Trans Mental Health Study 2012

Jay McNeil, Louis Bailey, Sonja Ellis, James Morton & Maeve Regan

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A UK research partnership between:

Scottish Transgender Alliance

TREC www.transcentre.org.uk

TRAVERSE CROSSING BOUNDARIES IN RESEARCH

Sheffield Hallam University

TransBareAll

Contents

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1. Introduction

The Scottish Transgender Alliance, based within the Equality Network, is funded by the Scottish Government to work in partnership with a wide range of public bodies, academics, community sector organisations and individuals to progress trans equality, human rights and inclusion. One of the Scottish Transgender Alliance's key areas of focus is improving health service provision for trans people. Anecdotal evidence among trans groups suggested trans people are experiencing high levels of depression, anxiety, self-harm and suicidal ideation related to transphobic discrimination experiences and lack of appropriate health service provision (especially in regard to lack of access to timely, good quality and patient-centred NHS gender reassignment services). Therefore, during 2012 the Scottish Transgender Alliance, in partnership with TransBareAll, the Trans Resource and Empowerment Centre, Traverse Research and Sheffield Hallam University, conducted research into trans mental health and wellbeing.

This research represents the largest survey of its kind in Europe, providing ground-breaking data on trans people's mental health needs and experiences, explored in the context of daily life, social/support mechanisms and when accessing healthcare and mental health services. Central here was an exploration of how the process of transitioning (social and/or medical) impacts mental health and wellbeing. The research was unique in its exploration of both the positive and negative impact that being trans has on mental health and wellbeing.

This research takes a humanistic approach equally valuing all diverse gender identities and gender expressions, however it is also a rigorous investigation of the factors which influence trans mental health and wellbeing. This perspective has enabled us to access a very large number of participants, many of whom have previously been too suspicious of researchers, in particular when talking about mental health, for fear of how they may be misinterpreted. Our approach, and history, reassured participants that their voices would be genuinely represented in the way that they intended. As such, where possible we have directly used their words. Our trans group connections have helped highlight areas for investigation, but all the findings have been reported without bias.

We hope that the findings of this report will be welcomed by trans people and enable them to feel that their voices have been heard. We also hope that they will be welcomed by public bodies and other service providers, as evidence of the need to commit resources to further understanding and better including the mental health needs of trans people, and to implement change to improve health and wellbeing outcomes for trans people.

For a summary of the key findings, please go to section 7.

2. Background 4

2.1. Acknowledgements

The study was mainly funded by the Scottish Government via the Scottish Transgender Alliance who employed Jay McNeil to lead the project, with the co-researchers time being funded by their respective organisations.

We would like to thank the following people for their support with this research:

The Advisory Group: Rosa Benato, Robert Jeffery, George Burrows, Ellis Ciruello, Gavriel Ansara, Lee Gale, Ruth Pearce, Tam Sanger, Colin Fischbacher.

Dr Greta Bauer and the team from the Trans PULSE Project in Canada (www.transpulseproject.ca)

Brian Bond, Consultant Statistician (Quercus Statistical Consulting Ltd., brianbond007@aol.com, 01462835630)

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We particularly thank all the participants who took considerable time and effort to complete the survey.

2.2. Methodology

Study Design: A questionnaire-based survey was chosen as the preferred method for this pilot study, allowing us to gather a large amount of surface information to help highlight which issues might be the most important to study further. The survey was administered online, with paper versions also made available, to maximise its reach. The design of the survey was conducted in several stages.

Firstly, a research team was convened. This comprised of Jay McNeil (Scottish Transgender Alliance, Traverse Research, & TransBareAll), James Morton (Scottish Transgender Alliance), Louis Bailey (Trans Resource and Empowerment Centre & Traverse Research), and Sonja Ellis (Sheffield Hallam University). Maeve Regan provided research support. At this stage the key topics most relevant to trans mental health and wellbeing were identified and listed. Ethical approval was sought and obtained from Sheffield Hallam University. The list of key topics was used to formulate questions for the initial draft of the survey. Topics explored included: Life satisfaction, physical changes, employment, housing, media impact, sex, gender-related health services, counselling/therapy, and mental health services.

Existing international research on trans mental health and wellbeing was explored in

order to inform the creation of the survey questions. The questionnaire used by the Trans PULSE team in Canada was regarded as particularly helpful and relevant (see www.transpulseproject.ca for further information). Following discussions with the Trans PULSE research team, it was agreed that where possible we would use the same question wording or measures to enable international comparisons to be drawn from combined data. Thus a small number of questions were included directly from the PULSE questionnaire. In addition, a number of standard psychometric tests were used in order to ascertain people's mental health, both past and present, in relation to being trans and experiencing transition.

The draft survey that was produced was then sent to an Advisory Group made up of academics, researchers, community members, and other interested parties. It was essential to the success of this project that trans people were involved not simply as some of the research team, but as advisors throughout the whole project, to ensure that the survey findings would genuinely represent the current mental health and wellbeing of the communities it aimed to represent. From the feedback received multiple drafts were produced, which were then shared for additional feedback. This process was undertaken for a number of months before a pilot questionnaire was completed. A further 11 diverse trans people who had not been involved in the survey design undertook the pilot questionnaire and provided feedback on the questions, and on their experiences of taking part. After further redrafting and feedback from the advisory group, the survey was uploaded to Survey Monkey and published.

Participants were encouraged to take part mainly through a process of snowballing. Trans support groups, online forums and mailing lists with UK members were contacted and given information about the study and asked to share the survey as widely as possible. Other equality and health groups, and professional networks with potential links to the trans population (e.g. LGBT networks; professionals whose work might bring them into contact with trans people) were also contacted and asked to distribute information about the survey. The survey spread primarily through word-of-mouth, and the researchers attended a number of trans groups in person to discuss the project and encourage participation. The survey was open for approximately 3 months (mid-April 2012 to mid-July 2012), during which time reminders were posted online, and the survey continued to be publicised.

As part of the online survey, participants were asked if they would like to provide contact details to enable us to form a database of future participants. 607 people provided details, also consenting to us linking data gathered from future studies they may take part in, with the data from this study. In this way we have a pool of participants available, and hope to conduct longitudinal research with this population.

The report: at the close of the survey 1054 participants had accessed the survey. For the purposes of this report, those living outside of the UK and Ireland were excluded, as were anyone who had not consented to take part or who was under 18. Those who had only answered the first question were also omitted. The final data set consisted of 889 people. As different numbers of people completed different questions, the actual

number whose data is being reported on for each question will be clear in the text as 'N'. For example if 100 people completed a question and we report that 50% of those agreed with a statement, the 50% figure will be followed by (N=100) to show how many this figure is based on. Where the words "of the sample" are used, this refers to the whole 889.

This report consists primarily of percentages, with very few statistical analyses. The aim of this report is simply to present and summarise the vast quantity of data, in order to highlight areas of further study. More comprehensive research articles will be submitted for publication at a later date, which will explore the different sections of the data in more detail. Where percentage figures are reported, they have been rounded up or down to the nearest whole number which can lead to rounding up/ down errors (e.g. percentages not adding up to 100). Complete data tables for each question were not included in the text due to their size and complexity, however these can be obtained on request.

Where quotes from participants are used, spelling mistakes have been corrected for ease of reading. The actual texts are available on request. A glossary explaining some of the terms used in this report (by the authors and the participants) can be found at the back.

On occasion the data was split by a number of "filter" questions. These were as follows:

By gender identity

The data has been separated using the question "Which of the following best describes you?" The possible answers by which the data is separated are as follows:

- ★ I have a constant and clear gender identity as a woman
- ★ I have a constant and clear gender identity as a man
- ★ I have a constant and clear non-binary gender identity
- ★ I have a variable or fluid non-binary gender identity
- ★ I have no gender identity
- ★ I am unsure of my gender identity

This question was used as it was felt that it might be possible that people who had clear binary identities may have different outcomes in terms of wellbeing, than those who had non-binary or fluid identities, or who were unsure of their identities.

By location

The data has been separated by regions, i.e. by England, Northern Ireland, Scotland, Wales or UK. The data was separated in this way to see if living in different places had

any impact on outcomes for trans people. A very small number of Irish participants were included (a separate adapted Irish version of the survey with a very large number of participants was run in partnership with Transgender Equality Network Ireland during June and July 2012 and will be reported in 2013).

By interest in or stage of transition

The data has been separated using the question "Do you consider 'gender reassignment' or 'transition' to be relevant to you? (Any part of a personal, social and sometimes medical or surgical, process by which you have changed the way you express your gender)"? The possible answers were:

- ★ No, I have not undergone and do not propose to undergo any part of a process of gender reassignment or transition
- ★ Yes, I am proposing to undergo a process (or part of a process) of gender reassignment or transition
- ★ Yes, I am currently undergoing a process (or part of a process) of gender reassignment or transition
- ★ Yes, I have undergone a process (or part of a process) of gender reassignment or transition
- ★ Unsure
- ★ Other

This question was used as it was felt that it might be possible that people who had no desire to undergo any transition, who wished to or had started a process, who were uncertain, and people who had undergone their transition, may have different outcomes. The question specifically stated that transition could mean some sort of social or personal transition rather than simply a medical process, to represent the diversity of people's identities and that transition is multi-faceted, meaning different things to different people. Although the question was worded in a manner that was as inclusive as possible, this does mean that it is open to different interpretations, which must be considered when interrogating the data using this as a filter question.

By how the participants felt that they were perceived by others

The data has been separated by the question "How do you think you are usually perceived/seen by others?" Possible answers included:

- ★ As the gender I identify as
- ★ As the sex I was assigned at birth
- ★ As a trans person
- ★ Other

This question was used to separate some data as it was thought that people who

felt they were more often perceived in a way different to how they feel, might have outcomes which were different to those for people seen as the gender they identified as. Again this question is dependent on the participant's personal interpretation of their interactions, which may not necessarily represent how they were interpreted in the world by others. Ultimately however, it is these personal feelings which would have the greatest impact upon mental wellbeing, hence the question was used as a filter.

A Note on Sampling

Sampling is a complex issue in undertaking research with trans populations. Those who might be considered as trans may or may not define that way; and perhaps more crucially many trans people are a hidden population, especially those who decide to keep their trans identity or history extremely private. Ideally in social research, samples should be representative of the population as a whole, and therefore are commonly constituted through random selection. However, there is no definitive way of identifying the trans population in its entirety and therefore no identifiable population base from which to draw a sample. For this reason, the present research relies on participants self-selecting. In setting up the study, we have aimed to be as inclusive as possible by making clear to potential participants that we were defining trans in the widest possible way. We also cast the net wide in terms of recruitment by publicising the survey through not just trans organisations, but equality and health groups, and professional networks with potential links to the trans population. While our sample is essentially one of convenience, we believe that we have fairly robust findings given the sheer size of the sample. With a total sample just short of 1000 participants this exceeds the sample size of recent online surveys with comparable 'hard-to-reach' populations (e.g. LGB people). We are mindful though that the sample may not be demographically representative of the trans population as a whole. In particular, the sample primarily comprised white trans people and a good proportion of those had undertaken post-Secondary education. There is no way of knowing for sure how representative this sample is. However, it is comparable to other research in that on the whole white, well-educated individuals are more likely to access support groups and to have private access to the internet than individuals who experience disadvantage on multiple grounds simultaneously.

3. Demographic Data

Age (N=501)

People of many different ages took part in the Trans Mental Health and Wellbeing (TMH) Survey. Participants ranged in age from 18-78 years old. As shown in Figure 1, over 55 years of age the number of people who took part tailed off. When the groups were split by gender identity, there were few differences between them in terms of age.

Location (N=518)

Most of the people who took part in the survey lived in England (around 84%), with the next largest group being in Scotland (11%), and 4% being in Wales. Less than 1% of the respondents lived in Northern Ireland or Ireland.

Ethnicity (N=514)

The vast majority of the sample, 86%, was White UK (British, Northern Irish, Scottish, Welsh or English), with fewer than 8% being from other white backgrounds. Other ethnic groups represented less than 7% of the sample. This is not representative of the UK population as a whole. Under representation of minority ethnic people is an on-going difficulty for UK trans and LGBT (lesbian, gay, bisexual and trans) research, and may be due to convenience sampling having lower engagement rates for people facing multiple discrimination and also the survey being only available in English due to lack of funding for translation.

Religion (N=504)

Most people who took part stated that they had no religious beliefs (62%). Of those who did, the majority were Christians (20%), with Pagans (6%) and Buddhists (3%) being the next highest groups represented. Jews, Muslims and Sikhs accounted for less than 1% of the sample each, whereas Hindus were not represented at all. Again this is not representative of the UK population as a whole and religious inclusion is an on-going difficulty for UK trans and LGBT support groups and research studies..

Sexual Orientation (N=530)

Participants were able to select multiple answers to this question to enable them to fully reflect their sexual orientation. Of the 530 people who answered the question, 300 gave only one answer, whereas 230 ticked more than one option as representing their sexual orientation. The largest group of participants (27%) identified with bisexual as a description of their sexual orientation. 24% identified with Queer as

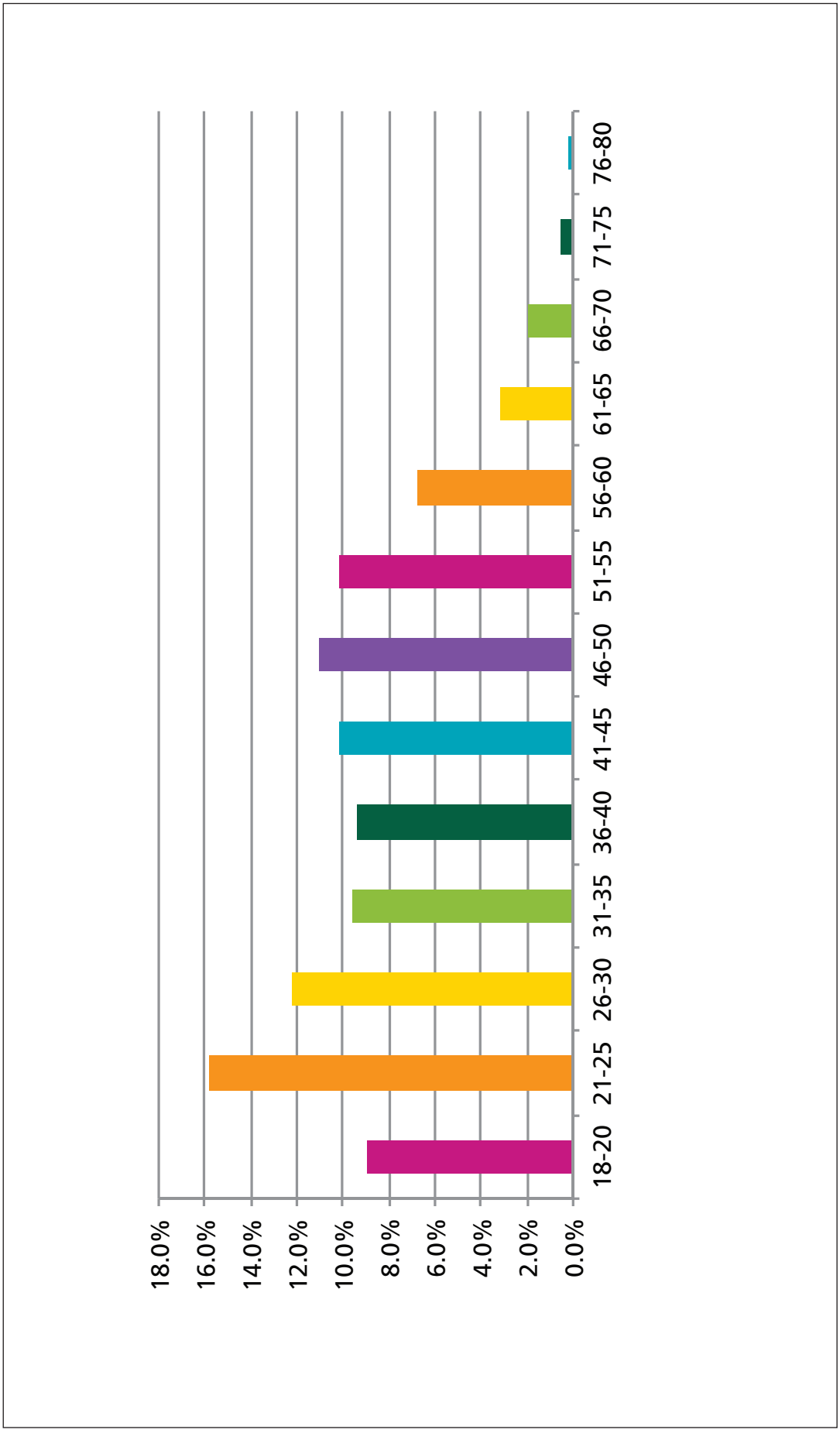

Figure 1: Ages of participants

their preferred term. 20% identified as straight or heterosexual.

Sexual Orientation	N	Percentage
Bisexual	145	27%
Queer	126	24%
Straight or heterosexual	104	20%
Pansexual	79	15%
BDSM/Kink	73	14%
Lesbian	69	13%
Not sure or questioning	64	12%
Other	59	11%
Don't define	55	10%
Gay	51	10%
Polyamorous	46	9%
Asexual	41	8%
Total	912	

Table 1: Sexual orientation of participants

'Other' identities which the participants added included polysexual, panamorous/panromantic, demisexual, gynesexual/gynocentric, and aromantic. For some their sexual attraction fluctuated, or had changed as they transitioned:

> 'Sexually straight but this may change. Politically bisexual'
>
> 'Was a lesbian. Now might be a gay man'
>
> 'A lesbian woman or straight man'

Relationship Status (N=502)

Nearly 38% were in monogamous relationships, whilst 12% were in relationships which were either non-monogamous or polyamorous. 55% were single, with almost half of those seeking a relationship. Where participants were not seeking relationships, some of the comments suggested that was not through choice, but through fear of rejection or through finding it hard to obtain a partner. 4.5% of those

who took part identified their relationship status as celibate.

Disability (N=492)

58% (N=492) identified as having a disability or chronic health condition. 36% identified that they had a mental health issue, with nearly a fifth of the sample experiencing some form of learning impairment or intellectual disability or other neuro-diversity. 8.5% were Deaf or hearing impaired, and 5% were blind or visually impaired. This finding, combined with 1% needing alternative communication strategies, and 10% having a physical disability, is clearly important in terms of ability to access support services and strategies, and to access spaces for social support.

Carers (N=518)

18% of the participants were carers, with 7% providing significant levels of care which would be expected to have a substantial impact upon their physical health, as shown in Table 2.

Carer Status	N	%
Yes, 50 or more hours a week	19	4%
Yes, 20-49 hours a week	16	3%
Yes, 1-19 hours a week	56	11%
No	427	82%
Total	518	

Table 2: Proportion of participants who are carers

4. Findings in detail

4.1. Gender identity

A wide variety of gender identities were represented among participants, with only around 65% (N=794) having a binary identity (i.e. identifying as a man or as a woman). Details are given in Table 3.

Which of the following best describes you?

Gender Identity	N	%
Constant and clear gender identity as a woman	317	40%
Constant and clear gender identity as a man	197	25%
Variable or fluid non-binary	122	15%
Constant and clear non-binary	63	8%
Unsure	49	6%
Other	25	3%
No gender identity	21	3%
Total	794	

Table 3: General gender identity of participants

Examples of the 'other' gender identities include:

> 'I say I am genderqueer as I don't see myself as male or female, but go under trans guy to simplify things.'
>
> 'I feel and know that I should be male but am scared of acting on these feelings'
>
> 'I am me, I don't think 'I am a woman' although I like female things the most, and as much as I can relate to women.'
>
> ' [I have] a female identity that is strong, and a male identity that is usually weaker, sometimes they are in balance and sometimes male is stronger but I generally consider myself as gender non-conformist female, or androgyne or more recently fluid. :)'

‘I identify as a “feminine” person; but it varies in how I express it and often goes against expected norms of what a Woman would do; in that like some female peers, I have aggressive interests, dress in a particular way.’

‘I’m sceptical about gender in general. I definitely don’t feel female and I’m generally comfortable being treated socially as male. But I think I have a constant and clear transmasculine identity (somewhere between male and non-binary).’

‘A year ago, my gender identity was Not Woman. I now identify as male, but part of the reason for that is that it’s easier than identifying as non-binary. If there were more accepted genders, I would probably be ‘just masculine of centre’.’

‘I do not feel like “man” is an accurate word to describe me. More accurate than “woman”, but still not quite who I am. I often describe myself as a “boy”, not really as an infantilism, but I think because it seems less rigidly defined. I also look more like a boy than a man since I am not taking hormones.’

‘I would almost say “constant and clear non-binary”, except I have put so much time and energy into my physical and official transition from binary-male to binary-female that to do so feels like a betrayal, of both myself and of the women I met in the process. I needed badly to transition away from maleness, and in order to get that I had to represent myself to various doctors and psychotherapists as being clearly and consistently female, which, while less wrong that my assigned gender, is not quite on the mark. I know that some of my comrades in the journey were in the same position’.

These comments highlight the complexity of people's gender identities. For example, some participants labelled themselves with a particular gender identity for ease of communicating it with others, whereas others presented an identity in order to access medical interventions even if it was not exactly how they felt.

This complexity was further highlighted when participants were invited to select more discrete identity categories with which they might identify. The identities which accounted for more than 20% each are shown below.

Do you consider yourself to be within any of the following categories?	N	%
Transgender person	368	46%
Woman	278	35%
Trans person	234	29%
Trans woman	221	28%
Man	214	27%
Trans man	200	25%
Female-to-Male (FtM) spectrum person	196	24%
Woman with a transsexual history	182	23%
Male-to-Female (MtF) spectrum person	166	21%
Genderqueer person	165	21%

Table 4: Specific gender identities of participants

4.2. Transition

Many of the participants had either permanently or occasionally lived as a gender different to the one usually associated with the sex they were assigned at birth. The average age at which participants began living part-time in their felt gender was 23 (N=487). The average age at which they began living full-time as their felt gender was 31 (N=545).

Participants were asked whether transition or gender reassignment were relevant to them (N=784). Most of the participants stated that they were undergoing a process of transition. 29% had already undergone some form of transition and 17% were proposing to start that process. 13% did not wish to undergo any transition.

4.3. Life Satisfaction

How satisfied are you with life in general now?

The majority, 55%, of the participants (N=746) were satisfied or very satisfied with their life. When separated by gender identity, this was true for all the groups except for those who were unsure of their gender (N=47) or those who selected 'other' (N=23), where the majority were dissatisfied (53% and 52% respectively). When separated by transition, those who were proposing to transition but had not started, and those who were unsure as to whether to transition, were also more dissatisfied than satisfied, whereas other groups were more satisfied with their lives.

Effect of Being Trans on Life Satisfaction

Of 744 participants, 57% felt that being trans had both positive and negative effects on their life satisfaction. Less than 20% each felt that being trans had either a positive or negative exclusively. Only 5% of participants felt that being trans did not affect their life satisfaction.

Stage of transition had a substantial impact upon life satisfaction within the sample. 70% of the participants stated that they were more satisfied with their lives since transition, compared to 2% who were less satisfied (N=671). When the data was separated by stage of or desire to transition, more people who were proposing to undergo transition but had not yet started, and who were unsure whether they wanted to, felt that they were dissatisfied with their lives than satisfied. Having undergone a process of transition, for those who wanted to do so, seemed to have the greatest impact on life satisfaction (N=745). The participants also stated that telling others they were trans had an impact upon their life satisfaction. The majority, 65%, felt that they were more satisfied since telling other people they were trans, compared to only 6% who were less satisfied (N=709).

How satisfied are you with your life in general? (By stage of transition)	N	Satisfied	Dissatisfied	Neither
No, I have not undergone and do not propose to undergo any part of a process of gender reassignment or transition	86	54%	22%	24%
Yes, I am PROPOSING to undergo a process (or part of a process) of gender reassignment or transition	131	31%	50%	19%
Yes, I am CURRENTLY UNDERGOING to undergo a process (or part of a process) of gender reassignment or transition	259	54%	28%	19%

(table continued...)

Yes, I have UNDERGONE a process (or part of a process) of gender reassignment or transition	214	75%	11%	14%
Unsure	40	35%	43%	23%
Other	15	33%	33%	33%

Table 5: Life satisfaction by Stage of Transition

The Diener Satisfaction with Life Scale, a widely used and accepted tool to demonstrate life satisfaction levels, was incorporated into the survey as a standardised measure. The higher the score, the greater the satisfaction with life. On a scale of 5 to 35, the mean score for the whole group (N=738) was 19, slightly below average. The range of scores in different categories is demonstrated below:

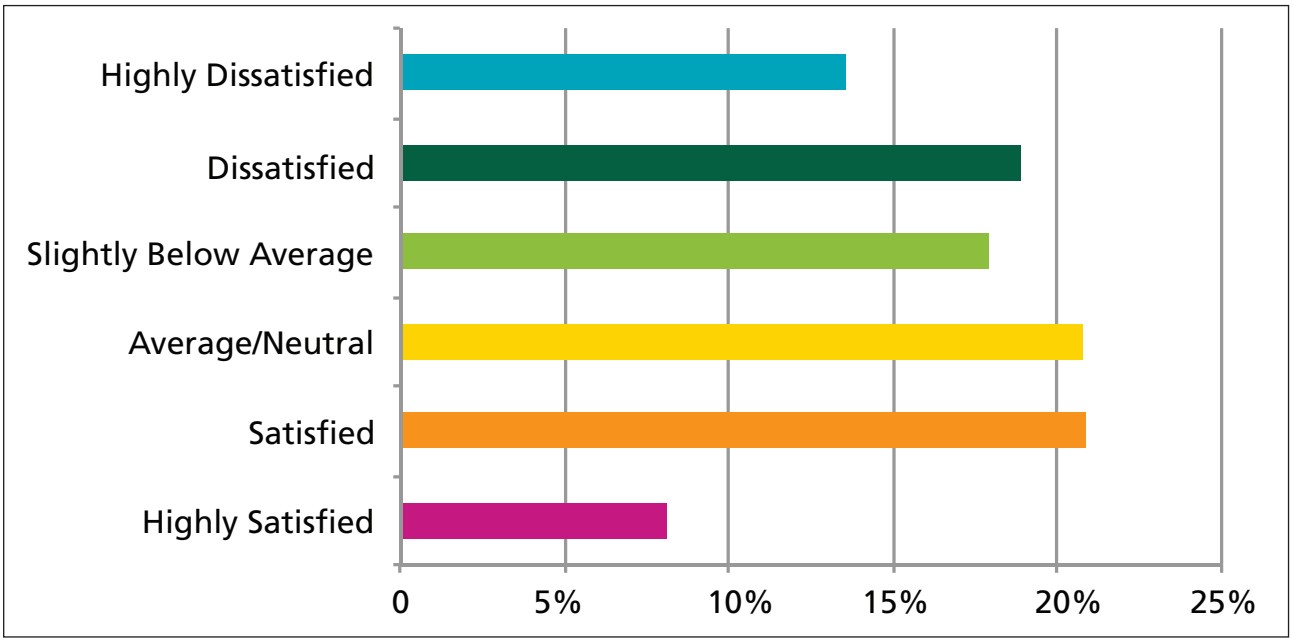

Figure 2: Number of respondents in each category on the Diener Satisfaction with Life Scale

When separated by gender identity, the differences in mean scores were statistically significant ($F=3.466$, $df=6$, $p=0.002$), with those having a constant identity or a variable non-binary identity having greater life satisfaction than those with no gender or who were unsure of their identity.

The differences in mean scores based on stage of or desire to transition were also statistically significant ($F=18.506$, $df=5$, $p<0.0005$). People who did not want to transition, or who wanted and had been able to do so, had substantially higher life satisfaction than those who were unsure as to whether they wanted to transition and those who wanted to transition but had as yet been unable to do so.

However, there is potentially an effect of expectation on satisfaction. For example, if trans people don't have particularly high expectations because their perceptions or experiences suggest that being trans limits their opportunities, they are likely to over-

rate their satisfaction. Therefore, it is possible that the mean score for trans people might actually be lower than is suggested by these statistics.

Body Satisfaction

Body satisfaction in relation to gender was explored within this study. The largest group of participants, around 49%, were dissatisfied with their bodies in relation to their gender, whereas 35% were satisfied (N=695). This was explored further by separating the sample by desire to/stage of transition as shown in Table 6.

	Not wanting or undergoing transition	Unsure if want to transition	Proposing to transition	Currently undergoing transition	Have transitioned	Total
Very satisfied	5%	3%	1%	3%	28%	69
Satisfied	27%	11%	1%	19%	49%	168
Neither Satisfied nor Dissatisfied	34%	20%	11%	16%	10%	106
Dissatisfied	28%	54%	54%	34%	11%	211
Very Dissatisfied	6%	11%	34%	29%	4%	126
Total	85	35	127	233	200	N=680

Table 6: Stage of transition and body satisfaction levels

A much greater trend towards dissatisfaction was evident in those who were unsure as to whether they wanted to transition, and those who were proposing to transition. This was also demonstrated in the group who were currently undergoing transition, although to a lesser extent. Those who had undergone some form of transition were markedly more satisfied with their body in relation to gender than the other groups. Those who were not undergoing and not wanting to undergo a process of transition, showed variability across the range of options. This suggests that being unsure of the desire to transition, or wanting to but having not completed a transition, are related to greater levels of dissatisfaction with people's bodies. The only group who had a majority who were satisfied or very satisfied with their bodies were those who had already undergone transition (total of 77%).

4.4. Physical Interventions

In terms of changing their appearance physically, 91% of participants (N=746) had made or wanted to make gender-related physical changes to their bodies.

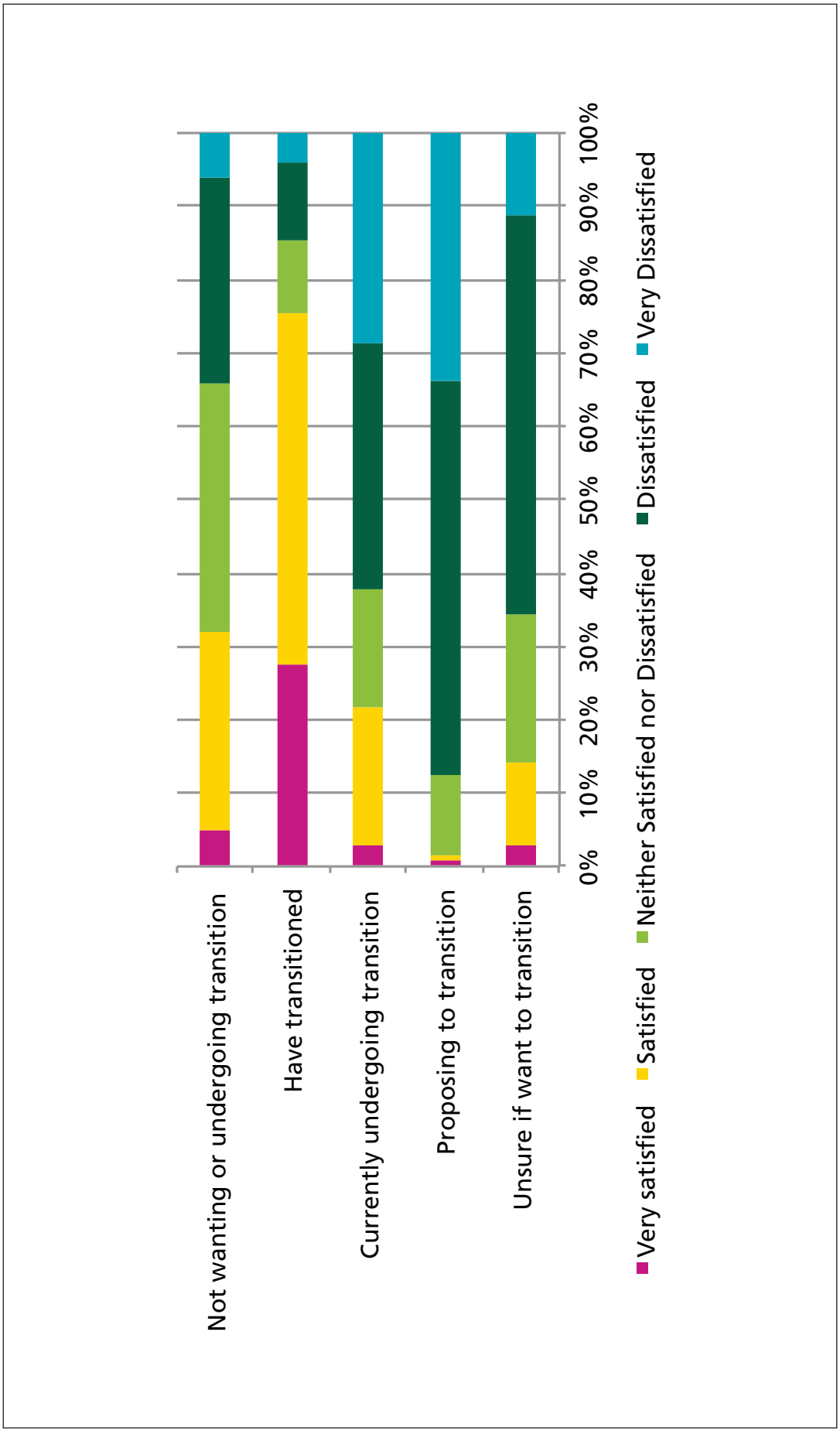

Figure 3: Stage of transition and body satisfaction levels

Hormones

55% of the participants were currently taking hormones in relation to their gender identity (N=747), with 5% having taken them in the past. Hormone therapy had started at a range of different times for the participants, with most having commenced treatment over two years previously. Just under 20% of those taking hormones (N=398) started under a year ago. Nearly three quarters of the participants (N=423) found that undertaking hormone therapy had led to changes in their emotional wellbeing or mental health.

Respondents reported significant differences to their emotional wellbeing and mental health as a result of taking hormones. There was a marked difference in outcome between those taking masculinising hormones and those on feminising hormones. In the main, people on masculinising hormones found that they experienced some degree of emotional dampening, short temperedness and generally found it more difficult to cry. They also reported dramatic increases in energy, stamina and libido. In contrast, those on feminising hormones generally described feeling calmer, more emotionally expressive and more sensitive to their surroundings, which made them more prone to crying. They also reported a decrease in energy and libido.

Respondents also described feeling more comfortable and confident in themselves since starting hormones. They reported feeling more balanced and experiencing more positive and less negative emotions on the whole. This was true for both sets of respondents:

> ‘Massive increase in my self-esteem and mood when experiencing the improvements induced by HRT’
>
> ‘Mostly, I feel that my emotional wellbeing dramatically improved after taking testosterone. I no longer experienced crying jags or depression for no reason after taking testosterone.’

However, some respondents noted that they have experienced more ‘mood swings’ since starting hormones and a few reported increased problems with memory and concentration. It is difficult to differentiate between chemical changes produced by the hormones and the emotional responses to the physical changes that the hormones induce. In other words, the respondents are likely responding to a combination of the direct effects of the hormone itself as well as the greatly welcomed physical changes that the hormones bring to their bodies. This, in turn, affects the way they interact with the world and, consequently, how they are seen and treated by society, which again affects their emotional wellbeing. As one respondent stated: ‘I have

been far less anxious and generally more relaxed since starting hormones which I believe is result of combination of the endocrine hormonal effects of testosterone and improved self-image and comfort with my own image as result of the physical changes produced by hormones'.

The participants were asked if taking hormones had changed how satisfied they were with their bodies. Of 417 people, 85% were more satisfied with their body since undertaking hormone therapy. Only 2% were less satisfied.

The participants were also asked if hormones had changed how satisfied they were with their overall lives. Of 398 people, 82% reported greater levels of life satisfaction than pre-hormones. As before, only 2% were less satisfied.

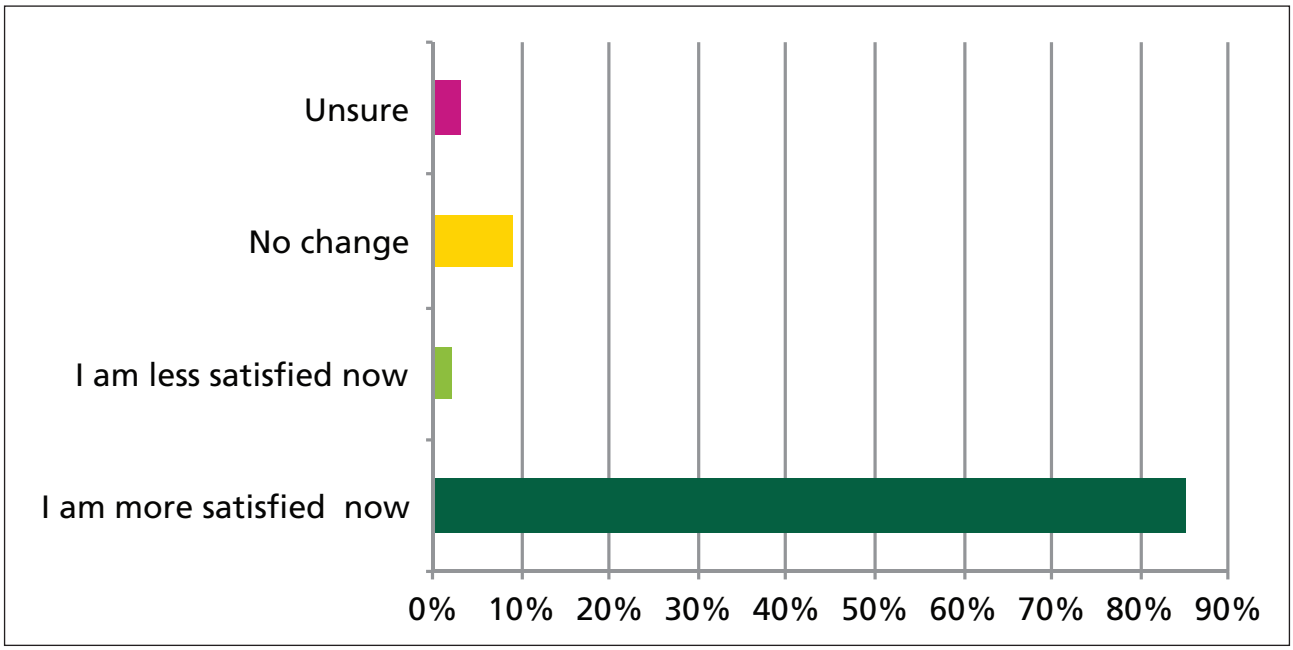

Figure 4: Has taking hormones led to any changes in how satisfied you are with your body? (N=417, not applicable excluded)

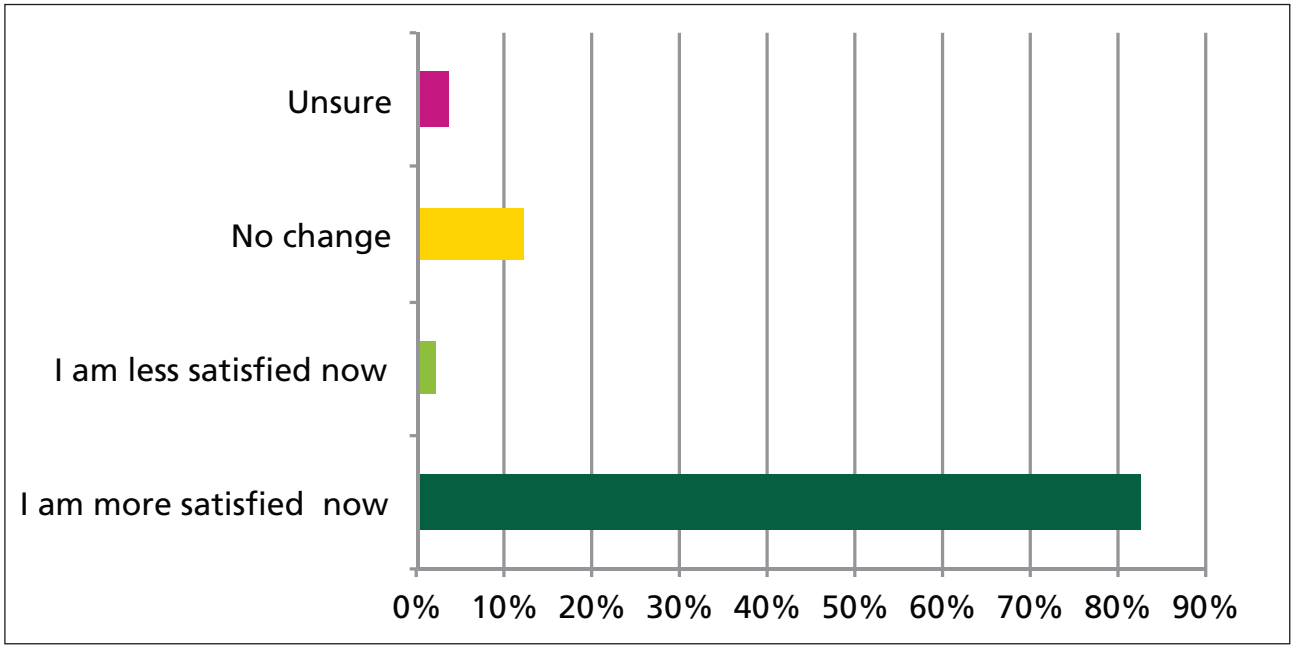

Figure 5: Has taking hormones led to any changes in how satisfied you are with your life? (N=398, not applicable excluded)

Surgery

The participants were asked about any surgical interventions they may have wanted or had. As Table 8 shows, just under 90% have wanted, or have undergone, surgery in relation to their gender identity. 11% have never wanted any surgical interventions.

Have you ever wanted to have, or undergone, any of the following?	N	%
Surgery to REMOVE MALE physical characteristics or to CREATE FEMALE physical characteristics	363	50%
Surgery to REMOVE FEMALE physical characteristics or to CREATE MALE physical characteristics	276	38%
BOTH of the above types of surgery	12	2%
I have never wanted to have, or undergone, any of these	79	11%
Total	730	

Table 7: Surgical interventions undertaken

Many more people with either a fluid or no gender identity reported no desire to undergo any surgery, compared to other gender identity groups.

The majority of participants who stated that they wanted to have, or had undergone surgery to remove male characteristics or create female ones, reported that they either wanted, were considering, or had undergone: removal of the testicles, creation of a vagina, creation of a clitoris and removal of the penis. The most sought after

intervention was the removal of facial hair, with only 3% of the participants stating that they did not want or need this. There were no interventions where the outcomes were rated overall as more dissatisfactory than satisfactory, although very small numbers of people had undergone some techniques making it difficult to draw conclusions.

Surgery type	Have Had	Would like	Considering	Don't want
Removal of testicles (orchidectomy)	30%	40%	15%	10%
Creating a vagina (vaginoplasty)	30%	42%	14%	10%
Creating a clitoris (clitoroplasty)	29%	42%	13%	9%
Removal of penis (penectomy)	29%	37%	12%	13%
Creating external appearance of female vulva/vagina but not a vaginal cavity	7%	14%	12%	47%
Making breasts bigger (breast augmentation)	12%	29%	28%	24%
Reshaping brow, nose, jaw and/or other parts of face (facial feminising surgeries)	12%	26%	28%	26%
Making voice higher by surgically altering vocal chords	3%	16%	21%	48%
Removal of facial hair using laser or electrolysis	60%	27%	6%	3%
Reshaping adams apple (trachael shave)	9%	18%	19%	44%
Hair transplants	2%	11%	14%	61%
Other gender related surgery	4%	3%	6%	43%

Table 8: Surgery to REMOVE MALE physical characteristics or to CREATE FEMALE physical characteristics (N=372)

The majority of participants who stated that they wanted to have, or had undergone, surgery to remove female characteristics or create male ones, reported that they either wanted or had undergone: removal of the uterus and chest reconstruction (mastectomy). Only 3% of the participants stated that they did not want or need chest reconstruction. Levels of satisfaction with procedures seemed much lower than for those undergoing feminising interventions, with the exception of chest reconstruction, however extremely small numbers of people had undergone some techniques making it difficult to draw conclusions.

Surgery type	Have Had	Would like	Considering	Don't want
Making breasts smaller (breast reduction)	1%	8%	16%	55%
Chest reconstruction removing breasts 'top surgery' (double mastectomy)	27%	52%	17%	3%
Removal of uterus (hysterectomy)	12%	38%	29%	16%
Removal of ovaries (salpingo-oophorectomy)	11%	33%	30%	20%
Releasing the clitoris (metaoidioplasty)	1%	14%	38%	35%
Lengthening of urethra to change where you pee from	2%	18%	30%	39%
Creation of scrotum (scrotoplasty)	2%	18%	28%	43%
Insertion of testicular implants to create testicles	3%	18%	27%	43%
Closure or removal of vaginal cavity (vaginectomy)	1%	13%	27%	49%
Creation of a penis using tissue from belly (abdominal phalloplasty)	1%	3%	20%	63%
Creation of a penis using tissue from arm (radial artery forearm phalloplasty)	2%	7%	20%	60%
Creation of a penis using tissue from thigh (antero-lateral thigh phalloplasty)	0%	3%	23%	61%
Creation of a penis using tissue from back (musculocutaneous latissimus dorsi phalloplasty)	0%	2%	20%	64%
Insertion of erectile device (rods/ pump) to enable erections of penis	2%	11%	19%	57%
Other gender related surgery	1%	2%	6%	55%

Table 9: Surgery to REMOVE FEMALE physical characteristics or to CREATE MALE physical characteristics (N=283)

It is important to note that in terms of the genital surgeries which many presume are the main purpose of a medical transition for trans people, there seems to be much less desire to undertake them amongst those seeking masculinising surgeries, than for those who wished to have feminising surgeries. For example between 20% and 40% of participants desiring masculinising interventions wished to undergo some form of phalloplasty (creation of a penis), whereas around 90% of those wishing to undergo feminising surgery were considering, or had undergone creation of a clitoris

and vagina. This supports anecdotal evidence from trans groups which suggests that genital surgeries are more sought after in general amongst trans women and others who wish to undergo feminising techniques, whereas chest reconstruction is generally the most sought after intervention amongst trans men and others who wish to undergo masculinising interventions.

The impact of surgery on body image, both genital and non-genital, was evident in this sample. Of those who answered that they had undergone non-genital surgery, 87% were more satisfied with their bodies. Only 2.6% were less satisfied (N=193). Of those who had undergone genital surgery 90% were more satisfied with their bodies than before, and only 3.7% were less satisfied (N=136).

Surgery also affected the participants' life satisfaction too. Again, of those who stated that they had undergone non-genital surgery 88% were more satisfied with their lives now, with 3.9% being less so (N=182). For those who had undergone genital surgery, 83% were more satisfied with their lives, and only 3.8% were less so (N=131).

When asked if there was anything that could improve satisfaction with surgery outcome, respondents cited: having access to good surgeons and surgical techniques; less visible scarring; having fewer complications from surgery, such as nerve damage, or options to address them; not needing to undergo revisions; and not requiring extensive amounts of surgery. Some respondents also reported significant loss of sensation, particularly after genital surgery, which resulted in the impaired ability to orgasm. In addition, respondents also stated that satisfaction would improve if they did not have to endure unnecessary delays or funding refusals on the NHS or the sheer cost of treatment if they went privately. One respondent felt that they would have benefited from 'proper psychological support and not just gatekeeping' whilst another stated that: 'It is a significant stage in the completion of a key life process, so a successful outcome is vital. There is a need for on-going post-op support and care: something which the NHS route is often criticised for lacking'.

Respondents also reported particularly unpleasant experiences:

> 'I was treated like a freak by the surgeon in hospital, who only communicated with me at a very basic level, at times was extremely brusque and rude, and made me feel of very little value as a human being'
>
> 'Whilst expecting scarring from chest surgery to have a lop side chest and macerated nipples due to surgeon not ensuring the right sutures were available on the day was negligent - I had a massive reaction and infection whilst [name of surgeon removed] did a runner from consultancy rooms'.

Those with non-binary identities also presented other concerns: 'The provision for genderqueer people to body-modify with hormones and surgery is better than it used to be but it could still do with improvement, as I still came under some pressure to present a somewhat more binary identity in order to access these treatments. I don't feel that this was helpful to me.'

The emotional impact of not undergoing surgery was significant, as the following statements reveal:

> 'By delays with my surgery I am in physical pain and more easily depressed'
>
> 'Not having had surgery yet has impacted severely - one is always afraid people will know or find out especially with certain sporting activities'
>
> 'Not undergoing surgery has left me feeling somewhat in limbo, frustrated and restless for the most part'
>
> 'Not having had my gender confirming or FFS surgeries yet has a constant effect on undermining my self esteem and self confidence as well as social transition - I hate every day I have to live with 'boy parts' and can't wait to get rid of all recognisable boy bits'
>
> 'I have been turned down for tracheal shave surgery on the NHS which has caused me a lot of stress. My adam's apple causes me a massive amount of dysphoria and I feel awful about it.'

In contrast, those that had undergone surgery reported significantly improved mental health and wellbeing as a result:

> 'When I woke from chest surgery I was woozy and confused but one thing I knew for sure was that I was so relieved to have a flat chest. I've never once regretted it. It has let me feel much safer and more comfortable in my body which has made my mental health and confidence much much better.'

'Permission for my chest surgery was delayed and I waited double the usual waiting time plus I had to fight my PCT for funding. This caused me to go into a deep depression. I had panic attacks when I left the house, I lost my job and then found I couldn't leave the house. Since having surgery I'm sociable and confident and have not had any depressive recurrences.'

'If I had not undergone surgery when I did I would almost certainly have either been a suicide or at very least a long-term depressive and possible inmate in some mental hospital.'

4.5. Gender Identity Clinics

Anecdotally, there have been substantial waiting times for people wishing to be seen at a Gender Identity Clinic (GIC). The time taken from first asking a health professional for support around being trans, to being seen at a GIC was explored in this survey to attempt to understand the impact it might have. Those participants who stated that they had attended a GIC were asked for information about these experiences. Nearly 60% of them reported being seen within a year (N=293), with around 32% waiting one to three years and under 10% waiting for more than three years. 58% of the participants (N=295) felt that this wait had led to their mental health or emotional wellbeing worsening during this time:

'I was scared that it was going to destroy my life. Which it did. I also was a regular in patient at the local mental hospital as I was suicidal'.

'I was expected to be open and confront years of repressed emotion relating to gender, only to be left for months on end with no support, my social functioning decreased as a result of the discomfort i felt, and the gender clinic may have used that as an excuse not to prescribe hormones or further treatment of my condition...(I am still waiting to hear from them)'.

'It took a very long time (in my opinion) and left me

feeling that my mental health/ me as a person wasn't important'

'There was no support from the NHS whilst I waited and this increased my sense of hopelessness and depression '

'Waiting for access to the GIC had a devastating effect on my mental health. By the time I came forward for help, I needed it urgently. Such a delay caused me serious mental distress. Moreover, my long-term relationship suffered because of the uncertainty about my transition going forward. Words cannot express the harm done.'

'I couldn't cope and had a breakdown leading to 12 weeks sick leave during the 10 months it took to get my first appointment.'

As the graph below demonstrates, most of the participants were seen within the last ten years, with 30% being seen at a GIC in the last year (N=202).

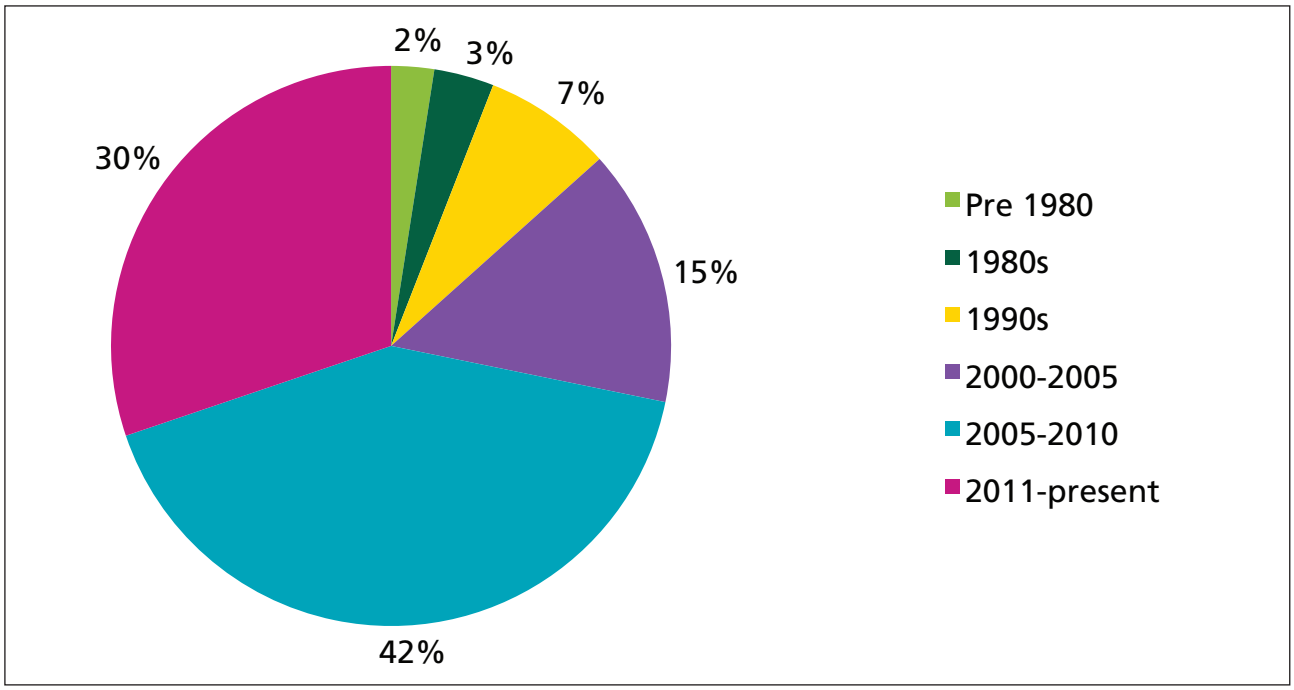

Figure 6: When were you seen at a GIC?

Once seen at a GIC, 46% of the participants felt that they had experienced difficulties obtaining the treatment or assistance that they needed. These included administrative errors, restrictive protocols, problematic attitudes, and unnecessary

questions/tests:

‘The GIC expected me to be some stereotypical image of a woman rather than being myself’

‘as my gender issue has created its own problems after being ignored and left untreated... to then go through such a narrow diagnostic procedure at the clinic with no degree of autonomy in the treatment of individual cases, I feel is.....unrealistic.... with regards to tackling this condition, for me and potentially others’

‘Refusal to provide treatment until I left my position in the army’

‘In Transactional Analysis terms [name of clinic removed] is like Parent (them) Child (me). Rarely Adult-Adult which is of course preferable. I appreciate they are oversubscribed - but this should be managed because at present the service is patronising and poor.’

‘one of the clinicians initially refused to start my hormone treatment due to HIS perspective on a personal situation within my close family. On my last appointment (where I was accompanied by one of my family to help explain the situation) another of the clinicians reviewed this matter and accepted that it should NOT have impacted on my treatment.’

‘I had an appointment with one Dr who couldn’t understand that I was temporarily using a wheelchair due to an accident I had 2wks before the meeting which had no bearing on my gender identity but because I was an overweight patient he refused to give me hormones on that visit because he said while I was in a wheelchair I couldn’t lose weight! Needless to say I then had to wait another 9mths before I got hormones.’

‘I experience the NHS GIC service as largely a paternalistic gatekeeping exercise where psychiatrists exercise inappropriate levels of control over the lives and choices of patients. They ensure compliance by withholding or threatening to withhold access to

treatment (hormones, surgery). Their primary purpose seems to be to make it as difficult as possible for people to access the hormones/surgery they need in order to save the NHS money. There is no transparency about the treatment pathway or clinical protocols, which leads to a 'kafkaesque' situation where clinicians are making decisions that directly affect your life but you have no knowledge or say about how those decisions are being reached… There are a few good, compassionate clinicians working in the GICs but they are the exception in the system that is set up to maintain the paternalistic control of a few egotistical psychiatrists over their patients. Having to negotiate the GIC system seriously hindered my transition. At many times, it has left me feeling angry, disappointed, manipulated, controlled and despairing. The system is deeply flawed.'

'Being misgendered, misnamed and mispronounced in all initial correspondence. This was a stupid insult and easily avoidable with a few amendments on forms. .. Questions were overly irrelevant, prying and sexual. My first doctor asked about masturbation repeatedly, which made me very uncomfortable... 2 years RLE is arbitrary, stressful, not supported by the WPATH SOC7 …the doctor tried to ask prying questions for the third time, which I refused to answer. I'm waiting to see how it gets written up. The report for my second assessment was sent to an NHS service that I don't attend. This was a gross violation of my privacy. Overall, I feel utterly powerless and infantilised in my dealings with them, entirely at the mercy of their restrictive, unpredictable, arrogant and incompetent service.'

'I found the attitude of the staff at the GIC to be very unhelpful. They seemed unnecessary concerned about my sexuality, and were paranoid about the risk of me wanting to become pregnant (even though I never stated that I wanted to carry a child, and do not ever intend to)... The GIC also seemed to have very rigid ideas of masculinity and femininity and seemed to be adhering to a now outmoded medical model. The outcome was the GIC failing to provide any form of support whatsoever (some emotional

support, and advice on speaking to my family would have been helpful), and instead focused their time on interrogating me about my gender and sexuality, with one my assessors asking me about sex positions, and how this "differed from heterosexual sex"'.

'After 3 yrs and 6yrs they tried stopping my hormones because I was not living RLE then despite meeting all criteria in SOC 6'

'Poor admin resulted in me dropping off the list many times for failing to attend appointments about which they had not told me.'

'I missed one appointment due to the recent snow and was promptly referred back to my GP because I did not show up - the trains had been cancelled - [name of clinic removed] did not accept my call to cancel because they expect the user to give 48 hours' notice. They were totally un-accepting of the unforeseen circumstances that happened on the day'.

'[name removed] refused to treat me because I have a non-binary gender. It is currently unclear why [name removed] have refused to diagnose me, since I do meet the criteria for diagnosis. However, even if I could get a diagnosis, my disabilities mean I would not be able to complete the RLE as they would like me to, since I am unable to work or volunteer.'

'I received no support when I explained why I was having trouble making appointments due to being raped and suffering PTSD [Post Traumatic Stress Disorder]. I was told that unless I could get to an appointment and had up to date bloods I would receive no further HRT even though I had recent bloods saying that my lipids, liver function and all the things except hormone levels were fine. They refused to prescribe twice on this basis'.

'The doctor had a very traditional, narrow view of transgender, and felt that he could decide what gender I was after talking to me personally for five minutes,

and reading the results of the questionnaire I had filled out with his assistant. This questionnaire included questions about my masturbation habits. At the end, he explained that people didn't have more than one gender identity, so I must have something cross dressing related and should be taken off hormones for a while to see how I settle down'

'…some things said to me at my last appointment (specifically that I should accept that my wife and daughters would be better off if I left them) upset me greatly. I left the GIC on that day and sat in the car crying for over an hour. I decided there and then never to go back.'

'When I finally got to see the locum doctor at the GIC he wanted to do an examination of my genitalia before providing me with my first prescription for hormones. However, this was not a physical exam - he made me stand in front of him wearing an unbuttoned shirt and stared at between my legs for 30 seconds. I didn't feel able to say no to this examination (give true consent), because I was concerned he would refuse me access to hormones. I still to this day do not know why he needed to do this examination, or what he gained from doing it in the way he did. I would have felt better if it was a proper physical exam, since being stared at in the way I was left me feeling like I was some sort of freak show'

34% of the participants (N=292) reported that they felt uncertain about their gender whilst attending the GIC. Of those, 52% (18% of those answering the question) stated that they felt unable to talk about their uncertainty about their gender at the clinic. The following quotes are particularly illuminating in this regard:

'I did not feel free to do so. They were gatekeepers and I did not want to jeopardise my chances. I arranged a separate psychological support to discuss my fears and hesitations, which turned out to be circumstantial rather than uncertainties of identity'

'In the beginning I was told by the local psychiatrist that the less I shared with the GIC practitioners at [name of clinic removed], the better my chances of a rapid progression to GRS.'

'I did this initially 2 years ago and it set me back considerably. I tell the truth but it gets me nowhere, others lie and [get] what they need. I'm not talking about any concerns now but playing the game that the standards of care procure. One size doesn't fit all'

'I did feel able to talk about my gender, but sadly, the fact that I confidently voiced uncertainty about my gender with the doctor meant that he didn't take my trans-ness seriously.'

In terms of mental health concerns, 62% of the respondents reported feeling emotionally distressed or worried about their mental health whilst attending a GIC (N=293). Of those participants 53% felt that they were not able to discuss these concerns at the GIC. Further information is needed to establish the concerns that these participants had, however it is worrying that 18% of those attending a GIC felt confused about their gender, and 33% were concerned about their mental wellbeing, but that they felt unable to discuss this. There have been anecdotal reports amongst trans people that discussing uncertainties might lead to treatment being withdrawn or withheld, however it is not possible to say whether this was the source of the anxiety within this study.

Those who felt emotionally distressed or worried about their mental health but did not feel able to talk about this at the GIC gave the following reasons:

'My initial consultation was... confrontational... the fact i dressed male, unsure as to whether i should dress one way or another and to avoid unwanted attention. To then be told "you don't appear overly effeminate to me.. not with your manly looks, stubble and receding hairline" there was no way in hell I was going to "bare my soul"'

'I have depression. The GIC has stated that treatment will be held back if a patient is depressed, and I have

had my depression interfere with my treatment. I literally cannot talk to them about it, because if I do I will not receive the treatment I feel will help me out of my depression. I feel in order to receive treatment I must go to my appointments and tell them that I am feeling fine and everything is okay, even if I am having a really bad day.'

'I didn't want to tell them I was depressed in case they withheld hormonal treatment from me for some bizarre reason. Once I got the hormones, I wasn't depressed anymore, I was relieved. .. I just wanted to get my hormones and surgery and get on with my life and I had to go through the GIC, it's nothing personal to the doctors there, they seemed like nice people, but I felt threatened by their authority and power over my life and future wellbeing. If they had refused me hormones and surgery, I would probably have committed suicide, that's a lot of power to have over another person. Surely that's not right? Having said that, they did do the right thing by me and I am grateful for their assistance. It's a strange relationship.'

Whilst attending a gender identity clinic, 27% of the respondents reported that they had either withheld information or lied about something to a clinician (N=295). Of those, 80% stated they had withheld information, with 40% lying. This, combined with the findings above suggests that there may be serious issues either within GICs in terms of what is expected of their patients or the service they provide, or that there may be misconceptions amongst trans people about what information to provide whilst attending a clinic. Most likely is that the issues relate to a combination of both of these factors, however regardless of the reason it would seem that clinicians may currently be treating a subset of their patients about whom they have been misinformed or who may not be providing the relevant information. This suggests that the GICs themselves may need to explore ways in which to encourage closer collaboration with their patients as individuals and with the trans populations they serve.

The reasons for why people lied or withheld information during GIC appointments are summarised as follows:

‘I presented to the NHS GIC as a binary-identified trans man who had fully socially transitioned and invented a narrative about my gender identity so that they could tick boxes. I have not had problems getting the treatment I require, but only because I heavily edited the truth in my relations with them.’

‘Said I was straight when I am bisexual. Did so because I thought it was none of their business, did not want to discuss my sexuality with them and felt that it may have an effect on whether they would allow me to physically transition ‘

‘I neglected to mention that I’d dropped out of university for fear of having my treatment put on hold.’

‘I’ve probably emphasised the positive and played down the negatives’

‘Because it took so long to get on the waiting list to begin with, as far as they know my family are supportive when in reality they are deeply ashamed of me.’

‘Was asked about whether I have penetrative vaginal sex (myself being penetrated) - didn’t see the relevance of the question, asked about the relevance and was told something along the lines of it being important for couples to consider the impact of bottom surgery on their relationship - this was at my first appointment, before even having had any top surgery.’

‘I do not tell them about the fact I enjoy my genital organs sexually in case treatment is withheld as a result.’

‘I am polyamorous, but did not speak about it because I felt that it would be pathologised, misunderstood or overly focussed on.’

‘Someone once said that the healthy personality has both masculine and feminine traits, a healthy balance, but I disowned anything that could have been

considered masculine to impress the psychologists there.'

'I was given the impression that I needed to have a background of gender dysphoria which extended before puberty in order to be 'accepted' as a patient. After explaining that I don't really trust my own re-interpretations of a fairly happy childhood, I was asked if I couldn't confirm "that there may have been some time, whether I remember it or not, when being a girl made me unhappy". I was repeatedly asked leading and pressuring questions until I confirmed that I had.'

'I didn't tell the clinician about all the abuse I'd experienced as a child. I told him of one set of incidents by one person, but none of the rest. I'm scared that they'll refuse me top surgery and force me to go through counselling instead and I just can't live with this body that long. I've been in therapy for the abuse before; I don't see the need to go over it again with these people. It's not relevant'.

When asked if attending a GIC had had an effect on their mental health and wellbeing, respondents felt positive that they were making the necessary steps towards seeking medical intervention but that the severe delays and rigid pathways had had a negative impact on their mental health. According to one respondent: 'It's fantastic to finally be getting the treatment I need through legitimate channels. I was lucky enough to make it through smoothly, the experience of friends has indicated that the sort of gatekeeping that the GICs practice is insulting, patriarchal and backwards - even if most of the doctors themselves are pleasant and polite, the system that they're part of is broken'. And according to another respondent: 'I felt at times they were testing me to see how good my resolve was by putting road blocks in my way or calling me names. However they also helped me find my way to happiness as well.'

Just under 50% of the respondents felt attending a GIC had a positive effect on emotional wellbeing and mental health (N=297), although 11% of participants did feel it had negatively affected them. It would be useful to explore this further to establish whether this was due to the GIC itself or simply an aspect of it such as starting hormone therapy or being able to access other interventions.

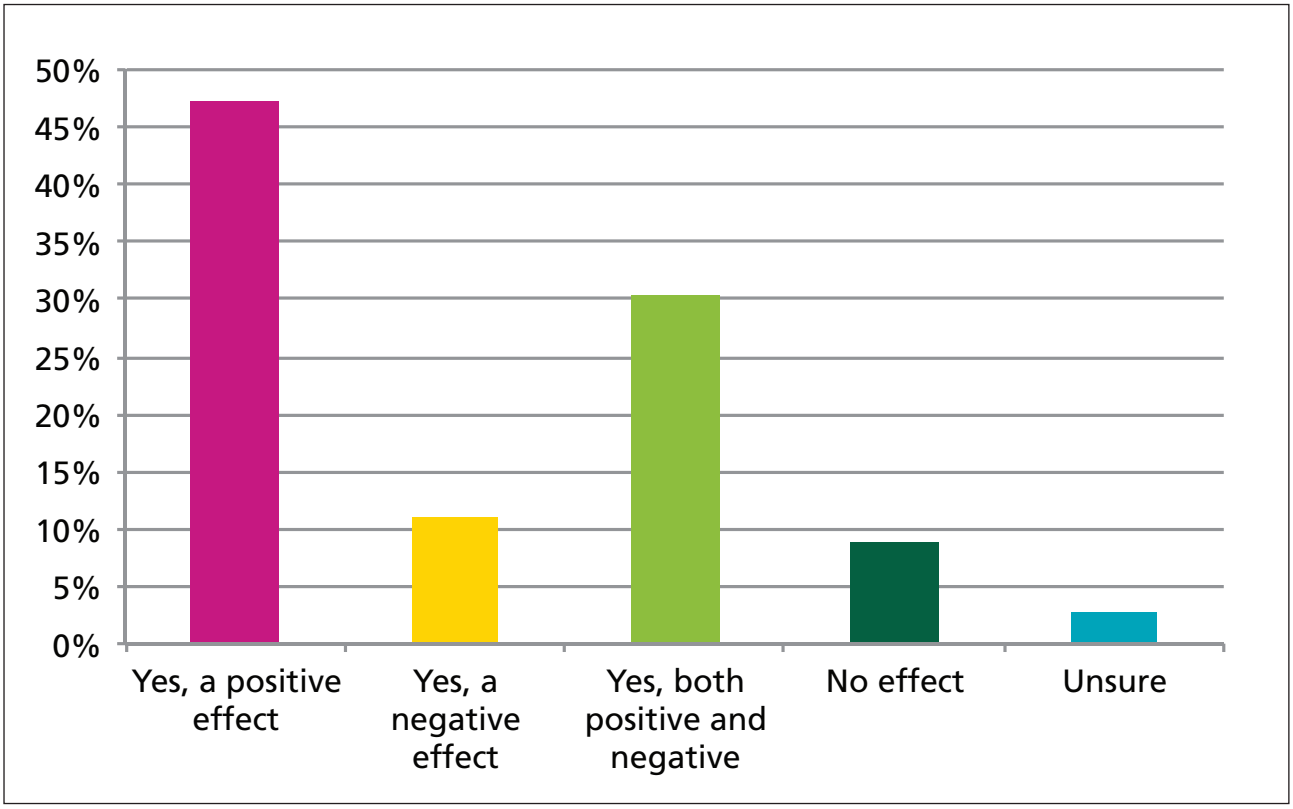

Figure 7: Has attending a GIC had any effect on your emotional wellbeing or mental health? (N=297)

4.6. Daily Life

As part of the survey it was important to explore the relationship between being a trans person and daily activities, in order to investigate whether these factors may impact upon mental wellbeing. The participants in this study highlighted a number of situations which they would avoid due to fear of being harassed, read as trans, or being outed (N=657). 81% of the participants did avoid some situations due to fear. Over 50% avoided public toilets and gyms, suggesting that these were the most problematic areas for the participants. Other difficult areas which over 25% of the participants avoided were clothing shops, other leisure facilities, clubs or social groups, public transport, travelling abroad, and restaurants or bars.

When the sample was separated by how the participants felt they were perceived by others, the majority of participants in all groups avoided some social situations. The group with the greatest level of avoidance were those who selected “other” in response to being asked how they thought they were perceived. Individuals who felt that they were perceived as a trans person were less likely to avoid social situations. Public toilets and gyms were still the most challenging situations, however those who were seen as the gender they identified as avoided public toilets less than the other groups.

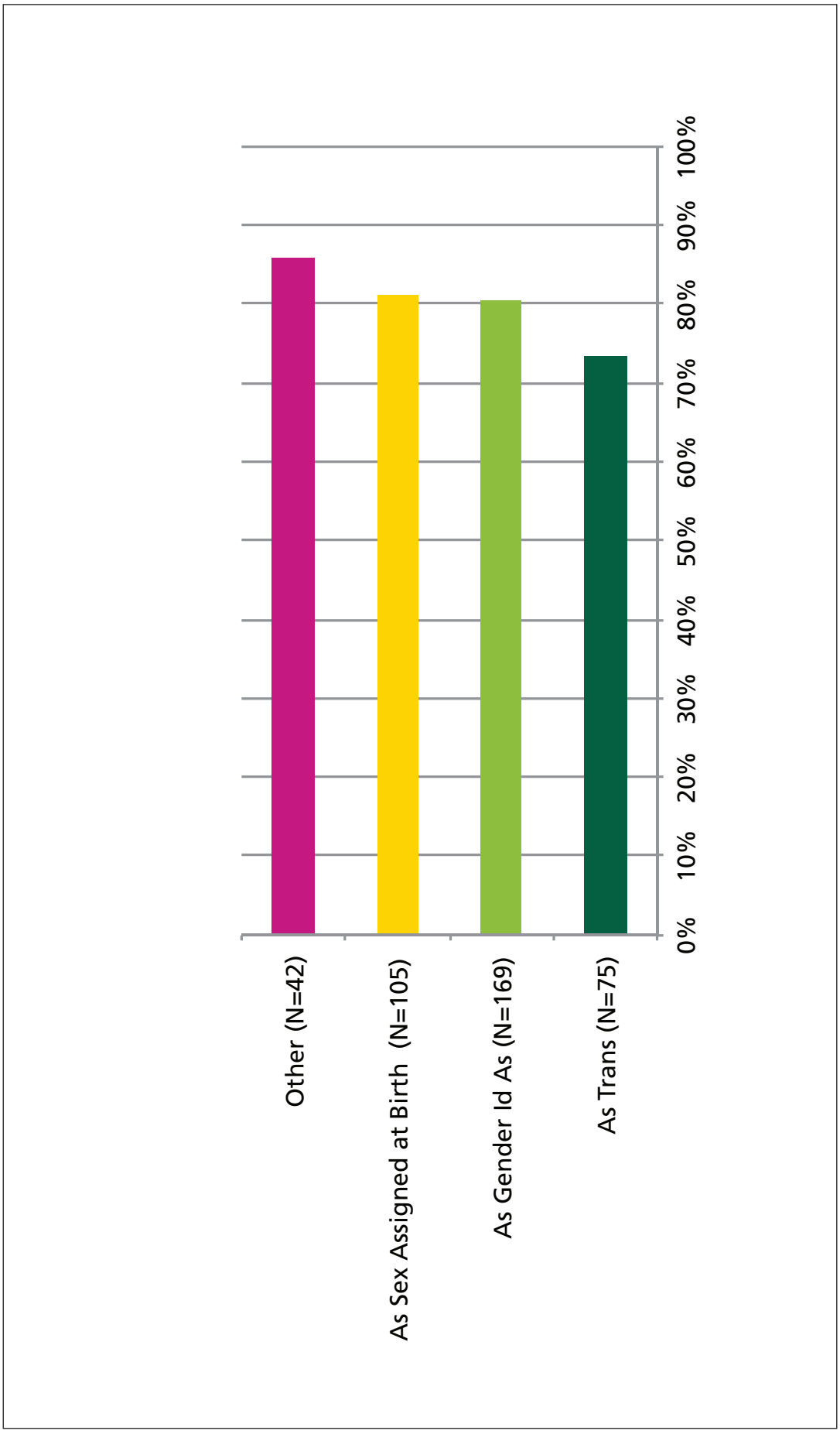

Figure 8: Percentage of respondents who avoid social situations, separated by social perception

When split by gender identity there was a large difference between those with clear and constant gender identities as women and those with clear and constant gender identities as men, with the men avoiding many more situations than the women. The participants with no gender identity avoided fewer situations than the other groups.

Public toilets were extremely problematic for the men in the sample, with 77% avoiding them. Those with a non-binary identity also avoided toilets more than the women in the sample and those who were unsure or had no gender identity. As previously, gyms were again problematic, mostly for the men. It would be useful to further explore the factors surrounding this, especially whether there is any connection between the low percentage of trans men who undergo masculinising genital surgeries and/or the visibility of trans men's surgical scars with levels of avoidance of public toilets and gyms.

Those who had undergone, or were currently undergoing a transition avoided fewer places than those who were in other transition groups or did not want to transition. They were more likely to avoid gyms and public toilets than other groups however, although less likely to avoid shops and other social spaces. 51% of the participants worried that they would have to avoid social situations or places in the future due to fear of being harassed, read as trans, or being outed (N=668). Only 29% said that they would not. When separated by gender identity, people who had a constant non-binary identity or whose gender identity was 'other' were more likely to feel that they would have to avoid situations in the future (63% and 68% respectively) than other groups. Those with a consistent female identity or with no gender identity were least likely to avoid situations in the future (48% and 47% respectively).

To explore further the types of harassment or discrimination which the participants may have experienced to lead to such high levels of avoidance, they were provided with a list of different hate crimes or insults which are sometimes used against trans people, and common fears they may have (many of which were derived from the Canadian PULSE study). They were asked if these things had ever happened to them (N=665), and when they happened (N=633). Over 90% had been told that trans people were not normal, with over 80% experiencing silent harassment. The responses showed that for some, being trans was something to be occasionally hidden, or which might be embarrassing for others. There were fears around isolation and aging, with many people losing family and friends or employment opportunities. Importantly, many individuals who experienced hate crime and discrimination had experienced these on multiple occasions. All of these societal issues would be expected to have a significant impact upon health and wellbeing in any group of individuals.

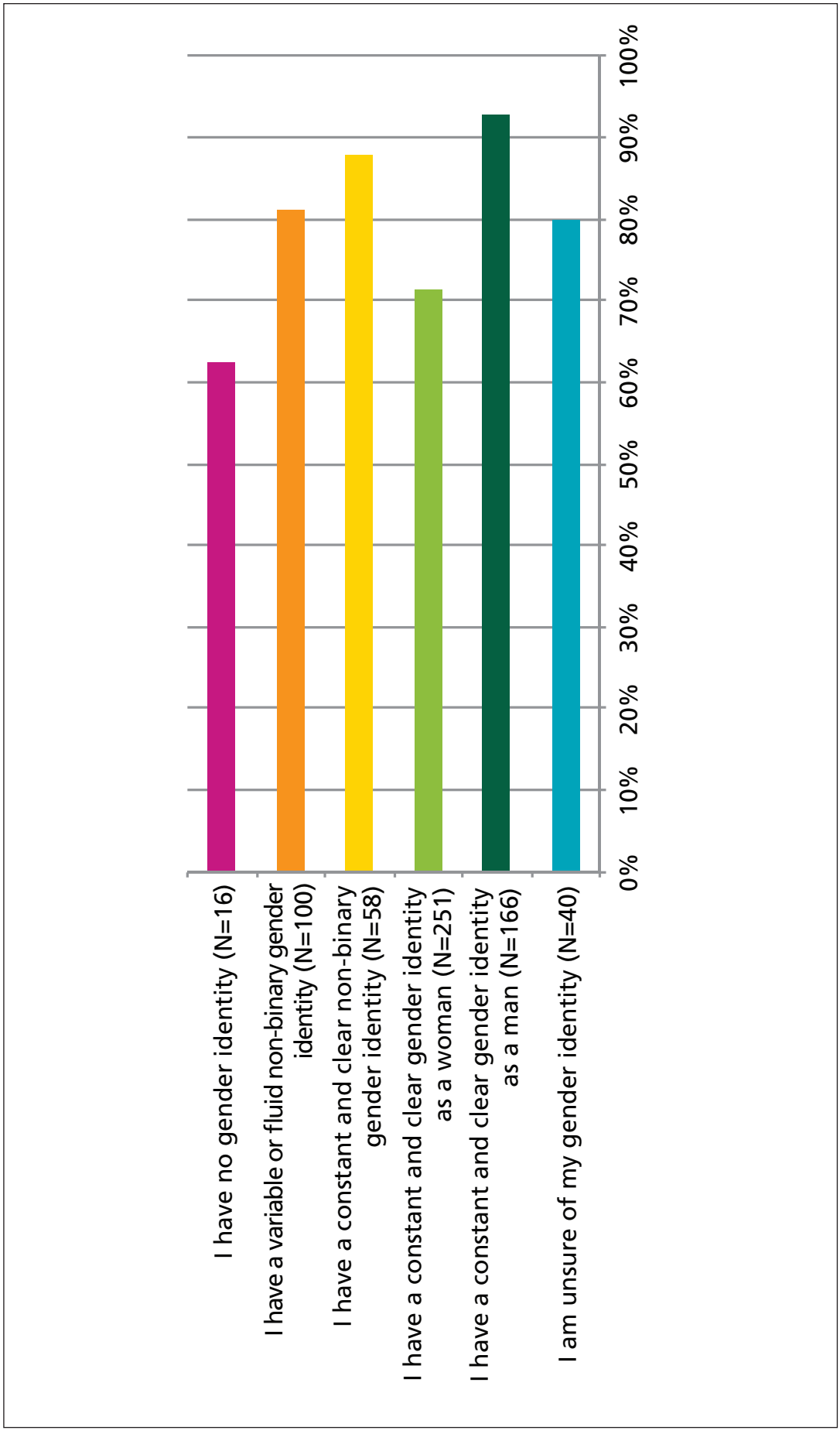

Figure 9: Percentage of respondents who avoid social situations, separated by gender identity

	% of those answering the question		
How many times have these things happened to you? (N=665)	Never	Total who have experienced	More than once
Heard that trans people are not normal?	7%	92%	90%
Experienced silent harassment (e.g. being stared at/whispered about) for being trans?	14%	81%	78%
Felt that being trans hurt and embarrassed your family?	20%	76%	71%
Been made fun of or called names for being trans?	24%	73%	65%
Had to try to pass as non-trans to be accepted?	29%	67%	65%
Worried about growing old alone because you're trans?	31%	65%	63%
Been objectified or fetishized sexually because you're trans?	46%	50%	42%
Feared you will die young because you're trans?	52%	42%	39%
Experienced sexual harassment (e.g. cat calling, being propositioned) because you are trans?	57%	38%	31%
Experienced physical intimidation and threats for being trans?	57%	38%	29%
Suspected you have been turned down for a job because of your trans identity?	58%	35%	26%
Had to move away from your family or friends because you're trans?	63%	25%	8%
Been hit or beaten up for being trans?	77%	19%	12%
Experienced domestic abuse because you are trans?	78%	17%	11%
Experienced some form of police harassment for being trans?	81%	14%	7%
Been sexually assaulted because you are trans?	80%	14%	7%
Been raped because you are trans?	87%	6%	3%

Table 10: Overall experiences of harassment

As the table below shows, most of these experiences or feelings were relatively recent, with few occurring over 10 years ago. For example, nearly 19% of the participants had experienced sexual harassment for being trans within the last year, and 17% experienced silent harassment within the last week.

	% of those answering question			
When did this last happen to you? (N=633)	in the last week	in the last year	1-10 years ago	over 10 years ago
Been made fun of or called names for being trans?	9%	38%	22%	6%
Been hit or beaten up for being trans?	0%	5%	10%	5%
Heard that trans people are not normal?	28%	45%	14%	1%
Been objectified or fetishized sexually because you're trans?	7%	27%	13%	3%
Felt that being trans hurt and embarrassed your family?	20%	33%	19%	4%
Had to try to pass as non-trans to be accepted?	29%	21%	13%	3%
Suspected you have been turned down for a job because of your trans identity?	1%	17%	15%	3%
Had to move away from your family or friends because you're trans?	1%	7%	13%	4%
Experienced some form of police harassment for being trans?	0%	5%	6%	3%
Worried about growing old alone because you're trans?	23%	28%	11%	1%
Feared you will die young because you're trans?	11%	20%	8%	2%
Experienced silent harassment (e.g. being stared at/whispered about) for being trans?	17%	40%	19%	3%
Experienced physical intimidation and threats for being trans?	1%	15%	18%	4%
Experienced domestic abuse because you are trans?	1%	4%	10%	3%
Experienced sexual harassment (e.g. cat calling, being propositioned) because you are trans?	2%	19%	15%	1%
Been sexually assaulted because you are trans?	0%	4%	7%	2%
Been raped because you are trans?	0%	2%	3%	2%

Table 11: When participants had experienced harassment

Interestingly, there seems to be little relationship between actual experiences, and fear of future events. For example similar percentages of people worry about experiencing silent harassment as worry about being turned down for a job, however whereas 81% have experienced harassment, only 35% feel they have lost employment opportunities.

	% who have experienced this (N=665)	% who worry about this happening in the future (N=642)
Heard that trans people are not normal?	92%	61%
Felt that being trans hurt and embarrassed your family?	76%	60%
Been made fun of or called names for being trans?	73%	59%
Experienced silent harassment (e.g. being stared at/whispered about) for being trans?	81%	57%
Suspected you have been turned down for a job because of your trans identity?	35%	57%
Experienced physical intimidation and threats for being trans?	38%	56%
Been hit or beaten up for being trans?	19%	54%
Worried about growing old alone because you're trans?	65%	54%
Had to try to pass as non-trans to be accepted?	67%	51%
Been sexually assaulted because you are trans?	14%	42%
Been objectified or fetishized sexually because you're trans?	50%	41%
Experienced sexual harassment (e.g. cat calling, being propositioned) because you are trans?	38%	39%
Been raped because you are trans?	6%	38%
Experienced some form of police harassment for being trans?	14%	34%
Feared you will die young because you're trans?	42%	32%
Had to move away from your family or friends because you're trans?	25%	26%
Experienced domestic abuse because you are trans?	17%	19%

Table 12: Comparison of participants experiences and future expectations

It does seem that many of the participants know others who have been victims of violence, which may be contributing to their fears around social spaces or interactions. Further study could help to explain which of these factors are most significant.

4.7. Health Care

The participants were asked whether they had ever used different types of health care. 61% had been seen at a Gender Identity Clinic (GIC), 75% had used general

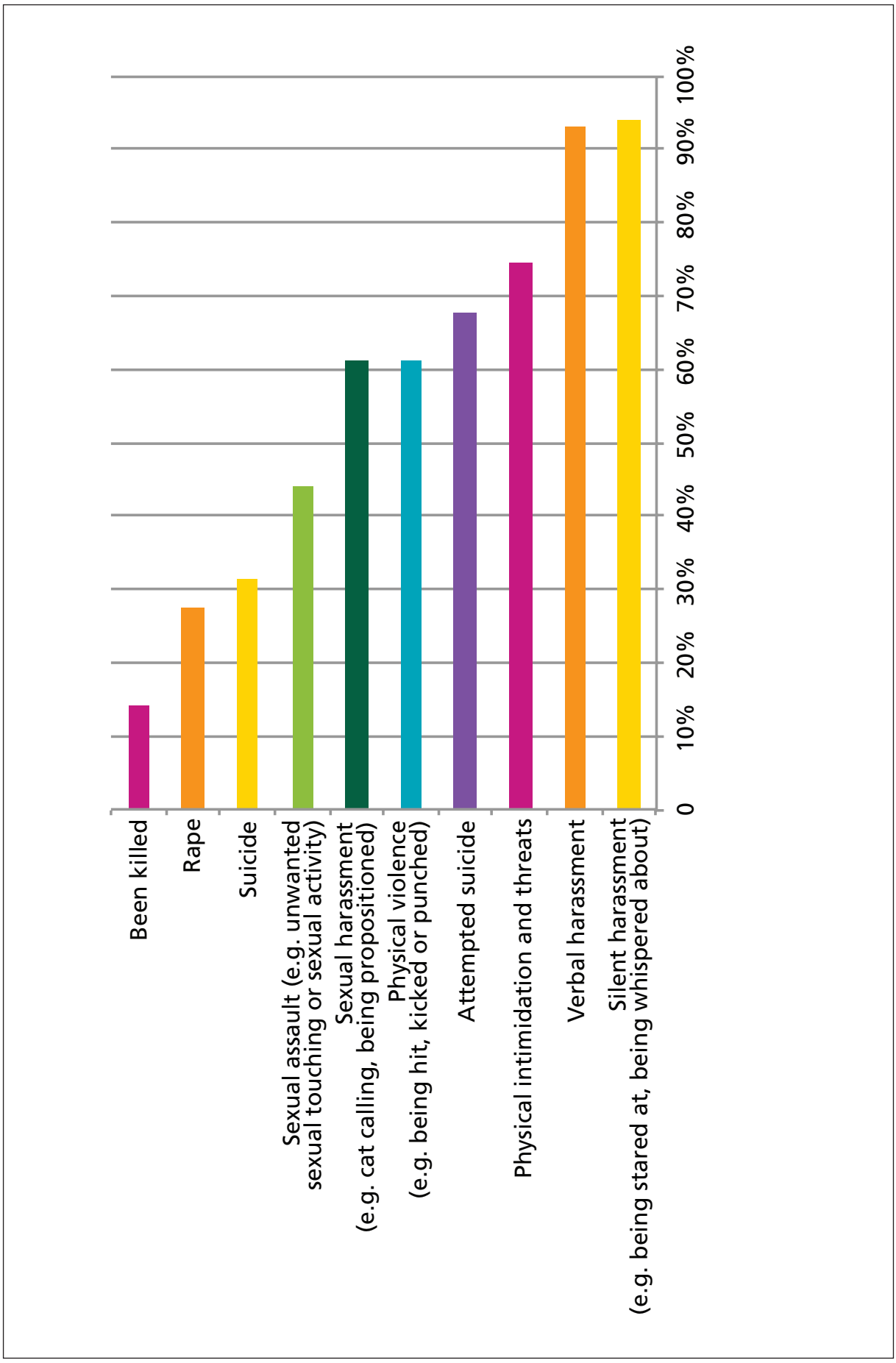

Figure 10: Percentage of participants who personally know of other people who have experienced the following because they are trans or because of their trans history (N=596)

mental health services, and 90% had used general health services (N=623). Of those who had used these services 62% had experienced one or more of the negative interactions below at a GIC (N=382), 63% in general mental health services (N=466), and 65% in general health services (N=558). Such high levels are deeply concerning in general mental and physical health care, and especially worrying in Gender Clinic settings. Within the GICs 8% of participants have been ridiculed for being trans, 6% have been discouraged from exploring their gender, 7% experienced someone using the wrong pronoun on purpose, and 10% felt that they were educating the professionals. These figures are deeply concerning within the context of Gender Identity Clinics which should be spaces where people feel able to discuss issues and concerns around their gender, be free from ridicule and be treated with sensitivity. However the figures are much greater for discrimination experienced in other health settings. Of concern among mental health settings particularly is that 1.3% had a mental health professional ask to see their genitals where this was felt to be inappropriate. Again the use of hurtful language and belittlement around trans identities is an issue, as in mental health (as in all healthcare), it is extremely important to express positive regard and a non-judgemental attitude. In general health, the findings were striking. Over 60% felt that they had to educate a health worker, and over 50% were told that the professional did not know enough about a type of trans healthcare to provide it. For nearly 30% of respondents, a healthcare professional had refused to discuss a trans-related health concern.

Have you experienced any of the following?	GIC (N=382)	Mental Health (N=466)	General Health (N=558)
Refused to see you or ended care because of the way in which you are trans or have a trans history	4%	9%	12%
Used hurtful or insulting language about trans people	8%	17%	24%
Belittled or ridiculed you for being trans or having a trans history	4%	11%	18%
Refused to discuss or address a particular trans-related health concern	6%	13%	29%
Told you that you were not really trans	8%	20%	16%
Discouraged you from exploring your gender	6%	25%	20%
Told you they don't know enough about a particular type of trans-related care to provide it	2%	29%	54%
Thought the gender listed on your ID or forms was a mistake	1%	9%	24%
Used the wrong pronoun or name on purpose	7%	18%	26%
Used the wrong pronoun or name by mistake	11%	27%	55%

(table continued...)

Used terms to describe your gender-associated body parts (e.g., genitals, chest, etc.) that made you uncomfortable	12%	17%	28%
Showed unprofessional levels of curiosity about what your gender-associated body parts look like	3%	7%	16%
Asked to see/examine your genitals, where you felt this was unnecessary or inappropriate	2%	1%	7%
Asked you questions about trans people which made you feel like you were educating them	10%	40%	61%
None of the above	38%	37%	35%

Table 13: Experiences of discrimination in healthcare settings

4.8. Mental Health Services

66% of respondents reported that they had used mental health services for reasons other than access to gender reassignment medical assistance (N=621).

The participants who had stated that they had used mental health services were then asked which types of services or support they had used. Antidepressants were the most used intervention, with 75% of those who had used mental health services taking these. 54% of the respondents had been taking antidepressants for one year or more. General Practitioners were also highly used for mental health reasons, which makes the concerns raised above over the treatment of people who are trans in general health care particularly relevant. Therapeutic interventions were very highly rated, as were the use of helplines and charities for support. Least used services included the Early Intervention for Psychosis teams, and support for drug and/or alcohol issues.

Have you used any of the following services/treatments for mental health issues? (N=396)	I am currently using this	I have used this	Total lifetime prevalence
Antidepressants	31%	44%	76%
GP/family doctor	29%	37%	66%
Some form of therapy from NHS	7%	39%	46%
Psychiatry	7%	28%	35%
Psychology	5%	27%	32%
Community Mental Health Team	7%	24%	31%
Some form of therapy – private	5%	27%	31%
Helpline	1%	21%	22%
Charity	5%	14%	19%

(table continued...)

Other medication	9%	10%	18%
Crisis Team	1%	14%	15%
Inpatient mental health support	0%	12%	12%
Social Worker	2%	9%	10%
Antipsychotics	3%	7%	10%
Spiritual leader	3%	5%	8%
Drug and/or Alcohol support	1%	6%	7%
Other below	3%	4%	6%
Early Intervention for Psychosis team	0%	2%	2%

Table 14: Mental health services used

Across all of those who reported using mental health services, approximately equal numbers were satisfied as were unsatisfied (N=396). This was also the case for Scotland (N=38) and England (N=274), however in Wales 57% were dissatisfied or very dissatisfied with their experiences of mental health services, and only 14% were satisfied or very satisfied. Levels of satisfaction were not calculated for other locations due to the numbers of participants using mental health services being too small.

The participants reported generally being able at least some of the time to be open with mental health professionals about being trans or having a trans history (72%, N=355). However 28% felt that they were rarely or never open about their trans status.

The experiences that participants had in terms of how their gender identity was viewed in mental health services were varied (N=411). 29% of the respondents felt that their gender identity was not validated as genuine, instead being perceived as a symptom of mental ill-health. 17% were also told that their mental health issues were because they were trans, when they disagreed and saw them as separate. 26% felt uncomfortable being asked about their sexual behaviours.

In relation to your experiences with mental health services, have you ever experienced any of the following due to being trans? (N=411)*	%
My gender identity was treated as a symptom of a mental health issue rather than my genuine identity	29%
I was asked questions about my sexual behaviour that I felt were irrelevant and that made me uncomfortable	26%
I was given advice or suggestions by a mental health provider that I thought were inappropriate	20%
I was asked questions about my body that I felt were irrelevant and that made me uncomfortable	18%

(table continued...)

I was asked questions about my gender identity that I felt were irrelevant and that made me uncomfortable	18%
I was told that my mental health issues were due to being trans when I felt that they weren't	17%
I was given treatment that I thought was inappropriate	8%
Other	5%

Table 15: Experiences of mental health services
* Based only on participants who have used mental health services.

The need to use mental health services was altered by undergoing transition (in those that wished to transition). 45% used mental health services more before transition, 18% more during, and 0% used mental health service more post-transition (N=187). This has implications for mental health services in that it suggests that there is a need for enhanced support during the process of transition, and prior to undergoing these processes.

In terms of future service use, only half of the participants stated that they did not have any concerns about accessing mental health services (N=605). Despite this 74% stated that they would use services in the future if they needed to, with 7% actively stating that they would not and 19% being unsure. Given the high rates of suicidal ideation amongst the respondents (discussed below), the finding that over 25% may not be willing to access mental health services if they need them in the future should pose some questions about the issues they face in the services currently available.

The reasons for those who did have concerns about accessing mental health services can be summarised as follows:

★ Witnessed negative or prejudicial treatment: 'I have experienced bigotry from an inter-professional 'fly-on the wall' scenario about other patients whilst being closeted myself at the time'.

★ Concern about the impact of the NHS reforms: 'In current NHS cut backs, services may not be there if I should go through a crisis'.

★ Inflexible computer systems which do not reflect trans identities and experiences: 'Top down administration computer models taking precedence over real world situations'

★ A lack of trans awareness training among managers and staff: 'I worry that I'll have to be the educator when I don't have the mental resilience to do so, or risk inadequate care because the 'professionals' don't know what they're doing'.

★ Fear of being denied gender-related treatment or having treatment stopped: 'I also worry admitting I have mental issues could affect my access to gender treatment'

In addition to the above, some respondents attempted to conceal their trans identity or history when accessing services or else avoided services altogether because they did not want to discuss their trans identity or history. Respondents also felt great concern that their trans identity or history would be subject to diagnostic overshadowing and that practitioners would pay too much attention to this aspect at the risk of ignoring their presenting issue. As one respondent put it: 'If I decided to disclose my gender identity, I am worried that it would again be treated as either a symptom of or the cause of my mental health issues. I am also worried that, even if it was not considered either of those options, it would not be respected as a legitimate identity'. In addition, one respondent stated that: 'I worry that people would consider the fact that I might still have mental health issues after transition to be evidence that transition was the wrong thing for me'.

Elsewhere, respondents felt that they are forced to access mental health services as part of the current requirements for obtaining gender reassignment treatment but that they would not otherwise do so. However, some respondents have decided not to pursue gender reassignment because they do not want a mental health diagnosis listed on their medical records. As one respondent explained: 'I do not require a diagnosis from any mental health service in relation to my trans identity. I do not want my trans identity listed as a mental symptom by *any* medical professional in a manner that has the potential to be used against me. As such, in the event of me needing to use a mental health service I would feel at odds with my ability to be open about myself and feel the need to protect myself from pathologisation'.

Inpatient Experience

10% of the participants had been an inpatient in a mental health unit at least once (N=607). 38% of those experienced difficulties due to being trans, with a further 16% being unsure. Less than half were able to say that their trans status or history led to no difficulties (N=56). Difficulties included being harassed, misgendered and uncertainty about placement within single sex facilities. One respondent describes some of the negative experiences he received whilst being an inpatient: 'the wrong pronouns were used while I was an inpatient, and I was threatened with being put on the female ward when I identify as male'.

4.9. Mental Health

The majority of respondents felt that being trans or having a trans history had a mixed effect on their mental health, however for those who answered that the effect was solely positive or negative, many more found it to be a negative impact. This pattern was repeated when the groups were split by gender identity and by stage of transition.

When asked to rate current mental health on a scale of 1 to 7, with 1 being very poor

and 7 being excellent, the average score was 3.7 (N=565), slightly on the negative side. When separated by gender identity there were no statistically significant differences between the groups, with the average scores ranging from 3.3 to 3.9. Again, all the average scores were slightly low. Most participants who had transitioned felt that their mental health was better after doing so (74%), compared to only 5% who felt it was worse (N=353).

Of the 5% that reported their mental health as being worse now than before they transitioned, respondents felt their issues related to a lack of appropriate support, losing family and loved ones, or for reasons which respondents felt were unrelated or 'not directly related' to the transition, such as employment or cultural/environmental issues. The exact circumstances were not expanded on. One respondent felt that the transition gave them something to focus on and that, once they had transitioned, other issues came to the fore which had worsened their mental health. Another stated that: 'Although I had mental health problems previously, I believe that realising that I am trans had worsened the problem significantly as now I have extra problems and feelings to cope with'.

Of the 22% who selected 'it is no different', 'unsure' or 'other', the reasons are mixed. As one respondent put it: 'The positives from no longer having to deal with being the wrong gender have been replaced with negatives arising from the loss of family, friends, marital home, social activities, sporting activities and financial security, particularly when I retire'. And: 'Better... I feel better with my appearance. Worse.. More funny looks, threats, family rejection'. Although participants in the main feel happier in themselves, many claim that their mental health has been negatively impacted by the social impact of their transition and the social stigma of being trans. Elsewhere, respondents stated that non-transition related factors have affected their mental health or that they were unable to distinguish between transition and non-transition related issues. Another respondent felt that there were 'different pressures pre- and post- transition'.

Rates of current and previously diagnosed mental ill health were high, with many participants additionally feeling that they may have experienced particular issues which remain/ed undiagnosed. Depression was the most prevalent issue with 88% feeling that they either currently or previously experienced this (N=549). Stress was the next most prevalent issue at 80% (N=498), followed by anxiety at 75% (N=512). For all but stress and depression, more participants felt that they had a mental health concern which remained undiagnosed, than had received a diagnosis. Further study should elucidate the reasons for this. In all cases, where a diagnosis had been given, the majority of participants felt that it had been accurate.

Do you have, or have you ever had, any of these significant mental health issues?		
	Currently/previously diagnosed	Believe had/have but not diagnosed
Depression (N=549)	55%	33%
Anxiety (N=512)	38%	37%
Addiction (N=445)	5%	18%
Eating Disorder (N=451)	5%	19%
Anger (N=441)	7%	20%
Stress (N=498)	27%	53%

Table 16: Diagnosis of significant mental health issues

The Center for Epidemiologic Studies Depression Scale (CES-D) was administered as part of the survey, due to anecdotally high levels of depression amongst trans people. Cut-off scores were:

0-15 Non-depressed
16-26 Mild/Borderline Depression
27-60 Major Depression
(Ensel, 1986)

These categories should be used as a general guide rather than as a diagnostic tool, however the higher the score, the greater the level of depression present. Amongst the whole sample, the mean score was 20.6 (N=477). The percentages of those who fell within each category can be seen in the chart below:

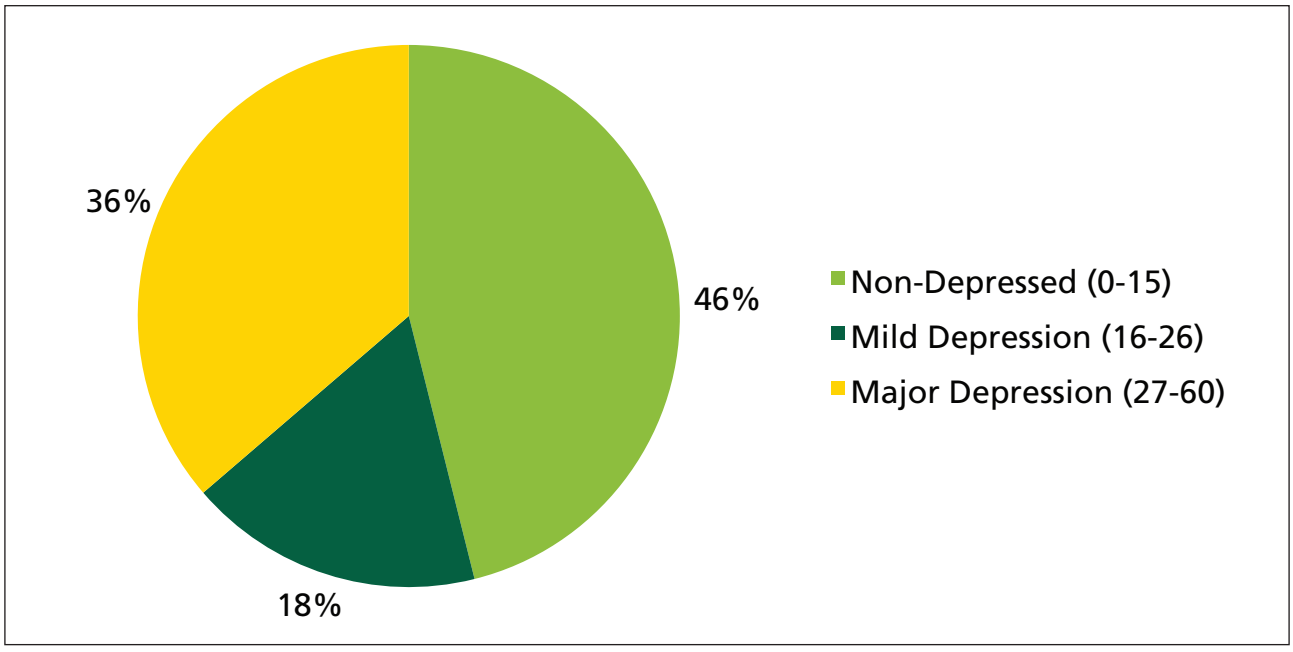

Figure 11: CES-D Scores of depression

This seems to suggest that there are two separate groups within the sample of participants, with people tending to be either non-depressed or very depressed. To explore this further, the data was separated by different variables.

When separated by gender identity, the mean scores ranged from 12-28, however the differences between the groups were not significant. Lowest scores were seen in those with no gender identity, with very similar scores present in those with different binary identities, and similar scores in those with different non-binary identities. Highest levels were in those with an 'other' gender identity and those who were unsure of their gender.

When scores on the CES-D were separated by stage of transition they ranged from 18 to 30. The results of statistical testing (a one-way ANOVA) showed that the differences in average score were statistically significant ($F=2.205$, $df=5$, $p=0.05$). Higher mean scores were seen in those who were unsure about transition, or who were proposing to undergo transition but had not yet started; whereas lower levels were evident in those who were undergoing or had undergone a process of transition or gender reassignment. This finding suggests that for those who wish to transition, it has a direct impact upon depression.

Crisis Support

Over half of the respondents (58%, N=607) felt that they had been so distressed at some point that they had needed to seek help or support urgently. When asked for more information about their experiences, 35% of those individuals had avoided seeking urgent help due to being trans or having a trans history (N=383). Avoidance was highest amongst those with a variable or fluid non-binary gender identity, and lowest amongst those with no gender identity or who were unsure of their gender.

When participants did need urgent support they were most likely to contact their friends, followed by their GP or partner. Relatively few chose to use other NHS support, choosing helplines or online groups over these. 18% stated that they did nothing when in need of support. The majority used multiple types of support with 19% using only one form (N=380).

When you have needed help or support urgently did you ever do any of the following?(N=380)	%
Contact non-trans friends	37%
Contact trans friends	36%
Contact your GP	30%
Contact partner	30%
Contact family	26%

(table continued...)

Call a non-LGBT helpline (e.g. The Samaritans)	24%
Nothing	18%
Contact a trans online group	13%
Contact named person	12%
Contact A&E	11%
Call a transgender helpline	10%
Contact NHS direct/NHS 24	10%
Call an LGBT helpline	10%
Contact a mental health charity	9%
Contact a local trans group	8%
Contact other NHS service e.g. CPN	7%
Contact a national trans group	4%
Private therapist	3%
Online support	1%
Uni support	0.5%
Local authority	0.3%

Table 17: Types of urgent support accessed

Abuse

Almost half of the participants, 49%, experienced some form of abuse in childhood (N=536). The table below demonstrates the types of abuse that were experienced, with emotional abuse being the most prevalent.

As a child (under 16 years old) did you experience any of the following? (N=536)					
Physical abuse	Emotional abuse	Sexual abuse	Neglect	Other (please specify)	I did not experience any abuse or neglect
146	215	104	76	54	276
27%	40%	19%	14%	10%	51%

Table 18: Experiences of childhood abuse

Self-harm

53% of the participants had self-harmed at some point, with 11% currently self-harming (N=583). These 311 people were asked for more information about their experiences. Of those who were currently self-harming (N=62), the greatest number did so on a monthly basis, with 31% self-harming weekly and 23% self-harming daily. 46% (N=308) had self-harmed on a daily basis at some point.

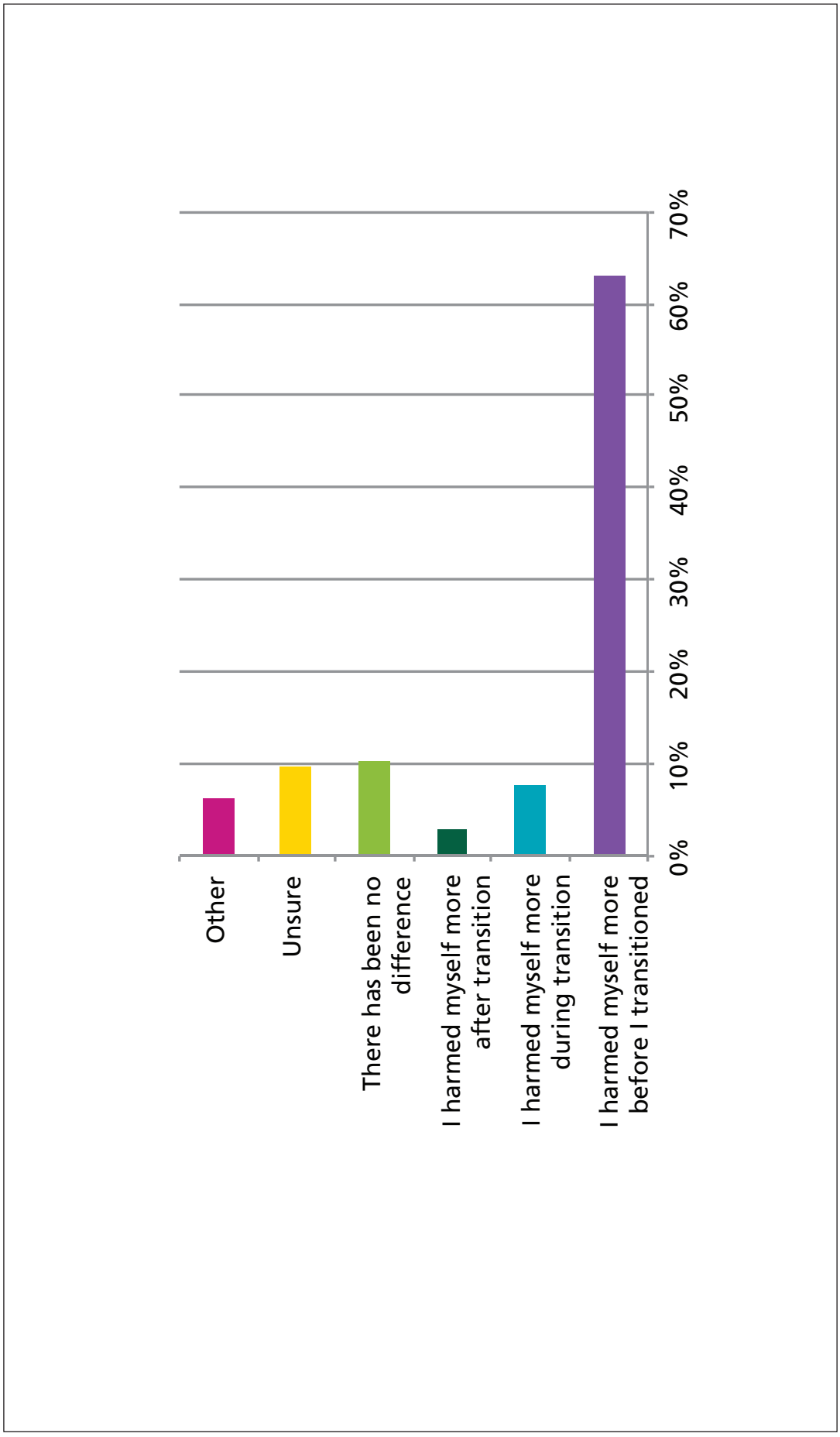

Figure 12: Changes in prevalence of self-harm after transition

The most common method of self-harm was cutting, which almost 73% of the participants with a history of self-harm had engaged in (N=309). Punching objects or walls was the next most common (51%), followed by punching self (44%), head banging (41%) and self-biting (41%). Other methods included asphyxiation / choking self, scratching deep enough to bleed, self burning, pulling own hair out, attempted self mutilation (of genitals or breasts), and picking at scabs and skin etc.

For participants who had transitioned, this had led to changes in their self-harming. 63% felt that they harmed themselves more before they transitioned, with only 3% harming themselves more after transition (N=206).

Just under 60% of the participants felt that there were reasons they self-harmed which related to them being trans, while 70% felt there were non-trans related reasons for their self-injury. This suggests that although being trans may be one factor, others are also relevant.

Reasons for self-harm which directly related to being trans included:

★ Gender Dysphoria: 'Trying to cut genitals off', 'hated the body I was given', 'frustrations that I can't be the woman I want to be', 'self-harmed as an escape from pain caused by incongruence between how I felt mentally from a gender point of view and my physical features and going through puberty which I didn't want because the changes were not wanted', 'My period starting would trigger me a lot'

★ Delays in getting gender reassignment treatment: 'When treatment was really slow, and I just needed something to lash out at but didn't want to lash out at anyone I relied on or would feel guilty about later, I would harm myself', 'Frustration of waiting 2years & 6months without medically supervised treatment'

★ Stumbling blocks in treatment, and negative attitudes: 'frustration with medical times for treatments, and their attitudes'; 'Frustrations with the GIC', 'Frustration with treatment and also feeling worthless and unwanted because of my status'

★ Not being to access treatment or being denied treatment: 'NHS refusals leading to failed suicide'; 'It is literally impossible to transition medically on the NHS in [name removed]. The only private practitioner who will help is in London. I can't f***ing afford this. You'd hit yourself with a hammer under the circumstances too'.

★ Not being taken seriously by medical professionals: 'Not being able to access treatment or not being taken seriously by medical professionals exacerbated my feelings of self hate'

★ Treatment complications: 'Stage 1 of my phalloplasty went really badly and I freaked out and cut it half way off'

★ Struggling coming to terms with identity or suppressing gender issues: 'attempting to punish myself for being cowardly and not coming out'

★ Not understanding identity/unwilling to admit to difference : 'With benefit of hindsight, I think may have been due to internalised transphobia and/or failing to deal with my gender dysphoria.'

★ Not being accepted or experiencing negativity from others: 'I was upset that I was so lonely and weird, and that people made fun of me because of my gender expression, as in short hair and not wearing skirt uniform'; 'self-harming after receiving trans related abuse - cut penis and thighs'.

★ Not having identity/gender recognised: 'Being unable to figure myself out, being told that my identity was nonsense.'

In addition, respondents listed the following indirect reasons for self-harming:

★ Loss of employment or reduced income: 'The lack of support and the denial of the actions that have destroyed my career and have left me in jeopardy of loss of wages and my home for an extended period'

★ Harassment and bullying: 'Bullying over being out publicly as bi in Secondary School'

★ Feelings of guilt, shame or inadequacy: 'Because I just hate myself and I feel like I am bad to release all the bad stuff and it is a release'

★ Breakdown of relationships: 'I had no father to speak of, my mother completely neglected me, I had anxiety & depression & had no idea that I had it nor how to deal with it, there was no one, adult or otherwise, to talk to'

★ Losing family, including contact with children: 'With relation to losing contact with my kids and being unable to do anything about it'; 'My immediate family no longer talk to me and this has been very upsetting', 'As I said earlier I'm having trouble with social services and ex-wife, they don't like that I'm trans and have severely limited my access with my kids, it's this that gets me so low that I self-harm'

Other reasons included: isolation, loneliness, misunderstanding, having a long-term disability or mental health condition, experiencing childhood abuse, rape, and homelessness.

Finally, and of significant concern, was the finding that just under 20% of respondents had wanted to harm themselves in relation to, or because of involvement with a GIC or health service (N=461). This was possibly the most serious impact of the difficulties which trans people were frequently experiencing in health care. One other impact of

this discrimination was feeling unable to disclose information about mental health issues within GICs, which raises significant questions about where those individuals would feel able to go to access support when they were at risk of self-injury. Considering the links between self-harm and suicide, this is particularly alarming.

Respondents who answered 'yes' to the question – 'Have you ever wanted to injure yourself in relation to, or because of, any involvement with a Gender Identity Clinic or health service?' – were then asked to explain their answer. The resulting responses can be grouped into the following categories:

★ Frustration with long waiting times and delays to treatment: 'It took ages for my PCT of the time to approve funding for hormones (from a private consultant). my regular GP was on holiday so I had an appointment with another GP at the practice who was patronizing and dismissive and chastised me for being so 'impatient'. I went home and cut 'HATE' into my thigh with a razor', 'I felt my last appointment went badly and that I wouldn't be allowed to medically transition yet. I found this extremely distressing', 'When I discovered (a year after I went to the NHS psychologist who approved my referral to the GIC) that my GP still hadn't secured funding from my PCT and hadn't referred me to the GIC I smashed my head against the wall in frustration. I now know I will have at least another 6 months to wait for an appointment - 18 months in all. I have waited 44 years to do this.'

★ Stumbling blocks to accessing services: 'Trying to deal with local mental health services and NHS administration/bureaucracy. 11 months of hoop-jumping and waiting lists, all to discover that my PCT apparently does not have a functional route to access a GIC at all', 'Self-harmed due to loss of referral by GP and frustrations with the way I have been treated'

★ Appointment cancellations: 'Despair after finding out the wait for my first appointment was 8 months. Later, when my second appointment was cancelled with 22 hours' notice, I took out the frustration on myself.'

★ Inaccurate assessment: 'the manager told me I would be in the service soon, and chest surgery soon, then I received a letter saying a load of rubbish about me (which was later retracted) and they would reassess in 12 to 24 months. There should have been support for this'

★ Being denied hormone therapy: 'refused treatment for being trans, being taken off HRT, having several bad experiences with GPs didn't help'

★ Being denied surgery: 'For some time, I was denied funding for surgery by my PCT. During that time, worrying that I might never be able to feel comfortable with my body, I started cutting more regularly'

★ Denied access to Gender Identity Clinic: 'I've had no involvement with a GIC, because [name removed] PCT aren't…funding it'

★ False hope for treatment: 'Frustration with them when I was told I would get T on the next visit only to be told the next visit!!'

★ After undergoing a physical examination

★ Given wrong information and advice: 'When I was told incorrect information by a healthcare professional I became frightened that I'd remain stuck like this forever'

★ Frustration with negative or inappropriate attitudes of psychiatrists (including gender identity specialists): 'Extremely down after visiting one psychiatrist, 2nd one was better but still asked what I feel as inappropriate and uncomfortable questions', 'I experienced stress-related voice loss, feelings of worthlessness and active self-harm after receiving an appalling letter from the psychiatrist who assessed me (and then I started official complaints procedures against her)', 'When I was dealing with inappropriate sexual questions (for eg) from psychiatrist; 'Awful awful abusive psychiatrist, whose wrong-doings take up several pages, but include misgendering me, claiming the only gender-neutral pronoun is "it" despite my explicit statement, sending a letter to the wrong name at the wrong address thereby outing me to my family, not believing in bisexuals, etc', 'A few years ago, during an appointment with a Psychiatrist, I was told that there was "no diagnosis for whatever was wrong" with me and upon becoming tearful was told that the psychiatrist was running late for another appointment and asked me to leave so that she could move on to the next patient.'

★ Discharged from Gender Identity Clinic: 'Directly after the appointment when it was explained that I would be discharged from [name removed] GIC I self-injured in the bathroom outside the clinic. As explained before, after this I self-injured severely for several months and then tried to kill myself'.

Elsewhere, respondents describe a general feeling of depression after attending Gender Identity Clinic appointments, though the reasons for this are not expanded on: 'I have felt incredibly low after my appointments and my thoughts have been dominated by feelings of self-harm', 'They don't help me and caused a lot of depression', 'I have felt awful after going and wanted to self-harm', 'The problems I have had with the GIC have led to punching myself in the head until I had bruises, this was purely through frustration', 'repeatedly, the GIC leave me tempted to self-harm after every appointment'.

One respondent's account is particularly disturbing and highlights the consequences that a lack of understanding and awareness of trans issues by GPs, as well as inappropriate and prejudicial treatment from other healthcare professionals can have: 'My doctor sent me to see a gynaecologist instead of the GIC. He said he didn't see

trans people but he wanted to have a look at me. He then called in my husband and asked if he was ok with me transitioning - I felt abused. I felt I wanted to kill myself. When I went back to the doctor it turned out it was too late to go to the GIC as they weren't seeing any more patients at that point. If I'd gone there in the first place, I'd just have got in in time. C'est la vie - after this I gave up hope of transitioning due to my family's attitudes and worry that I might be exposing them to ridicule or injury'.

Some respondents reflect on the irony of their situation: 'it's like you are waiting for permission to live. I would never have told them that at the time though or they may have refused to treat me'.

In light of the above, some respondents have gone privately for treatment – 'I accessed treatment privately to escape the emotional torment of waiting lists, lack of choice and pathologising doctors' – or no longer rely on the specialists to get the help they need – 'When I've made the mistake of thinking a psych might be really helpful and they've actually been really unhelpful, I have often felt despairing or suicidal with the disappointment of that experience. I have learned not to expect so much from others and to rely more on myself. I can trust myself more than I can trust professionals'.

Suicidal Thoughts and Experiences

The majority of participants, 84%, had thought about ending their lives at some point (N=581). These participants were then asked for more information about their experiences. 27% of those who had thought about ending their lives at some point, had thought about attempting suicide within the last week (N=471) with 4% thinking about it every day. In the last year 63% had thought about attempting suicide (N=472) with 3% thinking about it daily.

Prevalence of actual suicide attempts, among those who had thought about ending their lives at some point, was 11% within the last year (N=427), however lifetime prevalence was substantially higher, at 48% (N=436). 33% had attempted to take their life more than once in their lifetime, 3% attempting suicide more than 10 times. More significantly, 11% of the respondents were unsure as to whether they were planning to attempt suicide in the near future, and 3.2% were planning to (N=473).

When the participants who had never thought about suicide (and therefore were not asked further questions about suicidal ideation and attempts) are factored back in, this results in overall suicide attempt rates (N=581) of 35% attempting suicide at least once and 25% attempting suicide more than once.

Suicidal ideation and actual attempts reduced after transition, with 63% thinking about or attempting suicide more before they transitioned and only 3% thinking about or attempting suicide more post-transition. 7% found that this increased during transition, which has implications for the support provided to those undergoing these processes (N=316).

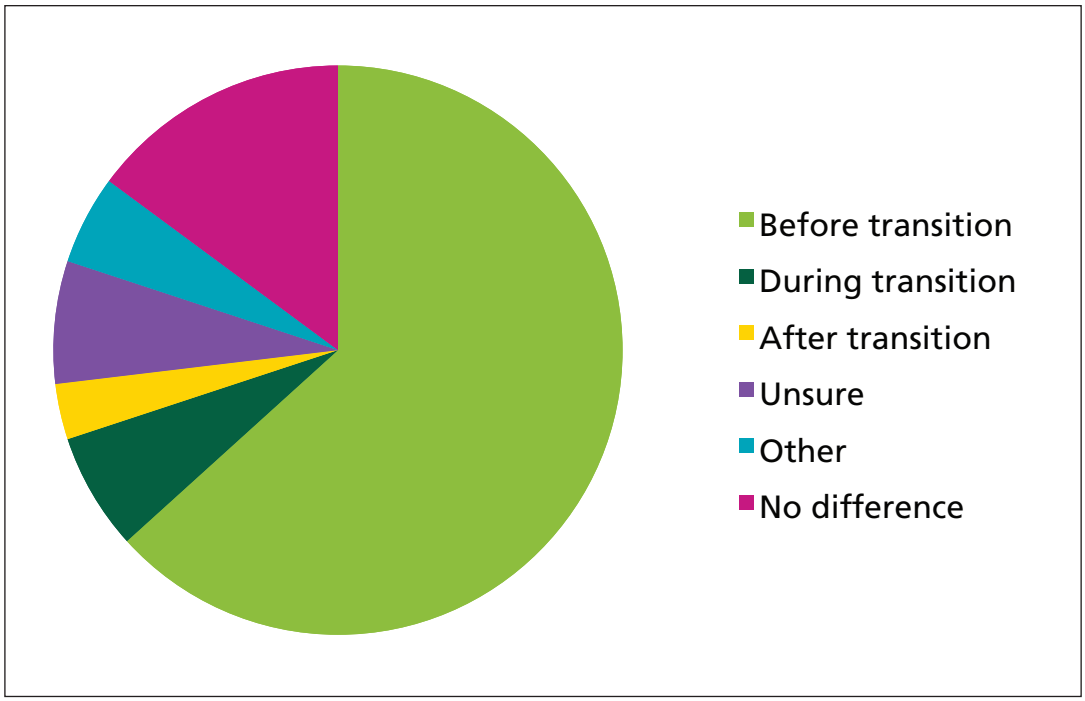

Figure 13: When did you think about or attempt suicide the most?

For the participants in this survey, 65% felt that there were trans related reasons which made them think about or attempt suicide, while 61% identified non-trans reasons as relevant. This suggests that although being trans may be one factor, others are also relevant.

4.10. Substance Use

Drugs

24% of the participants had used drugs within the last 12 months (N=577). A range of drugs had been used, however the most common were cannabis (11%), poppers (3%) and ecstasy (4%).

Of those who currently used drugs (N=107) 5% felt that this was a problem for them, and 18% felt their use was sometimes a problem. 2% of those who had used drugs within the last 12 months (N=142) had injected drugs for non-medical purposes.

Smoking

Over half of the sample had smoked at some point, with 19% being current smokers (N=583). Of those who smoked currently, 78% did so on a daily basis (N=108). Just under 56% had been smoking for over 10 years (N=109).

Alcohol

The AUDIT-C was included in the survey as it gives an indication of damaging levels of drinking. A score of above 3 suggests that an individual is dependent on alcohol or engaging in alcohol abuse (see http://www.patient.co.uk/doctor/Alcohol-Use-Disorders-Identification-Test-%28AUDIT%29.htm#ref3)

Of 576 participants 62% scored above 3, with 47% scoring between 4 and 12. This suggests that there may be significantly harmful levels of alcohol use amongst trans people and warrants further investigation.

4.11. General Wellbeing

In this section of the survey, participants were asked about a range of other factors that might impact upon their general wellbeing and mental health, where other studies have revealed that they may do so in other populations.

The Rosenberg Self-Esteem Scale was incorporated into this survey, whereby scores range between 10 and 40, with higher scores suggesting higher self-esteem. The mean score for the whole sample was 22 (N=281). When broken down by stage of or desire to transition, the average scores ranged from 20 to 23. The differences between these groups were not statistically significant. In addition to this, the participants were asked to rate their self-esteem on a scale of one to seven with one being very low, and seven being very high. The average score for the group was 3.7, slightly on the low side. When separated by stage of, or desire to transition, the scores ranged from 3.2 to 3.8, but these differences were not statistically significant. Most of the participants, 37%, felt that being trans had both negative and positive effects on their self-esteem. More felt that it had a mainly negative effect than a mainly positive effect however (26% and 18% respectively). Only 13% felt that being trans had no impact upon self-esteem (N=565).

Those who felt that being trans had a negative effect on their self-esteem stated that this was due to the following reasons:

> ‘I don’t feel as worthwhile as cis people.’
>
> ‘Due to consistently being misgendered, erased, and denied existence.’
>
> ‘It makes me feel like I ain’t even good enough to have the correct body’

'I am uncomfortable with how I look and with my body. I am unhappy with how people treat me stemming from what they perceive my gender to be.'

'I feel that I am always going to be treated as different by the society around me, and either patronised as a "brave survivor" or avoided as an incomprehensible alien artefact - never just treated as a person.'

Those who felt that being trans had a positive effect on their self-esteem explained that:

'Being able to be me makes me happy.'

'If you're going to be this different you might as well be loud and proud about it. I'm not in the wrong for being like this, the haters are.'

'I now consider myself gender gifted'

'My self-esteem was extremely low before discovering I was trans and transitioning. Now I am very content and satisfied with myself.'

'I am proud of the fact that I have fought my way through the NHS GIC system, had the guts to be who am I am, do what I can to make things better for trans people and that gives me self-esteem.'

Those that felt that being trans had both a positive and negative effect on their self-esteem stated that:

'It's a good thing to be trans, and other people should take lessons from us... but prejudice makes life difficult.'

'Sometimes when at home being myself, by myself things can feel better but most of the time because I cannot be

myself outside of my own space I feel very low.'

'Being trans means I am more comfortable with my appearance and who I am, but also makes me very aware others aren't.'

'Body dissonance and societal bigotry push self-esteem down; the fact that I survive and fight pushes it up.'

'I am a unique person that rises above the mundane, I am also a freak that is less than normal.'

The following statement sums up the feelings of those who felt that being trans had no impact on their self-esteem: 'Being trans is who I am – it doesn't reflect poorly on me but on those who would deny trans people opportunities, rights and recognition. Being trans is not inherently shaming or negative, it just is.'

Participants were also asked about the amount of stress that they felt they experienced in daily life (N=566). 61% felt that most days were at least quite stressful, with 14% finding daily life very stressful and 6% extremely stressful.

The Life Orientation Test (Revised) was incorporated into the study as a measure of optimism and pessimism, both of which may impact upon health and wellbeing. Higher scores on this measure indicate optimism with between 14 and 15 being approximately average. The mean score for the participants was 12.5 (N=536). When separated by stage of, or desire to transition, the average scores ranged from 12.2 to 14.9 with these differences not reaching statistical significance.

Participants were asked about the amount of control they felt that they had over their lives at the moment, on a scale of one to seven (with one representing very low levels of control and seven representing very high control). Based on anecdotal reports of trans people feeling that they lacked control due to the medicalisation of their trans identities, it was felt that this would be a valuable question to ask, particularly as perceived control can impact upon mental health. As with the other measures presented here, the mean score was 3.8 (N=558), which was slightly low. When separated by desire to, or stage of transition, people proposing to undergo a process of transition had a lower mean score than those who had undergone the process that they desired (3.7 and 4.0 respectively). None of the differences between groups however were statistically significant. Despite this, when asked overtly about the relationship between being trans and control, 72% of the participants did feel that being trans had an impact (N=563). More participants felt that it was an entirely negative one (28%), with 25% feeling that being trans both positively and negatively impacted upon the amount of control they had, and 9% who felt that being trans had

an entirely positive impact.

Those that felt being trans negatively affected the amount of control they had explained that:

> ‘I feel like I can’t just be referred to how I want to be or dress/present how I would like because then other people would judge me.’
>
> ‘Since becoming openly Transgender my life and career has been dismantled through no fault of my own.’
>
> ‘I can’t do the stuff I want to do as my history always comes up and I have to cover for it’
>
> ‘My life is basically in the hands of the people at the GIC, because unless they treat me I will probably kill myself. They are treating me. I do not feel like my body is my own.’

Those that felt that being trans positively affected the amount of control they had stated that:

> ‘Transition has taught me just how much control we all have over our lives, ourselves, our bodies, the structure of our relationships, and our roles in society.’
>
> ‘It’s the main thing I feel I have been able to make a change in.’
>
> ‘It frees me from the expectations put on me by society or by my family.’
>
> ‘I feel empowered by making this step in my life. I am going to transition and nobody will stop me.’

Those that felt that being trans had both positive and negative affect on feelings of control explained that:

> ‘It is my choice to transition but the pace and how that happens is set by the NHS.’
>
> ‘I have control over how I interact with the world, but often others choose to react inappropriately.’
>
> ‘I can do little things, such as dress a certain way, but as a whole things just are not set up to accommodate non-binary genders.’
>
> ‘I’m more in control of my life, but attitudes can sometimes mean you don’t have opportunities open to others.’

To explore further the effect that being trans might have upon the participants wellbeing, they were asked if they had lost or missed out on anything due to either being trans, transitioning, or expressing their gender identity. Only 30% felt that they had not lost or missed out on anything. 39% reported that they had lost something, and 50% felt that they had missed out in some way (N=534).

Things that people had lost or missed out on as a result of being trans or transitioning included: jobs and a career, money, reproduction, home, childhood and youth, sports and leisure opportunities, equality and respect, family life, relationships and dating, happiness, friendships, intimacy, social life, personal development, education and qualifications. Other kinds of loss included the following:

> ‘Although I haven’t yet lost it, I will have to break my Civil Partnership with my partner in order to gain a Gender Recognition Certificate which is currently causing me a lot of upset.’
>
> ‘The last 20 years of my life, where I’ve kind of being treading water, waiting for the world & NHS to catch up with me & help (still waiting!)’
>
> ‘I missed out on attending my aunt’s funeral as I was not allowed to enter either the women’s or men’s sections if the synagogue. It was upsetting and humiliating to turn up and not be allowed in.’

'Before transitioning, I had a good job, a nice home, a stable relationship, lots of money, and I was very fit. Since transitioning, I lost my job and have been mostly unemployed, mostly homeless (sofa surfing), in unstable relationships, in poverty and unhealthy with depression and addictions.'

'Missed out on opportunities to travel to other countries due to being obviously trans and being a target for violence and even worse bigotry than is prevalent in the UK.'

In contrast however, being trans seems to provide opportunities as well. 81% of the participants felt that they had gained something as a result of being trans, transitioning or expressing their gender identity. These included: confidence, new friends, improved/better quality relationships, community and a sense of belonging, self-expression and acceptance, knowledge and insight, happiness and contentment, resilience, and a future:

'I can see things from both sides of the gender binary. That gives me a unique viewpoint.'

'I've gained respect for myself and other trans people; I've also gained a voice and awareness about the community.'

'I feel better about myself now, and my life is richer. It has also cast the quality of my friends and family in a very positive light indeed.'

'Transitioning made me happier in my own skin.'

'I gained the guts to stop caring what other people thought about me. I wake up every day with a few billion people hating me just for existing, and it doesn't matter.'

The participants were then asked about any regrets that they may have had in relation to changes that they have made. In terms of social changes that they had made in relation to being trans or transitioning, only 53% had no regrets (N=523).

34% had minimal regrets, whilst only 9% had significant regrets. In contrast, when discussing the physical changes which they had undergone in relation to being trans or transitioning, 86% had no regrets, with only 10% having minor regrets and 2% having major regrets. The most common regrets – in terms of social, medical and in general – were: not having the body that they wanted from birth, not transitioning sooner/earlier, surgery complications (especially loss of sensitivity), choice of surgeon (if surgery required revisions and repairs), losing friends and family, and the impact of transition on others. In addition, respondents had the following insights:

> ‘Regrets over loss of relationships and friends are minimal because, in general, I think there is little alternative [to] being trans - there is little room for regretting what has been done, because transition was essential’
>
> ‘Sometimes I regret ever being out, sometimes I regret the extent that I’m “stealth”. I walk a bit of a tightrope with it and it’s hard to know which way is best. I regret both at intermittent times.’
>
> ‘I have no regrets for transition, it is the best thing I can do under the circumstances. I have regrets that I’m trans and wasn’t just born male but that isn’t something I’m able to change.’
>
> ‘I do not regret transitioning, but I do wish that society was more understanding and accepting of trans people. I wish that the physical outcomes were better and that I had not lost so much (relationship, job, physical and mental health, home).’
>
> ‘I regret the loss of the privilege I had as someone perceived as cisgendered.’

4.12. Being Trans

The participants were asked to rate how positive or negative being trans was on a scale of one to seven (with one meaning 100% negative, and seven meaning 100% positive). The average score for all participants (N=465) was 4.4, slightly higher than the median, with mean scores ranging from 4.2 to 4.6 when the question was split by gender identity.

When asked on a seven point scale how much part of a ‘trans community’ the

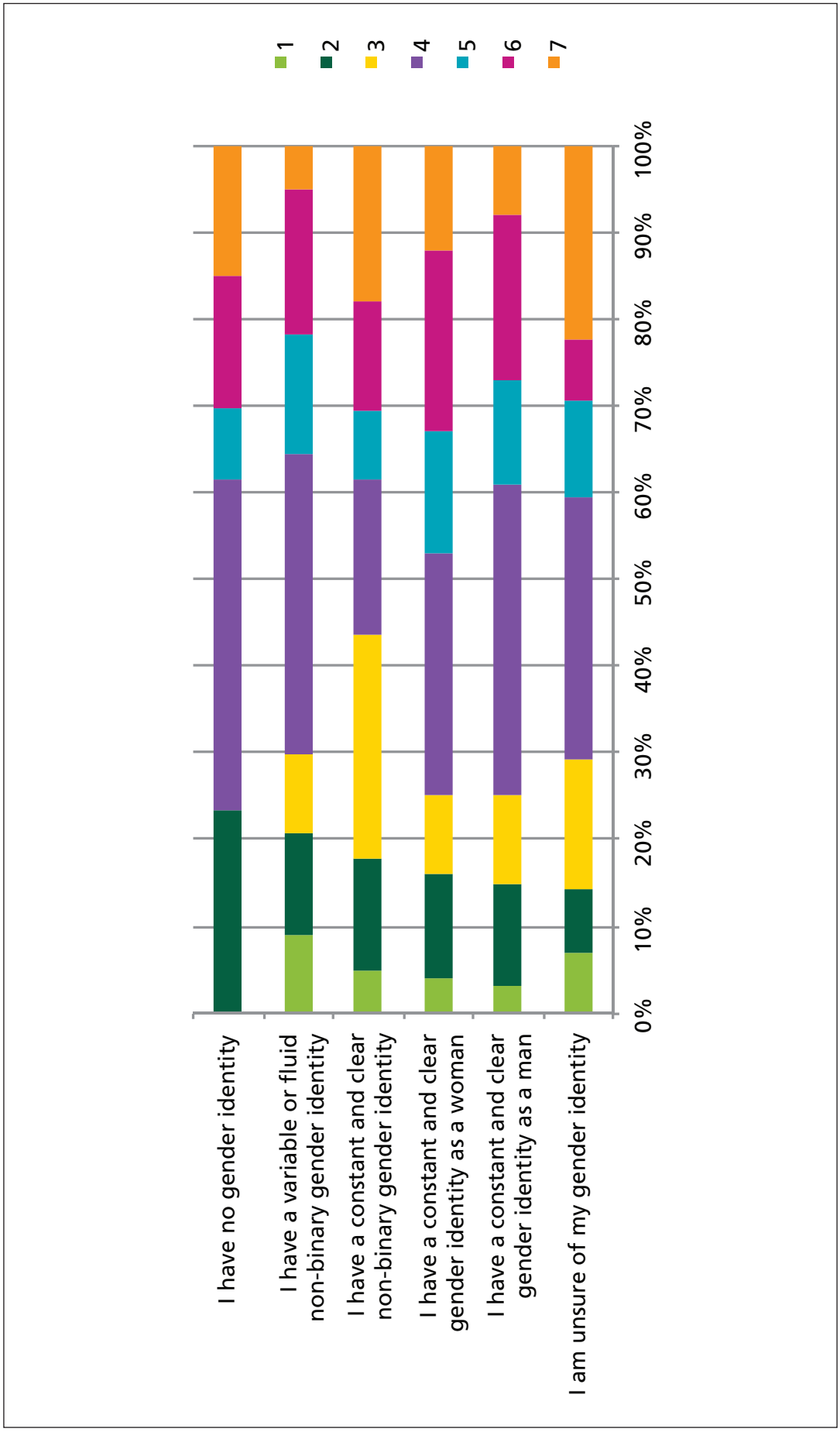

Figure 14: Overall experience of being trans

participants felt they were (with one being 'not at all' and seven being 'very much so'), the mean score was slightly on the low side (3.75; N=539).

The participants were further asked how much they felt part of mainstream (i.e. non-trans specific) society. The mean score, 4.1, was almost exactly in the middle between 'not at all' and 'very much so' (N=542). When separated by stage of or desire to transition, the differences between groups were not significant. The data was then separated by gender identity, with those having a female identity or a consistent non-binary identity feeling the most part of mainstream society, and those who felt they were 'other' or who had a variable non-binary identity feeling the least included. The differences between mean scores on the basis of gender identity were statistically significant (F=3.022, df=6, p=0.007).

Related to this, the respondents were asked to rate how often they felt isolated due to being trans or having a trans history. On the rating scale a score of one represented never feeling isolated, whereas a score of 7 reflected constant isolation. The average score was 3.9 (N=539), with no statistically significant differences being found on separation by gender identity.

In their daily interactions most of the participants were out as trans with trans friends (86%). Other situations where they were mostly out included with close family, LGB friends, sexual partners and other friends. 4% of the participants were not out to anyone at all and only 8% were out at a religious centre (N=546).

In what situations are you open about being a trans person or having a trans history? N=546	
With trans friends	86%
With close family	77%
With LGB friends	71%
With sexual partner(s)	68%
With friends who aren't LGB or T	66%
With extended family	45%
At work	39%
At social groups I attend (e.g. running club)	27%
Other (please specify)	15%
At my religious centre (e.g. church, mosque)	8%
I am not out to anyone	4%

Table 19: Which groups of people participants were out to

4.13. Employment and Housing

When asked to describe their current work situation, respondents were able to select

more than one answer, such as being in part-time employment and also being in education. The largest group of respondents, 38%, were in full time employment, with a further 19% being in education. 12% were employed part-time and another 12% were self-employed. 44% were not currently working for various reasons, such as being unemployed and seeking work, being retired and being unable to work due to illness or disability.

How would you describe your current work situation? (N=557)	
Employed full time	38%
In further/higher education	19%
Employed part time	12%
Self-employed or freelance	12%
Unemployed and seeking work	11%
Permanently/long-term sick or disabled	10%
Other	9%
Retired	7%
Looking after home or family	2%
Unable to work because of short-term illness or injury	3%
Temporarily laid off	1%
Unable to work in the UK	1%
On a government sponsored training scheme	0%
On maternity leave	0%

Table 20: Employment status

52% of the participants had experienced problems with work due to being trans or having a trans history (N=544). The most common issue was harassment or discrimination, with 19% experiencing this. 18% believed that they had been unfairly turned down for a job, whereas 16% had not applied for one due to fears of harassment and discrimination. Of concern in relation to the economic wellbeing of the participants were the findings that some had not provided references because of their gender history (9%), which may affect the jobs they could apply for, whilst others had left a job due to harassment or discrimination even though they had no other job to go to (7%). This could have significant implications should the person be reliant upon work in order to pay for their accommodation and food.

4.14. Housing

The largest group of participants, 22%, owned their own property, with 11% renting privately as a joint tenant and 9% renting privately as a single tenant (N=526). Only 1.3% were in unstable housing, which is not representative of the UK population, and may represent a sampling issue. As expected, most participants lived in a city (53%) with a further 20% living in a town near a city (N=545). Only 23% lived in an area

that they described as rural.

171 participants provided information about having to leave housing. Of those, 7% stated that they had left their parental home due to people's reactions upon finding out that they were trans or had a trans history. 6% had left a home shared with a partner and 4% had left a home that was shared with other people. 3% had had to leave their own home which they lived in alone due to others reactions to their trans status. Of 542 participants, 19% reported having been homeless at some point, with 11% having been homeless more than once.

4.15. Social Support

For the participants in this study being seen as the gender they identified as was essential. Of 530 people, the average score on a scale of one (not at all important) to seven (very important) was 6.1 for the importance of being seen as the gender they identified as.

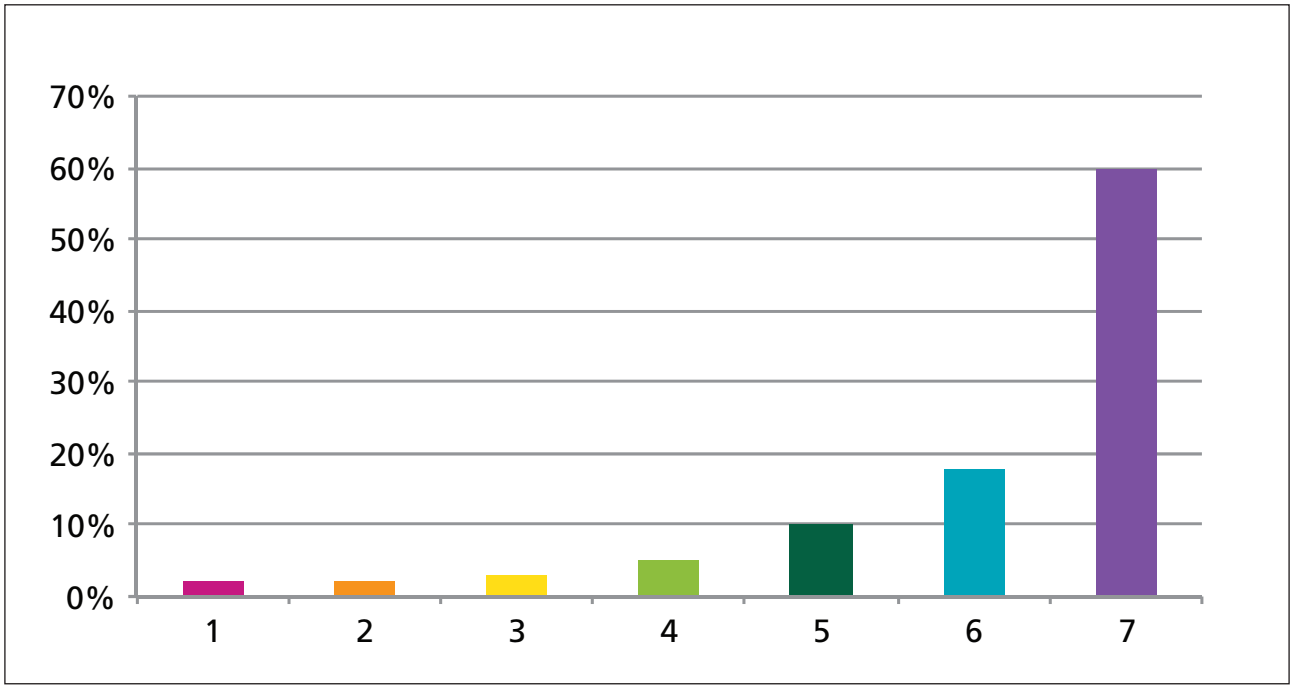

Figure 15: Importance of being seen as identified gender

42% of the participants did feel that they were seen by others as the gender they identified as, compared to 28% who felt that they were seen as the sex they were assigned at birth. 20% felt that they were viewed as a trans person (N=528). 39% felt that other people would know that they were trans or had a trans history without being told, more than half of the time (N=526).

In general the participants found that when they told others that they were trans or had a trans history, people were more supportive than unsupportive. The exceptions were flatmates where this trend was reversed, and co-workers where there was an almost equal chance of them being supportive or unsupportive.

How supportive have the following been? (N=525)						
	N	Not at all supportive	Not very supportive	Somewhat supportive	Very supportive	Not applicable
My parents	511	17%	12%	22%	28%	22%
My sibling(s)	492	14%	10%	21%	28%	29%
My spouse(s) or partner(s)	489	7%	4%	13%	40%	36%
My child(ren)	473	4%	3%	6%	11%	77%
My extended family	477	7%	8%	29%	17%	40%
My flatmates	453	20%	16%	8%	15%	74%
My trans friends	492	1%	0%	13%	71%	13%
My non-trans friends	497	1%	6%	38%	43%	12%
My church/ temple						
/mosque	450	3%	1%	4%	5%	86%
My cultural community	441	3%	4%	9%	6%	79%
My co-workers	468	30%	4%	16%	19%	58%
My supervisor/ boss	468	4%	3%	14%	23%	55%
My teachers/ lecturers	451	2%	4%	10%	10%	76%
My classmates	443	3%	3%	14%	4%	8%

Table 21: Supportiveness of different groups

Importantly, following transition, most participants felt that there was no change in the level of support they received from the different groups. The only group who were less supportive post-transition than previously were the religious institutions. Other groups were more supportive.

The respondents in the study had a variety of people available for support. On average they had 7 close friends (N=504) and 2 close relatives (N=496) who they felt that they could talk with about things that were on their mind. There was no significant difference between people with different gender identities in terms of the number of close friends or relatives that they had. Since either undergoing some form of transition or telling people that they were trans, only 18% of participants felt that the number of close friends they had had decreased (N=467). For over 50% the number of friends they had stayed the same, with 20% having similar sized friendship groups but which comprised of different people to pre- transitioning or coming out.

Sadly, transitioning did seem to impact upon people's parenting options. Of 188 participants who were parents, 14% experienced no changes in their parental relationship from transitioning. The negative experiences people had were seeing their child(ren) less (19%), losing contact with younger children (9%), losing contact with older children (9%), and losing or having custody reduced (5% and 3% respectively). Only 17% found telling their children to be a positive experience.

Experience of parenting and transition (N=507)		
		Of the 188 (37%) who were parents:
I lost custody of my child(ren)	9	5%
I had my custody of my child(ren) reduced	6	3%
I see my child(ren) less	35	19%
I lost contact with my child(ren) under 18	17	9%
I lost contact with my adult child(ren)	16	9%
Telling my children about my gender was a positive experience	32	17%
None of the above	102	54%
There were no changes when I told my child(ren)	27	14%
Not applicable / I am not a parent	319 (63%)	

Table 22: Experience of parenting and transition

The Medical Outcomes Study Social Support Scale was included in the study to provide an indication of the levels of social support available to the participants. Scaled scores range from 0-100, with higher scores being indicative of higher levels of social support. The mean score for the participants in this study (N=478) was 66.8. There were no statistically significant differences between mean scores for different gender identities, or people at different stages of transition or different desires around the need to transition.

In terms of trans groups which participants used for support, there were differences between countries. For example, 33% of those who lived in Scotland did not access trans groups, compared to 17% in England and only 9% in Wales. The Scottish participants were substantially less likely to use international or national trans groups for support than their English and Welsh counterparts. They were also less likely to use internet groups (55%) compared to the English (69%) and Welsh (68%) participants. Participants living in rural areas were most likely to use internet groups for support, although most participants did use them. People who lived in cities were most likely to use local trans support groups, with no rural-city split in terms of the use of national or international groups. Those in very rural areas or rural villages were less likely to access trans groups in general than those in cities.

As a quarter of the participants (N=479) felt that groups were too far away, this may explain in part why people living in rural areas were less likely to attend local support

groups, however other factors such as being uncertain about what could be gained from the groups, and feeling that the groups were not personally relevant, were cited as reasons that prevented more people from accessing groups. Only 30% of the participants felt that there were no barriers to their accessing groups.

Is there anything that stops you from accessing trans groups? (N=479)	
Nothing	30%
Trans groups are not relevant enough to my life	27%
I do not know what I want to gain from it	26%
Trans groups are too far away	25%
I worry I am not 'trans' enough	17%
I worry that other people in the group may not like me	16%
I worry that I may not like other people in the group	15%
Other	14%
I worry someone will see me go	6%
It is not accessible to me (for example, steps with no ramp, no language translation, no sign language interpretation)	3%
I don't have regular access to the internet	1%

Table 23: Accessibility of trans groups

For the Scottish and Welsh participants the groups being too far away was the main reason for not accessing trans groups. The English participants were most concerned with being uncertain as to what could be gained. The Scottish participants seemed to face the greatest barriers to access, with only 20% feeling that nothing prevented them attending trans groups, compared to 27% of the English and 37% of the Welsh participants. In addition, respondents identified the following barriers:

> 'Being trans is only a small part of who I am and what interests me.'
>
> 'Lack of confidence'
>
> 'A lot of local groups are just transwomen so sometimes it's harder to relate to.'
>
> 'I tend to find that if you don't conform to the way they think, you are ostracised'
>
> 'I'm trans, doesn't mean I have to hang around with trans people. I'm also a Morris dancer and a domina.

Some things feel very focussed on early transition - coming out, hormones, surgery etc. The BDSM community is my favourite of the three.'

'Don't want the slightest risk of being 'outed' about my history '

4.16. Media

Given recent media portrayals of trans people, from reality shows such as Big Brother, to the furore over trans men conceiving children, it was important to explore the impact which this could be having upon trans individuals and communities. Of 525 participants, 51% felt that the way trans people were represented in the media had a negative effect on their emotional wellbeing. Only 4% felt it had a positive impact, and 31% that it had no impact at all.

Some of those that felt that the media had a negative effect on their wellbeing stated that:

'Tabloid stories about trans people are often exploitative, invasive of privacy, inaccurate, irrelevant or intended to drum up transphobia in their readers, often successfully as revealed in the comments on stories. Reading these sometimes upsets and angers me because it shows how hostile many people are to trans people in current society.'

'The caricatured and stereotyped portrayal of Trans issues is the same as racist and sexist jokes. It gives phobic people a means of expression towards other people who are specifically targeted by these jokes. Where are the Transgender social heroes who have raised thousands of pounds for charity?'

'It makes me angry. It also denies me my civic rights. I would never DARE to stand for election, either to the parish, borough or county council, much less to parliament as I would be sure to be 'outed' and made to look stupid by the gutter press'

'The media consistently misgenders, refers to previous names, makes a trans person's body theirs, theorises why we do it without talking to us properly, makes assumptions about our genders and motivations. They use language that makes 'trans' a third gender, stripping us of our identities. They use language that refers to us as abnormal and disrespects our bodies and our rights'

'Aside from "out" championing activists eg: Paris Lees (whom I count as a friend) for the most part TV/media is still full of "SEX CHANGE SOLDIER GENDER BENDS IN SEXY HEELS" type nonsense, or genuinely offensive caricatures in "comedy" and this increases the desire to stay 100% stealthy as possible.'

'I very much wish that trans characters were included in television and film narratives without comment or particular note - just as any other type of character might be'

'It becomes tiresome to hear of cis people having authority on trans issues'

'At best it's patronising, at worst it's a hate crime'

'The recent story of 'trans man gives birth' (sold to the paper by the ex-partner) resulted in the newspaper encouraging people to hunt down the man in question, who I know. It made me feel physically sick that he would be targeted that way'

'Because we are made out to be freak shows and I am scared that they may come after me or my friends next'

'We are seen as having sex swaps and mutilating our genitals or we are sexual deviants, we are never just seen as us, the trans angle is always there for titillation'

'It is a constant reminder of how much most people despise me for what I am.'

'My parents read into the news too much and think being trans is wrong, this affects their treatment of me'

'Paddy Power's recent misogynistic and transphobic Lady's Day ad stopped me going the gold cup event in Cheltenham'

'Negative stereotypes of trans people make it even harder for me to overcome my social phobia and isolation.'

'The ways trans people are portrayed in the media generally fosters negative views of trans people. It makes me feel unsafe because it normalises ridicule and violence towards trans people, portrays our identities as invalid, posits being cis as the 'natural', 'normal' way to be etc.'

'It can get a bit much when there's a story in the paper every other day about what a bunch of hateful, deviant, female only space invading, sponging drains on the NHS trans people are (I'm looking at you *The Sun, The Mirror* and *The Daily Mail*)'

Other comments were mixed:

'Most of what little I have seen of trans people in media coverage has been sensationalist/exploitative news stories, although I have seen a couple of sensitive documentaries'

'While I can see trans in media as positive role models, I am concerned that the public sees reinforced stereotypes, which can feed back into their attitudes to me'

'It doesn't really affect me because there's little representation. but sometimes it really bothers me because they only show people who identify as transgender but still lie on the gender binary and that's fine for people to be like that, but that's not the only type of transgender person there is and so it's annoying that the only people we have to look up to are ones

> getting surgeries and hormones and coming out on national tv, etc'

A few comments were more positive:

> 'Of the limited media portrayal I have seen it has all been positive, making it feel like I would be accepted when I come [out]'

4.17. Sex

Many of the participants had substantial worries about sex and their bodies (N=490). Most worried that other people would find their bodies unattractive (81%) or that few people would want to have sex with them (79%). Feelings of shame were evident as was a sense of the disparity between the expected body and the body that participants actually had. 58% were also worried about their physical safety in relation to having sex.

When I think about having sex, I worry… (N=490)	Not at all	Have worries
That other people think my body is unattractive	17%	81%
That there are very few people who would want to have sex with me	19%	79%
About feeling ashamed about my body	24%	74%
That once I'm naked, people will not see me as the gender I am	24%	74%
That I will be upset by differences between my actual physical body and the body I instinctively expect to have	27%	70%
About my physical safety	40%	58%
That people only want to have sex with me because I'm trans	46%	53%
That I can't have the sex I want until I have (another) surgery	44%	51%

Table 24: Worries about sex

Following transition, many participants experienced changes in their sex lives, with 38% finding that this improved (N=372). Only 20% felt that their sex life had worsened following transition. It would be useful to gather more information

concerning this as it may be a product of poor surgical outcomes, or other issues such as relationship difficulties.

Many respondents reported that they did not currently have a sexual partner or an active sex life. For some – who identified as asexual or celibate – this was not a concern. Others wanted an active sex life but their gender dysphoria prevented them from being naked and/or sexually intimate with others. Others hoped that surgery would enable them to feel more comfortable with their bodies and, therefore, with sex and intimacy: 'Until I'm comfortable with my body (including post-surgery) I have not engaged in sexual activity.'

Elsewhere, respondents stated that exploring their gender identity had improved their sexual expression: 'being able to express this part of my identity sexually has definitely improved my sex life'. In addition, respondents noted the positive impact of medical transition on their sexual confidence: 'Now I don't feel that my body is gross and icky, I can actually enjoy it!' Others, however, reported the opposite effect: 'I feel even more aware of my physical body now that I've started transitioning. I feel as though I have completely regressed sexually since identifying as trans.' People who had transitioned also noted the difficulty they faced finding potential partners: 'well I have no sex life... I became "invisible" after coming out and people my age group still cannot handle me as a potential lover...they are deep down in their hearts transphobic, and cannot really see me as a woman despite my look and my voice'. Another reported that: 'I used to fit into a neat category but now I don't so it is hard to find sexual partners who are interested in me as I don't have what they are looking for.' This new-found gendered and bodily expectation was summed up by the following comment: 'I find the process of getting along in the gay male world without a regular set of cock and balls very intimidating. It's about acceptance. On their part - but maybe on my own part too'. As well as shifts of identity and community expectation, others found that the new gender role adjustment had impacted on their chances of finding a sexual partner - 'I have sex very VERY rarely now. I am not sure how to flirt or let someone know I'm attracted as a man'.

Those taking testosterone reported an increase in their sexual drive and often, an increase in sexual satisfaction, as this respondent noted:

> 'Before transitioning my sex drive had become almost non-existent due to my depression. Now that I have started transitioning I have become sexually active again. I know that the testosterone has had a lot to do with it but I enjoy sex'.

However, some respondents reported losing their sex drive and thus pleasure in sex as a result of taking the hormone oestrogen:

> ‘I no longer have one, the hormones have killed my libido’

Others noted its impact on relationships:

> ‘Anti Androgens prevent erections. Feminisation means my wife is no longer attracted to same sex’.

In addition, some of those who had undergone genital surgery reported a loss of sensitivity and corresponding loss of sexual pleasure:

> ‘Complications after surgery and the lack of PCT knowledge and support has resulted in loss of critical tissue and sensitivity’

> ‘Following the surgery, I have abdominal scarring, no clitoral sensation and little sensation in the rest of the genital area (loss of nerve endings). Due to my negative life situation (unemployment, homelessness, poverty, poor health), I am also depressed. These problems and an irregular hormone regime have left me with no sex drive or sex life.’

4.18. Quality of life

Of 520 respondents, 86% felt that being trans may have an effect on their quality of life, with more feeling it was a positive influence than negative (24% compared to 13%). 42% however felt that being trans had a positive and negative impact on quality of life.

Those that felt that being trans had a negative impact on the quality of their life cited their frustration with the current delays and stumbling blocks that they experience whilst obtaining gender reassignment treatment on the NHS:

> ‘Stuck, awaiting referral. Frustrated and in limbo’
>
> ‘I find it difficult to cope with day to day tasks at the moment because being trans feels like it’s taking over everything in my life.’
>
> ‘I am still anxious about some social interaction, can’t have the sex and body I want and have to deal with [name of clinic removed] GIC. Money I could have used for other things has had to go on HRT, electrolysis, saved for surgery, etc.’
>
> ‘Has reduced my earning power, created lots of stress, isolated me from others’

Another negative impact was the social penalties they incurred as a result of transitioning:

> ‘Without friends to do things with regularly and family around you, quality of life is poor. They are the most important things and it hurts to be rejected by them’

The positive impact of being trans on quality of life was summed up by the following statements:

> ‘I accept who I am now’
>
> ‘I am happy with myself and my sense of identity, and it gives me a lot of inner peace.’
>
> ‘I am more confident now’

In summary, most respondents reported that exploring their gender, making a social and/or medical transition and being seen as their felt gender had a positive impact on their quality of life. However, the same respondents stated that social pressure, rejection, stigma, harassment and discrimination as well as gender dysphoria had negatively impacted on their quality of life:

‘I am content with my body and live life as the woman I feel I was born to be. However, I do face ridicule daily’

‘Being trans has helped me get fit, stop smoking, drinking and doing drugs. It has shown what a strong person I am and coming out has calmed me down. However, living dual roles is agonising at times and I need to transition full time to improve the quality of my life.’

‘I have gender dysphoria, but overall I am glad that I am trans* because of the many opportunities it has afforded me.’

‘I know I am a strong person having done what I have… I am not yet fully over the scares being trans has given me’

‘I love being a woman, I hate being treated as a freak.’

The vast majority of participants reported that recognising their gender identity or transitioning had improved their quality of life (78%), compared to 9% who thought it had got worse (N=499).

5. Impact of transition on wellbeing 83

Around 13% of the sample had not transitioned in any way and did not have any desire to transition. For the other participants however, transition was an issue which affected them in many ways, warranting a separate section here to explore this further. The findings from this report have demonstrated that for those who wish to undergo some form of transition or gender reassignment, being able to do so dramatically improves their outcomes. As demonstrated above:

★ Transition was related to improved life satisfaction (Satisfaction with Life Scale scores being statistically significant when separated by stage of/desire to transition; $F=18.506$, $df=5$, $p<0.005$).

★ Transition was related to improved body satisfaction in relation to gender.

★ Transition led to less avoidance of public and social spaces, and changed the nature of those that are avoided.

★ Transition was related to a decrease in mental health service use. Support is mainly needed before and during transition.

★ Transition was related to reduced depression (with differences in CES-D scores being statistically significant; $F=2.205$, $df=5$, $p=0.05$).

★ Mental health was rated as being better post-transition that previously.

★ Self-harm reduced following transition for the majority of those who had a history of self-harm.

★ Suicidal ideation and attempts were more frequent pre-transition.

★ Very few participants regretted the physical changes that they had undergone as part of transition. The regrets which they did have were related to surgical outcome – in particular, revisions, repairs, complications, and loss of sensation.

★ Post-transition many people found that they had the same amount or more support socially than previously.

★ Transition had many implications for parenting, most notably the possibility of it negatively impacting upon the participants' relationships with, and particularly access to, their children.

★ Most participants experienced improvements in the quality of their sex lives following transition.

6. Closing Comments

The participants were asked as a closing question whether they had any final comments which they would like to make about trans mental health and emotional wellbeing. A selection of these have been included below, which best represent the issues raised by participants through this report. They are included without explanation or description, to ensure that the participants' voices are genuinely heard.

'I'm tired, that's the problem. I'm tired of being stressed about it all the time and I'm deeply unhappy that I can't be who I want to be. I hope that trans people can work to change the attitudes of people in the health services so that they're more accepting and polite.'

'As Trans Mental Health is such a unstudied area, Peer Support is likely a good way so Health & Social Care should recognise how resources should be flexible (e.g. Direct Payments to go to Trans Events).'

'The lack of support in the system can be very damaging, particularly so for younger people who have no support or no understanding from their families. The lack of safe spaces for people to escape to or access to residential/therapeutic communities just means people get worse but don't tell anyone else. the fact that someone has not actively tried to kill themselves is not sign that they are coping, it can just be that they haven't quite reached that stage yet.'

'Depression is not an indicator that transitioning is a bad idea. Sometimes depression is caused by transitioning. Sometimes depression is caused by not receiving treatment fast enough. Sometimes depression has nothing to do with transition.'

'Being trans is not in itself a mental health problem or indicator of poor wellbeing. It is the pressure that society puts you under that leads to anxiety, stress and depression. And many trans people can, and do, lead happy and successful lives. It is also time for the removal of GID from DSM classification.'

'I think that mainstream mental health services have a long way to go with becoming educated about trans

identities. Trans people often have to deal with a lot of difficult issues and have very few options for where to access appropriate, non-judgemental mental health support. In my opinion safety is a key issue when it comes to (improving) trans people's mental health.'

'I think my mental health would have not suffered in the way that it did during transition if I was more prepared for the process and had better emotional support during it.'

'More needs to be done to improve the general health of trans people, and especially to provide support at a one-to-one level.'

'Right now I'm OK. The thought of needing to use the NHS terrifies me.'

'I find that my other health issues are more debilitating than my gender identity. The main problem about my gender identity is society wanting to put everyone in little boxes and I don't really want to have to 'come out' to every new person that I meet just to have them view me remotely how I am inside. People should start just treating people equally, like people, not like genders.'

'… Just to flag up how utterly useless the GICs are. They offer no meaningful support at all and just put obstacles in our way. Sorting them out to work more effectively would lift a massive burden on trans people I think, me included.'

'I believe being trans is a problem, due to dysphoria and social attitudes. Once dysphoria is resolved via transition, all that remains is people's attitudes. Once society stops discriminating against us, then it will be safe to say that being trans is not a bad thing.'

'There needs to be more training for NHS mental health people! SERIOUSLY!'

'We need to start helping trans teenagers. This would have helped me and probably prevented me from

attempting suicide.'

'Other than the current NHS pathway can cause preventable harm to the patient.'

'…I'm mentally ill AND transgender, not mentally ill because I'm transgender. Also there doesn't seem to be much emphasis on transgender emotional health, be that in a gender-reassignment or fully transgender context.'

70% of the participants were more satisfied with their lives since transitioning and only 2% were less satisfied. Those that were less satisfied after transitioning cited poor surgical outcome, loss of family, friends and employment, everyday experiences of transphobia and non-trans-related reasons.

85% were more satisfied with their body since undertaking hormone therapy, 87% were more satisfied after non-genital surgery and 90% after genital surgery. Only 2% were less satisfied with their body since undertaking hormone therapy, 2.6% were less satisfied after non-genital surgery and 3.7% after genital surgery Those that were less satisfied after surgery cited poor surgical outcome (in terms of aesthetics, functionality and surgical complications - nerve damage, loss of sensation), treatment delays, funding refusals on the NHS or sheer cost if they went privately, as well as a lack of support both during and after surgery.

Of those who have attended Gender Identity Clinics, 60% have been seen within a year, 32% wait 1-3 years, under 10% wait over three years for an appointment. 58% of the participants felt that this wait had led to their mental health or emotional wellbeing worsening during this time. Once seen at a Gender Identity Clinic, 46% of the participants felt that they had experienced difficulties obtaining the treatment or assistance that they needed. These included administrative errors, restrictive protocols, problematic attitudes, and unnecessary questions/tests.

62% of people that had used Gender Identity Clinic services experienced one or more negative interactions, 63% in general mental health services, and 65% in general health services. For nearly 30% of respondents, a healthcare professional had refused to discuss a trans-related health concern.

27% of the respondents reported that they had either withheld information or lied about something to a Gender Identity clinician. This was mainly because participants' feared that treatment would be stalled or stopped, and because they did not feel that the questions were relevant to their diagnosis. 18% of those attending a GIC felt confused about their gender, and 33% were concerned about their mental wellbeing, but felt unable to discuss their concerns at the GIC.

Within mental health services, 29% of the respondents felt that their gender identity was not validated as genuine, instead being perceived as a symptom of mental ill-health. 26% felt uncomfortable being asked about their sexual behaviours. 17% were also told that their mental health issues were because they were trans, when they disagreed and saw them as separate. 45% used mental health services more before transition, 18% more during, and 0% used mental health services more post-transition. 10% of the participants had been an inpatient in a mental health unit at least once. 38% of those experienced difficulties within the inpatient unit due to being trans or having a trans history, including harassment, misgendering and uncertainty about placement within single sex facilities.

81% of the participants avoided certain situations due to fear. Of these, over 50% avoided public toilets and gyms, and 25% avoided clothing shops, other leisure facilities, clubs or social groups. 51% of the participants worried that they would have to avoid social situations or places in the future due to fear of being harassed, read as trans, or being outed.

Over 90% had been told that trans people were not normal, over 80% had experienced silent harassment. 50% had been sexually objectified or fetishised for being trans, 38% had experienced sexual harassment, 13% had been sexually assaulted and 6% had been raped for being trans. Over 37% had experienced physical threats or intimidation for being trans, 19% had been hit or beaten up for being trans. 25% had to move away from family or friends for being trans; over 16% had experienced domestic abuse, and 14% had experienced police harassment for being trans. 62% of respondents have alcohol dependency or abuse issues. Almost half of the participants, 49%, experienced some form of abuse in childhood.

74% felt that their mental health had improved as a result of transitioning. The 5% who reported a decline in their mental health since transitioning felt that their issues related to a lack of appropriate support, losing family and loved ones, or for reasons which respondents felt were unrelated or 'not directly related' to the transition, such as employment or cultural/environmental issues.

Rates of current and previously diagnosed mental ill health were high, with many participants additionally feeling that they may have experienced particular issues which remain/ed undiagnosed. Depression was the most prevalent issue with 88% feeling that they either currently or previously experienced it. Stress was the next most prevalent issue at 80%, followed by anxiety at 75%. For all but stress and depression, more participants felt that they had a mental health concern which remained undiagnosed, than had received a diagnosis.

Over half of the respondents (58%) felt that they had been so distressed at some point that they had needed to seek help or support urgently. When asked for more information about their experiences, 35% of those individuals had avoided seeking urgent help due to being trans or having a trans history. When participants did need urgent support they were most likely to contact their friends, followed by their GP or partner. Relatively few chose to use other NHS support, choosing helplines or online groups over these. 18% also stated that they did nothing when in need of crisis support.

53% of the participants had self-harmed at some point, with 11% currently self-harming. 20% of respondents had wanted to harm themselves in relation to, or because of involvement with a Gender Identity Clinic or health service. The reasons listed included: long waiting times and delays to treatment, appointment cancellations, inaccurate assessments, being denied hormones, being denied surgery, being denied access to a Gender Identity Clinic, being given the wrong information or advice, receiving negative or inappropriate treatment from psychiatrists, and being

discharged from a Gender Identity Clinic.

The majority of participants, 84%, had thought about ending their lives at some point. 35% of participants overall had attempted suicide at least once and 25% had attempted suicide more than once. Looking in depth at the 84% of participants who had thought about ending their lives at some point revealed that 27% of them had thought about attempting suicide within the last week with 4% thinking about it every day. In the last year 63% of them had thought about attempting suicide with 3% thinking about it daily. Prevalence of actual suicide attempts among those who had ever thought about ending their lives was 11% within the last year, however lifetime prevalence was substantially higher, at 48%. 33% had attempted to take their life more than once in their lifetime, 3% attempting suicide more than 10 times. More significantly, 11% of those who had thought about suicide in the past were unsure as to whether they were planning to attempt suicide in the near future, and 3.2% were planning to. Given the high rates of suicidal ideation and attempts amongst the respondents, the finding that over 25% may not access mental health services in the future should pose serious questions about the issues they face in the services currently available.

Suicidal ideation and actual attempts reduced after transition, with 63% thinking about or attempting suicide more before they transitioned and only 3% thinking about or attempting suicide more post-transition. 7% found that this increased during transition, which has implications for the support provided to those undergoing these processes.

70% of respondents felt that they had lost or missed out on something as a result of being trans, transitioning or expressing their gender identity. These included: jobs and a career, money, reproduction, home, childhood and youth, sports and leisure opportunities, equality and respect, family life, relationships and dating, happiness, friendships, intimacy, social life, personal development, education and qualifications.

81% of participants felt that they had gained something as a result of being trans, transitioning or expressing their gender identity. These included: confidence, new friends, improved/better quality relationships, community and a sense of belonging, self-expression and acceptance, knowledge and insight, happiness and contentment, resilience, and a future.

In terms of social changes that they had made in relation to being trans, only 53% had no regrets, 34% had minimal regrets, and 9% had significant regrets. In contrast, when discussing the physical changes which they had undergone in relation to being trans, 86% had no regrets, 10% had minor regrets and 2% had major regrets. The most common regrets – in terms of social, medical and in general - were: not having the body that they wanted from birth, not transitioning sooner/earlier, surgery complications (especially loss of sensitivity), choice of surgeon (if surgery resulted in complications or required revisions and repairs), and losing friends and family.

52% of the participants had experienced problems with work due to being trans or having a trans history. The most common issue was harassment or discrimination, with 19% experiencing this. 18% believed that they had been unfairly turned down for a job, whereas 16% had not applied for one due to fears of harassment and discrimination. 9% had not provided references because of their gender history, whilst 7% had left a job due to harassment or discrimination even though they had no other job to go to.

High rates of homelessness were evident in the sample, with 19% reported having been homeless at some point, and 11% having been homeless more than once. Of 188 participants who were parents, 19% reported seeing their child(ren) less, 18% lost contact with their children, and 8% had custody issues. Only 17% found telling their children to be a positive experience. 51% felt that the way trans people were represented in the media had a negative effect on their emotional wellbeing.

Most worried that other people would find their bodies unattractive (81%) or that few people would want to have sex with them (79%). 58% were also worried about their physical safety in relation to having sex. Following transition, many participants experienced changes in their sex lives, with 38% finding that this improved. However, 20% felt that their sex life had worsened following transition. This appeared to be due to decreased sex drive in participants on feminising hormones, and complications from genital surgery resulting in loss of sensation and sexual pleasure. There were also knock-on factors, such as relationship breakdown or difficulty adjusting to a new gender role (and resultant social expectations).

8. Policy Recommendations

Training

There is a significant need for trans health and awareness training for all staff and managers across general healthcare, mental health and within Gender Identity Services, to ensure that the discrimination evident in this survey is curtailed so that trans people have the same access to all forms of healthcare as other people. Many of the issues which respondents faced related to a simple lack of understanding which could easily be avoided through appropriately targeted, mandatory training.

Suicide Prevention

Suicide prevention research, campaigns and targeted interventions with the trans population. Further research is vital to better understand the complex interaction of factors which influence suicidal ideation amongst trans people, and this research must involve trans people at all stages of the research process. Targeted interventions are vital for reducing the exceptionally high prevalence of suicide and suicidal ideation amongst trans people. Trans mental health needs to be written into suicide prevention policies and addressed at a local and governmental level to ensure a comprehensive and uniform strategy is introduced. As trans people are more likely to use friends and family when in need, due to their concerns about health services, it is essential that services are developed to ensure that they are supported with information and assistance, as an interim measure whilst current services are enhanced to take in to account the needs of trans people.

Research

There is a substantial need for further research concerning transgender mental health and wellbeing. This study represents a pilot and clearly demonstrates areas where further exploration is necessary and essential. Any future research must fully involve and engage with trans people in order to ensure that their needs and experiences are truly considered.

Enhanced Collaboration

Closer work between voluntary and community sector organisations and mental health services (including commissioning of services) in the area of trans support and outreach, to enhance trans people's experiences of services and the types of services which they can receive.

Exploration of Alternative Health Care Models

There should be a shift towards models of trans healthcare incorporating informed consent and patient flexibility. This could be within the context of Gender Identity Clinics, however there are substantial issues within this system as it currently stands in terms of patient experience and outcomes. Many other models of trans healthcare are used globally and should be explored as alternatives. For example, the THInC model from Chicago (Trans Hormones Informed Consent) has very positive outcomes with the communities being fully engaged and involved in decisions around their healthcare. Informed Consent models are easily adapted to the UK health system (for example the T-PIC model; Traverse Research). These alternatives should be developed and researched to provide a valuable resource for informing true evidence-based practice focussed on enhancing outcomes, and in the process reducing costs.

9. Glossary

Some of the terms used within this report (either by the authors or the participants) have been explained below.

FFS – facial feminisation surgery

Trans - an umbrella term for people whose gender identity and/or gender expression diverges in some way from the sex they were assigned at birth, including those who identify as transsexual people, those who identify as non-binary gender people, and cross-dressing people. More information is available at www.scottishtrans.org

Cis/cisgendered/cisperson – a person whose gender identity is the same as the sex they were assigned at birth.

GIC – Gender Identity Clinic. A specialist NHS services providing assessment for trans people who are seeking hormone treatment and/or surgical gender reassignment procedures. They are usually run by consultant psychiatrists who may or may not have other types of NHS staff working with them.

GRS – Gender Reassignment Surgery

Trans man/FTM - A person who was assigned female at birth but has a male gender identity and therefore proposes to transition, is transitioning or has transitioned to live as a man, often with the assistance of hormone treatment and perhaps various surgical procedures.

Trans woman/MTF – A person who was assigned male at birth but has a female gender identity and therefore proposes to transition, is transitioning or has transitioned to live as a woman, often with the assistance of hormone treatment and perhaps various surgical procedures.

RLE – Real Life Experience, the process of a person changing their name and living full-time in accordance with their felt gender identity as part of a treatment pathway required by Gender Identity Clinics prior to approval for surgical gender reassignment procedures.

WPATH – World Professional Association for Transgender Health.

SOC (6 or 7) – Standards of Care (version 6 or 7), the care pathway recommended for transgender people by WPATH

T-PIC – Transgender Pathway of Informed Consent. A model of transgender healthcare which centres around Informed Consent principles and the use of the mental capacity assessment. It locates transgender healthcare in the less-costly, pre-existing Care Programmes Approach used in England and Wales, and in other primary and secondary care services.

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