look at individual experiences of psychological interventions during gender reassignment surgery.

What do I have to do?

Taking part in this study means that you will be interviewed. You do not have to do anything else.
What are the possible risks or disadvantages of taking part?

There are no risks involved in taking part but it is possible that talking about your experiences may cause you to feel upset or distressed. The researcher will therefore always offer the opportunity after the interview to discuss this with them and support will be provided if you have found it distressing in any way. A break can be asked for at any point within the interview should distress become too great.

What are the possible benefits of taking part?

We hope that this study will help you by discussing your experiences of psychological intervention during the course of your gender reassignment. However, this cannot be guaranteed. We are also hopeful that findings from the research may be used to help services be more sensitive to the needs of patients and their families and inform future clinical practice.

What if something goes wrong?

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the National Health Service complaints mechanisms are available to you. Advice on the NHS complaints procedure can be obtained by calling Leicestershire Partnership Trust Customer Services on: 0116 295 0830.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the study will be kept strictly confidential. All information recorded from you in the interview will not have any information attached to it that you could be recognised from. Interview data will be kept on encrypted computer hardware and will be destroyed five years following the study.

Should information be disclosed during the course of the research which causes the researcher to believe either you or a vulnerable other is at serious risk your confidentiality may need to be broken, in line with Leicestershire Partnership NHS Trust policy. In the event of this occurring, wherever possible the researcher will discuss that your confidentiality will be breached.

What will happen to the results of the study?

The results of this study will be available in 2014-2015. The results will form the researcher’s doctoral thesis and is expected to be published in a peer-reviewed journal. A copy of the collected results will be sent to the Gender Identity service and any other interested organisation. If any participants wish to receive a report about the study’s findings they can inform the researcher at the time of the interview.

Who is organising the study

The research is organised by the University of Leicester and Leicestershire Partnership NHS Trust. The research has obtained NHS permission and Research and Development approval from Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust. The study has been reviewed by Derby Ethics Committee.

Contact for further information

If you have any questions or would like more information about the study, or to arrange a meeting to discuss it, please me on the following email address:

Emily Callan, TraineeClinicalPsychologist  ec195@le.ac.uk

Alternatively, if you would like me to telephone you, please leave your contact details with the group organisers, including a preferred time to call and I will get back to you as soon as possible.

Thank you for considering taking part in this study.
Appendix L - Participant Consent Form

Title of Project: Experiences of Psychological Intervention during Gender Reassignment Surgery

Name of Researcher: Emily Callan

1. I confirm that I have read and understand the information sheet dated February 2013 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant sections of data collected during the study, may be looked at by individuals from University of Leicester, where it is relevant to my taking part in this research.

4. I understand that no access to my medical records is necessary for this study.

5. I agree that Emily can audio record this interview.

6. I understand that relevant sections of the data collected during the study may be looked at by the individuals from the regulatory authorities or the team researchers, where it is relevant to my taking part in the research. I give permission for these individuals to have access to my records.

7. I understand that the use of the demographics form and notes taken during the interview are strictly confidential to the researchers involved.

8. I agree that Emily can use the information gathered in our interview in the write up of this research of which I will receive a summary once completed.

Please initial all boxes

__________________________________________  ________________  ________________
Name of Participant   Date   Signature

__________________________________________  ________________  ________________
Name of Person   Date   Signature
Appendix M - Example of Initial Coding

Participant number 1

I: So, just to start, I'd like to ask you a little bit about yourself and who you are, and what life was like for you growing up.

P: Really? Ok so my name is (deleted), err, I'm 52 years old, err I transitioned about err, four years ago, I think, back in 2008 it was. I was at a point in my mind where I could no longer deal with being (pause) living the life that I was living. I supposed I was being, it's like, living, I suppose I was living a lie. Living a lie, I resented myself as being a err, man. Though at the same time, living my life like that, for an awful long time. Though in the back of my mind I'd always known what I was, but it was so difficult to deal with I suppose, I just get a bit lost with everything. Growing up, when I was growing up, my family knew there was something slightly different about me. My sister has always said she's always known she could tell something about me but she couldn't put her finger on it, but she knew I wasn't gay. My middle brother has always said, I always thought you were gay. They're all very happy and, accommodating of me, they're completely accepting of me, my mum and dad are the same (pause). They're quite really - they know there was something different about me but couldn't, couldn't really quite say. It just until recently, like in recent years, which I'm kind of willing, it's like willing to admit to what I was, and what I wanted to be. To think about what I was as a person and there was something missing to it, but admitting to
Appendix N - Example of Emergent Themes

Interview 1

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