Speaking from the Margins

Trans Mental Health and Wellbeing in Ireland

Jay McNeil, Louis Bailey, Sonja Ellis & Maeve Regan
Transgender Equality Network Ireland (TENI)

IRIS O'BRIEN FOUNDATION

Copies of this report are available for download from the TENI website: www.teni.ie.

Acknowledgements

This is the largest survey of trans people conducted in Ireland, and the data we have will effect positive change for the trans community. Transgender Equality Network Ireland (TENI) would like to thank everyone who participated in this groundbreaking survey. 164 people completed the online survey, and we are grateful for the time they took to answer the questionnaire and share their experiences.

We want to thank the researchers who have analysed the data and produced a report that is rich with information and highlights the voices of participants. We are indebted to Jay McNeil, Dr Louis Bailey, Dr Sonja Ellis and Maeve Regan for all their work.

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"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Preamble to the Constitution of the World Health Organization, 1948

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Foreword

The trans community in Ireland is incredibly diverse and through our different journeys to become our authentic selves we have shown great resilience in the face of adversity. This research is ground-breaking and represents the largest study of transgender mental health and wellbeing in Ireland. It was made possible through a partnership between Transgender Equality Network Ireland (TENI) and the Scottish Transgender Alliance, TransBareAll, Traverse Research and Sheffield Hallam University.

Through TENI's work with the trans community in Ireland, we know that many members of our community are on the margins of society. Trans people face high levels of stigmatisation and discrimination that negatively impact our lives. Issues such as isolation, family rejection and marginalisation at home, in schools and in the workplace can lead to poor mental health outcomes such as stress, anxiety, depression and suicidality. In this survey almost 80% of participants had considered suicide, and half of those had made at least one attempt.

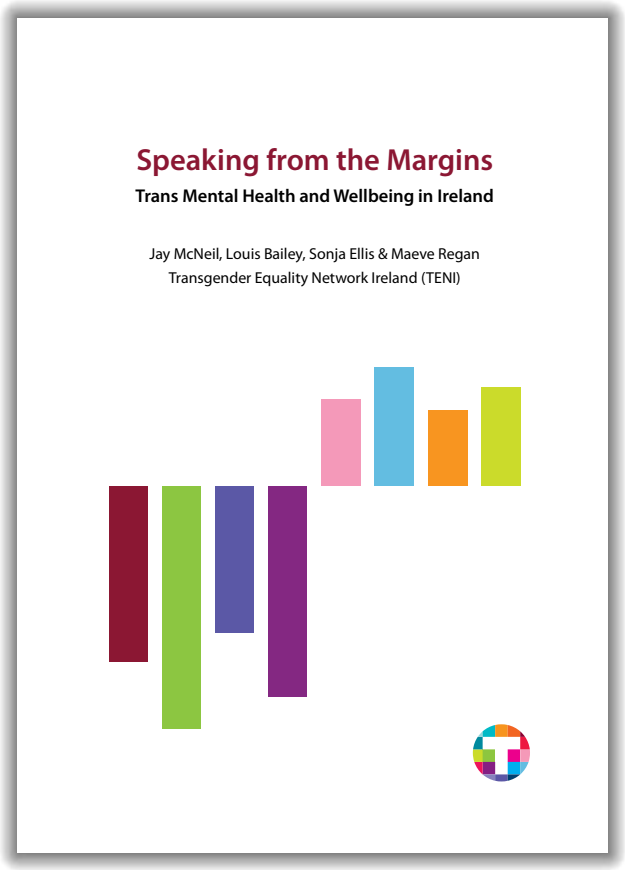
This research also highlights the barriers to accessing appropriate health care, particularly in terms of mental health and transition services, which put significant strain on trans people and their families. One striking finding was that many participants avoided mental health services due to prior negative experiences.

This report is significant because it acknowledges the diversity of the trans community and illustrates the nuances of our experiences. A majority of participants felt that being trans had both negative and positive impacts on their life satisfaction. Mental health, wellbeing and life satisfaction scores increased for most people after going through transition.

The overriding message from this report is that there is a critical need for greater education and awareness of trans experiences. There is a clear necessity for increased training with health care professionals working with trans people, development of appropriate trans health services, enhanced collaboration with community organisations and mental health services and investment in suicide prevention research, campaigns and interventions. There is also a lack of research in relation to the experiences of young trans people, older trans people and trans families.

Despite the many obstacles, we are active members of Irish society: we are your children and parents, we are teachers and students, we are professionals, artists, activists and change-makers. When we have the support of our families, friends and community, we can and do thrive. It is our hope that this research will contribute to a greater understanding of trans lives which will lead to positive legislative and policy changes and the development of new services, programmes and campaigns that will support our community to move in from the margins.

Broden Giambrone
Chief Executive



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1. Executive Summary

Speaking from the Margins: Trans Mental Health and Wellbeing in Ireland

Jay McNeil, Dr Louis Bailey, Dr Sonja Ellis & Maeve Regan

This report presents the findings of the largest study of the mental health and wellbeing of trans people in Ireland. The results from the 164 participants echo the findings in the UK *Trans Mental Health Study 2012* (McNeil et al., 2012).

A majority of participants felt that being trans had both positive and negative impacts on their life satisfaction. Mental health, wellbeing and life satisfaction scores increased for most people after going through transition. Transition refers to the personal, social and sometimes medical or surgical process by which an individual changes their gender. Unfortunately, negative experiences with general medical and gender-specific services were widespread, with fewer than half of the participants reporting being satisfied with their experience of using Gender Identity Services in Ireland.

Unemployment was high among the participants, with only half employed part-time or full-time. Almost half had experienced some problems in work due to their trans status. More than 70% of participants considered media portrayals of trans people to be negative, and 40% stated that these representations negatively affected their emotional wellbeing or mental health.

Over the course of their lifetimes, the participants were at much higher risk of negative mental health, self-harm and suicide than the general population. Almost half reported having self-harmed at some point in their lives. Almost 80% had considered suicide, and half of those people had made at least one attempt.

Despite high rates of stress, depression and anxiety, almost half of respondents reported avoiding seeking urgent help or support when distressed. They reported often avoiding mental health services, due to prior negative experiences.

In addition, more than 80% of participants avoided some public places or situations due to fear of harassment. Almost all participants knew someone who had experienced harassment due to being trans, and alarmingly, over 20% reported knowing someone who had been raped and almost 10% knew someone who had been murdered due to being trans.

Improvements to their mental health following transition were reported by 75% of applicable respondents. Over 90% of post-transition participants were more satisfied with their bodies and over 80% more satisfied with their lives as a whole since transitioning. Self-harm and suicidal thoughts were both higher for virtually all respondents prior to transition.

As a result of this study, the authors make the following recommendations:

- Training for all staff and managers in health care on working with trans people
- Greater investment in research around trans mental health
- Enhanced collaboration between community organisations and mental health services
- Investment in suicide prevention research, campaigns and interventions
- Exploration of alternative trans health care models, focusing on informed consent, in line with other international health services

2. Introduction

Transgender Equality Network Ireland (TENI) is a non-profit, member-driven organisation that was founded in 2005. The work TENI undertakes falls into three main areas – support, education and advocacy – all of which aim to address the stigma, discrimination and inequality facing transgender (herein trans) people.

TENI's education and advocacy work must be underpinned by reliable data regarding the circumstances and needs of trans people in Ireland. Historically, there has been a dearth of research in this area. The availability of good quality research is vital to ensuring that trans communities have a voice in policy development and service delivery. It was in this context that the following research was undertaken.

A Word on Language. **Transgender**: an adjective used to describe people whose gender identity, gender expression or both differ from the sex assigned to them at birth. In this report we chose to use trans as a shorthand. Individual participants use a myriad of terms and language to describe their experiences, which have not been changed in this document. See glossary for more detail.

3. Background

Over the last two decades, Ireland has witnessed significant social change and increasing levels of awareness and acceptance of diversity. However, trans people are among the most vulnerable members of Irish society and experience high levels of stigmatisation and marginalisation. Despite the limited data from the Irish context, research from the UK shows that trans people experience some of the highest rates of suicidality (McNeil et al., 2012), regular harassment and violence (McNeil et al., 2012; Turner, Whittle & Combs, 2009) and systemic discrimination (Whittle, Turner & Al-Alami, 2007).

One factor that contributes to the challenges and barriers facing the trans community is the lack of legal gender recognition that acknowledges their preferred gender. Ireland is the last country in the EU with no provision for gender recognition, despite a High Court ruling. Trans people are also not explicitly covered in Equality Legislation, although the gender ground has been interpreted to protect transsexual people.

Information on the size and key health indicators of any population group is critical in order to meet that population's health care needs and address health issues particular to that group. Trans experiences are not captured in the national census, and research is lacking this area, which means there is no exact data about the size and composition of the trans population.

Estimating prevalence of trans people is very difficult, as epidemiological studies are rarely conducted and efforts to achieve realistic estimates are fraught with difficulties (Institute of Medicine, 2001). The data that is generally cited suggests that approximately 1 in 11,900 assigned males (trans women) and 1 in 30,400 assigned females (trans men) seek treatment for gender dysphoria in specialised clinics (HBIGDA, 2001). The data underpinning these figures is over 20 years old, and it likely significantly underestimates numbers of trans people by relying only on the experiences of people who have pursued gender reassignment surgery, which many trans people do not or cannot access. In recent years, as recognition of trans people has increased, the rates of children seeking services at treatment centres in the UK has risen sixfold (UK DOH, 2008). Anecdotal evidence in Ireland suggests that a number of children and families from Ireland travel to the UK each year for transition services. Current evidence suggests that the trend appears to be towards higher prevalence rates, possibly indicating increasing numbers of people seeking clinical care. For instance, recent research from the UK reported a doubling of the numbers of people accessing care at gender clinics every 5 or 6 years (Reed et al., 2009). Anecdotal evidence suggests that an increasing number of trans people are seeking out care from both child & adolescent and adult mental health services in Ireland.

In the Irish context, the data is also limited. An article in the *Irish Medical Journal* on gender identity disorder (GID) described the patient population of all new referrals to the endocrine service in St Columcille's Hospital and St Vincent's University Hospital (De Gascun et al., 2006). The authors found that between 2000 and 2004, 52 referrals of individuals diagnosed with GID were received to this endocrine service for consideration for hormonal treatment. Of the 52 patients, 45 were male-to-female (MTF) and 7 were female-to-male (FTM). The article concludes that the scale of referrals confirms that GID exists in the Irish population to a significant degree.

The World Professional Association of Transgender Health (WPATH) (2012) has noted that the numbers yielded by studies such as these can be considered minimum estimates at best. This is because these estimates do not take into account that treatments offered in a particular clinical setting might not be perceived as affordable, useful or acceptable. Therefore, by counting only those people who present at clinics for a specific type of treatment, an unspecified number of trans individuals are overlooked.

3.1. Key Health and Wellbeing Issues for Trans People

The Health Service Executive (HSE) produced the report *LGBT Health: Towards Meeting the Health Care Needs of Lesbian, Gay, Bisexual and Transgender People* (2009), which identified key health issues for trans people:

- Isolation, fear, stigma, physical violence and family rejection contributing to depression, anxiety, substance misuse, self-harm and suicide
- Multiple discriminations – for example, where the trans person also identifies as LGB, has a disability or is an ethnic minority
- Absence of a designated gender specialist to coordinate delivery of national trans health services
- Limited provision of psychological support services for trans person's family members and significant others
- Limited availability of essential health services – surgeons, post-operative care, endocrinologists, psychiatrists and therapists
- Prohibitive cost of gender reassignment treatment such as laser hair removal/electrolysis

There is very little routine data or information about the health determinants, health status, risk profiles and health-seeking behaviours of the trans population in Ireland. The data that is available is limited by small sample sizes. In general, these studies have looked at facets of trans experiences: older LGBT people (Higgins et al., 2011), mental health and resilience (Mayock et al., 2009), transphobia (TENI, 2009), GID (De Gascun et al., 2006) and health service access (Collins & Sheehan, 2004). Nonetheless, these studies have provided some evidence and discussion regarding specific trans health needs. They highlight that trans people face significant health challenges that are further compounded by inequities in access to health and social services. There are specific health issues that trans people face that are further discussed below.

3.2. Mental Health

Current international evidence suggests that trans people are at a heightened risk of psychological distress and substance use. Many trans people have experiences of transphobic harassment, discrimination, violence and being stigmatised (Lombardi et al., 2001). This results in what is labeled as 'minority stress', which describes the mental health consequences of stigmatisation, harassment and marginalisation (Meyer, 2003). Given the pervasiveness of transphobia, trans people are particularly vulnerable to developing negative mental health outcomes.

International studies have highlighted the link between minority stress in trans people and increased risk of mental health problems. High rates of depression have been recorded among trans people, which in certain cases may be directly related to stresses arising from gender issues. For instance, a long history of suppression of trans feelings can result in isolation, loneliness and feelings of hopelessness (Bockting, Knudson & Goldberg, 2006). In one large study of trans people (N=515), 62% of MTF respondents and 55% of FTM respondents met the clinical criteria for depression, while 22% of MTFs and 20% of FTMs reported a history of mental health hospitalisation (Clements-Nolle, Katz & Marx, 1999).

Suicidal ideation is extremely prevalent within the trans population, with current data suggesting that 77–84% of trans people seriously consider taking their own lives at some point (McNeil et al., 2012; Trans PULSE, 2010; Mayock & Bryan, 2009; Dean et al., 2000). Rates of attempted suicide are also alarmingly high, with research indicating that between 18% and 54% of trans people attempt suicide (McNeil et al., 2012; Trans PULSE, 2010; Kenagy, 2005; Dean et al., 2000; Grant et al., 2000; Clements-Nolle, Katz & Marx, 1999). In the Irish study *Supporting LGBT Lives*, 80% of trans respondents reported having seriously thought about ending their lives; 26% reported that they had attempted suicide at least once (Mayock et al., 2009; Mayock & Bryan, 2009).

Some evidence suggests substance use is an issue in the trans community. Studies from North America illustrate that drug and alcohol use is common among trans individuals (Herbst et al., 2008; Kenagy, 2002; Clements-Nolle, Katz & Marx, 1999). As with the general population, trans individuals' history of substance use varies widely.

3.3. Accessing Health Services

Collin and Sheehan's (2004) report *Access to Health Services for Transsexual People* explored the health needs of trans people and health service responses to these needs in an Irish context. The findings suggested that trans people encounter significant difficulties in accessing appropriate health care. Findings from the report include the following:

- Trans experiences are characterised by stigma and exclusion
- Policy and practice in relation to the treatment and support of trans people is underdeveloped
- Service provision fails to specifically acknowledge and address trans needs
- Treatment in relation to gender reassignment, and associated treatment paths, is key to the quality of life of trans people

3.4. Current Health Service Provision

The lack of health policy for trans people has led to ad hoc arrangements between individual medical practitioners, mainstream health services and individuals seeking care and treatment. Treatment arrangements have been made by local health services on a case-by-case basis. These decisions have not been underpinned by policy or protocols and could be subject to the willingness, sensitivity and knowledge of the health personnel involved. Some geographical areas lack a high level of trans awareness among health professionals, leaving the individual seeking treatment and care in a vulnerable position that increases their health risks. Some health care providers are operating in the private health care system only, and therefore lack of resources can be a limiting factor for individuals seeking treatment.

In addition to general health needs, trans people seeking transition services or gender reassignment have specific health needs. While anecdotal evidence suggests that awareness on the part of health care practitioners is improving, trans people seeking health care in Ireland still face unpredictable and sometimes negative responses from practitioners (Mayock et al. 2009). This experience is compounded by a number of challenges including the distinct lack of services and of designated treatment paths, lack of information and understanding of trans health needs and of formal training on trans health issues for medical and other health care professionals, and the absence of a coordinated delivery of transgender and in particular transition-related health services.

There are currently limited psychiatric and psychological supports for trans people. Individuals navigate the system without signposts. Health care professionals in the general mental health services are taught about gender identity during their professional training but may not have current or specialist knowledge in this area. The understanding of gender identity in health care is a rapidly evolving field, and health care needs can be met by building the capacity of primary care and mental health professionals to provide services to trans people and their families and through referral to specialist care services. There are no specialists in Ireland for gender dysphoria in minors, nor support services to meet the needs of family members affected by a diagnosis of gender dysphoria.

There is one endocrinologist with expertise in hormone therapy for trans people. Their clinic ostensibly serves the needs of all individuals medically transitioning in the Republic of Ireland and has links with mental health services. The clinic has a waiting list and serves a limited catchment area.

It is the experience of TENI that the lack of coordinated and accessible services and the social stigma associated with trans people prevent individuals from readily seeking the health treatment they need. Furthermore, when people do access services, they can experience delays and barriers, such as lack of knowledge and awareness of the specific health care issues and prejudice on the part of some health care providers, which cause unnecessary hardship.

4. Methodology

In 2012, the Scottish Transgender Alliance (STA), together with the Trans Resource and Empowerment Centre, TransBareAll, Traverse Research and Sheffield Hallam University, undertook a study focusing on trans people's mental health and wellbeing in the UK (McNeil et al., 2012).

TENI elected to use the same survey, in order to obtain an overview of trans mental health and wellbeing in the Republic of Ireland and to allow for Irish people's experiences to be compared to those of trans people in the UK (including Northern Ireland). By using this survey, the different needs of Ireland's population could not only be understood but also placed in a wider international context. The survey was open from the 17th June until the 5th August 2012, with a total of 210 people responding.

This report explores some of the data that was gathered and, where applicable, compares it to the UK data.

4.1. Study Design

A questionnaire-based survey was chosen for this research, which gathered a large amount of surface information to help highlight which issues might be important to study further. Respondents were able to fill out surveys online or by hand, in order to maximize the study's reach.

Firstly, a research team was convened, comprised of Jay McNeil (Traverse Research and TransBareAll), James Morton (STA), Dr Louis Bailey (Trans Resource and Empowerment Centre and Traverse Research) and Dr Sonja Ellis (Sheffield Hallam University). Maeve Regan provided research support. At this stage the key topics 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. Following discussions with the Trans PULSE research team, it was agreed that where possible the same question wording or measures would be used to enable international comparisons to be drawn from combined data. Thus, a small number of questions were included directly from the Trans 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 members 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.

Participants were encouraged to take part in this survey mainly through a process of snowball sampling. This recruitment technique is used when the members of a population are difficult to identify or locate. Research participants are asked to assist researchers in identifying other potential subjects. The survey spread primarily through social media and word of mouth. Trans support groups, online forums and mailing lists with Irish members were contacted, given information about the study and asked to share the survey as widely as possible. LGBT and equality organisations were also contacted and asked to distribute information about the survey.

4.2. Reporting the Data

Although 210 people filled out some part of the survey, data is not reported for all of them. 20 people were removed because they were either under 18 years of age or did not give consent to take part in the survey. The first set of questions in the survey concerned intersex people and, following their completion, a further 26 participants were removed as they either said that they did not want to complete any more of the survey or they did not complete that first section. As such, the data set that was analysed for the report was comprised of 164 participants.

In the report, the number of people who answered each question is reported so you know exactly how many people to which a percentage or figure refers. It is written as 'N=' followed by a number and simply represents the number of people this particular piece of data is describing.

It must be noted that, although important, the survey represents a relatively small number of people, so powerful statistical analyses and firm conclusions and statements about causality (i.e., this thing definitely causes this outcome) cannot be robustly made. However, the data does represent the real and genuine experiences of a sizeable minority of people in Ireland and as such is clinically and socially meaningful. It adds depth and richness to understanding the lived experience of being a trans person in Ireland and the challenges and opportunities to which this may lead. It is important, therefore, that although an understanding is necessary that the data may not generalise to all Irish trans people's experiences, such an understanding should not detract from the fact that the data represents the experiences of the people who answered these questions.

Due to the relatively small number of respondents, statistical analyses have only been completed where previous research has suggested that a finding may be statistically meaningful. Overall, this report is intended as a description of the data to enable the experiences and views of trans people in Ireland to be recognised. Percentage data that has been reported may have been rounded up or down, therefore may not always add up to 100%. Where quotes have been used, any spelling mistakes have been corrected for ease of understanding.

At times, the data has been split using a number of variables to allow for comparisons between groups. The following text, taken from the original report, explains how this separation of data has been conducted:

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 it could 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 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 was possible that people who answered it differently 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 the fact that transition is multifaceted, meaning different things to different people. Although the question was worded in a manner that was as inclusive as possible, its potential different interpretations must be considered when interrogating the data using this as a filter question.

How the participants felt that they were perceived

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

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

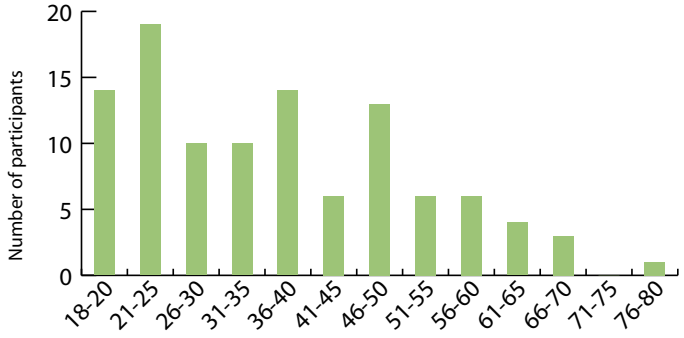
This question was used to separate some data, as it was thought that outcomes might differ between those who felt they were more often perceived in a way different from how they identified and those who felt they were more often seen as the gender with which they identified. Again, this question is dependent on the participants' personal interpretations of their interactions, which would not necessarily be aligned with others' interpretations . Ultimately, however, these personal feelings would have the greatest impact upon mental wellbeing, hence the question was used as a filter.

5. Demographic Data

5.1. Age (N=106)

People representing a variety of age groups took part in this survey. The youngest participants were 18, and the oldest was 76. The average age of participants was 37 years old. There were substantially fewer participants over the age of 50 than under.

Figure 5.1: Age (N=106)



5.2. Location (N=107)

Eighty-seven percent of respondents lived in the Republic of Ireland, whilst 7% lived in Northern Ireland. Six percent reported that they lived in other locations, including England, Canada and Denmark.

5.3. Ethnicity (N=105)

The vast majority of the participants in this study were white Irish (71%) or from another white background (25%). Only 4% were from other ethnic groups. This is broadly representative of the Irish population as given in the 2006 census.

Table 5.1: Ethnicity (N=105)

	%
White Irish	71
White British	14
Other white background	9
White Northern Irish	2
Mixed/multiple ethnic groups	2
Other ethnic group	2

5.4. Language (N=106)

Eighty-nine percent of the sample stated English was their first language, with a range of 9 other languages or combinations making up the remainder. Only 3% stated that Irish was their first language.

5.5. Health (N=106)

Seventy-six percent of the respondents felt that their health was either 'good' or 'very good'. Only 3% reported that it was 'bad', with the remaining 22% stating that their health was 'fair'.

5.6. Disability (N=95)

Just under half of the participants reported having a disability or chronic health issue (44%). The most common issue represented in the sample was poor mental health (32%). Eighteen percent reported experiencing some form of neurodiversity such as Asperger's syndrome or some form of intellectual or learning impairment. Other issues reported included hearing and visual impairments and mobility issues.

Just over a quarter of the participants reported that their day-to-day activities were limited because of a health issue or disability that had lasted or was expected to last for at least 12 months (26%; N=103).

5.7. Carers (N=103)

Twenty-one percent of the respondents looked after or gave support or help to family members, friends, neighbours or others because of either long-term health issues or disability, or because of problems related to old age. Six percent were providing 50 or more hours of support per week. Having a caring role can lead to substantial negative health and wellbeing outcomes, and this data suggests that carer support groups may need to target trans people to ensure that they are able to access these services.

5.8. Relationship Status (N=106)

Forty-two percent of the participants stated that they were in some form of relationship, with the majority having one partner only and identifying the relationship as monogamous. Fifty-four percent were single; however, only half of those people were looking for a relationship. The remaining 4% identified as celibate.

Table 5.2: Relationship Status (N=106)

	%
In a monogamous (with one person) relationship	36
Single and not seeking a relationship	27
Single and seeking a relationship	27
Celibate	4
In a non-monogamous (open) relationship	3
In a polyamorous (multiple-people) relationship, but only with one partner currently	2
In a polyamorous (multiple-people) relationship, but with more than one partner currently	1

5.9. Sexual Orientation (N=107)

In order for their diversity of attractions to be accurately reflected, participants were able to select multiple identities when asked about their sexual orientation. The majority (30%) identified as bisexual, with straight/heterosexual (23%) and queer (21%) being the next most common identities.

Thirty-three percent of the participants selected more than one sexual orientation, with some identifying with as many as 5 of these terms.

Table 5.3: Sexual Orientation (N=107)

	%
Bisexual	30
Straight or heterosexual	23
Queer	21
Lesbian	18
Pansexual	13
BDSM/Kink	13
Not sure or questioning	12
Doesn't define	11
Gay	7
Polyamorous	7
Other	7
Asexual	4

Comments made by the participants demonstrated the complex relationship that exists between gender identity and sexual orientation, in addition to naming other sexual orientations with which participants identified:

"More specifically Demi-panromantic asexual".

"I still haven't a clue and it doesn't worry me. I am interested in how they look and what's behind their eyes".

5.10. Intersex Participants (N=190)

Four percent of the participants stated that they were born with a physical intersex variation, where their external genitals, internal reproductive system or chromosomes varied from what would be considered typically male or female. A further 8% were unsure. For some of the participants who said they were born with an intersex variation, qualitative responses indicated that they considered being a trans person to be a subset of intersex.

6. Study Findings

6.1. Gender Identity

Seventy-four percent of the sample felt that their gender identities were different from the gender usually associated with the sex they were assigned at birth. Eighteen percent said that this was not the case, and 9% felt uncertain. Of those who said it was not, one gave further information: "I was born Female!! My sex is male but not for much longer". Comments from those who were unsure suggested that many were people who identified themselves as transvestites or cross-dressers, but who were comfortable with their assigned sex. For others this question led to some confusion. Others stated that they had a more fluid identity, so a definitive answer to this question would not be possible:

"I was identified as male, I then in my mid-20's transitioned to something between male and female. I now primarily identify as non-gendered but leaning far more female than male".

"I was assigned female at birth but have always felt like I should have been male. Began transition in 2007 but spent a huge portion of time before that struggling with my identity".

"I feel more in the middle with my gender identity, I am very confused about being labelled as either male or female as both make me feel uncomfortable but I tend to lean more towards the male gender".

"I was born as male and happily fathered children but always wanted to be female and it tends to consume my life".

"I am physically assigned male but feel more female though not to the extent of seeking SRS [sex reassignment surgery]".

"I'm female, but I identify as an androgyne. This means that I consider my gender to encompass both masculine and feminine traits equally – I am both man and woman, yet neither. I first began to notice that I didn't feel comfortable with being called a woman when I was 17, but I quickly realised that I wouldn't be comfortable with being called a man either. I started identifying as an androgyne at 18, after I had become more educated about the gender spectrum".

Of the 164 participants, most had a constant and clear identity as either female (37%) or male (25%). Aside from having a slightly higher number of participants who were unsure of their gender identities, the proportions of participants in each group were generally similar to those in the UK study.

Table 6.1: Gender Identity (N=164)

	%
Constant and clear gender identity as a woman	37
Constant and clear gender identity as a man	25
Unsure	13
Variable or fluid non-binary gender identity	13
Constant and clear non-binary gender identity	7
No gender identity	2
No answer	2

Many of the comments which were made by participants highlighted how complex and diverse gender was felt to be by different individuals, as well as the range of factors which affected its expression:

"Though I largely identify as female, I'm not quite sure to what extent right now. I've spent most of my life in denial as regards my transgenderism, so it's only recently that I've begun exploring myself and my identify.

Although these broad categories did largely encompass participants' experiences, it was important to allow them to express this complexity in more detail. A number of different terms and labels were offered from which participants could pick those which applied to their experiences. They were also asked to add their own. The most commonly selected was 'transgender person' with more binary options (e.g., 'woman', 'male-to-female (MTF) spectrum person') also ranking highly.

The number of gender identities that participants held was explored amongst the whole sample. Thirty-five percent of the participants had only 1 primary gender identity; however, a further 14% and 18% had 2 or 3 gender identities respectively, with some identifying with up to 10 different terms to describe their gender.

Table 6.2: How People Identify (N=164)

	%
Transgender person	38
Woman	29
Male-to-female (MTF) spectrum person	26
Trans woman	23
Man	23
Cross-dressing person	18
Transvestite person	17
Trans person	16
Trans man	16
Female-to-male (FTM) spectrum person	16
Genderqueer person	16
Woman with a transsexual history	12
Androgyne person	11
Non-binary gender person	9
Man with a transsexual history	9
Bi-gender person	5
Gender neutral person	5
Other	2
Non-gendered person	1
Bissu	1

6.2. Transition

The age at which participants first lived either part- or full-time as their preferred gender was variable; however, it tended to be clustered around teenage years and twenties, decreasing as people aged. No one reported beginning to live as their identified gender after the age of 60. There was a tendency for participants to begin living part-time earlier on average (22 years old) than full-time (26 years old). Starting around the age of 40, more people lived full-time than part-time as their identified gender.

The participants were asked about their feelings concerning transition (defined as 'any part of a personal, social, and sometimes medical or surgical, process by which you have changed the way that you express your gender'). Around a quarter of participants had no intention or desire to undergo any form of transition or gender reassignment. Only 17% had undergone some process, compared with 22% who wanted to and 27% who were currently doing so. Seven percent were unsure as to whether they wanted to transition (N=163). In comparison to the UK data set, a much greater number of Irish participants were not intending to undergo any form of transition (26% compared with 13% in the UK study).

Table 6.3: Transition Status (N=163)

	%
Has not undergone and does not intend to undergo any part of a process of gender reassignment or transition	26
Intends to undergo a process (or part of a process) of gender reassignment or transition	22
Currently undergoing a process (or part of a process) of gender reassignment or transition	27
Has undergone a process (or part of a process) of gender reassignment or transition	17
Unsure	7

Participants made a number of comments in relation to this question to further explain their decision-making:

"Have taken HRT [hormone replacement therapy], am being treated by a gender clinic. Intend to have surgical castration. But that is the extent of what I wish to have done (barring a surgery which would make me truly dual gendered, vaginoplasty without the need to remove my phallus)".

"I am unsure because transitioning is something that I am still trying to understand how I feel about. I want to present more androgynously but am unsure how far I wish to pursue that".

"Yes, this is very important. I am unable to feel happy with myself until I have completed the process".

"Personally and socially yes, currently undergoing".

One person felt that they could not answer this question as the terminology used was irrelevant to them:

"Although I have used medical interventions – top surgery and hormones (testosterone gel) – I do not feel that my gender has been 'reassigned' nor have I 'transitioned' to another gender. Neither of these terms are relevant to me and my experience".

6.3. Life Satisfaction

Impact of Being Trans (N=151)

Twenty-seven percent of participants felt that being trans had a negative impact on their lives, whilst only 12% felt it to be positive. The majority, 55%, stated that being trans had a mixed positive and negative impact upon their life satisfaction. A small minority (3%) believed that being trans had no impact on their life satisfaction, and 4% were unsure.

Thus, over 90% believed that being trans or having a trans history had an impact on their life satisfaction. When compared to the UK participants, being trans seemed to have a more negative impact on life satisfaction for the Irish participants. The following comments demonstrate how being trans can have such varied effects on people's lives.

Positive impact:

"I think it's given me a perspective in life that is different from most people. I like to think that this can be a positive thing".

"My trans experience has taught me to see life much more positively and find satisfaction in the small everyday things".

"It took a while for me to become comfortable with the fact I was trans, but now I embrace it as a part of me as a person".

Negative impact:

"I do not regret my transition, but it created [a] whole new set of problems for me that has cost me 3 jobs, a marriage and now my current relationship".

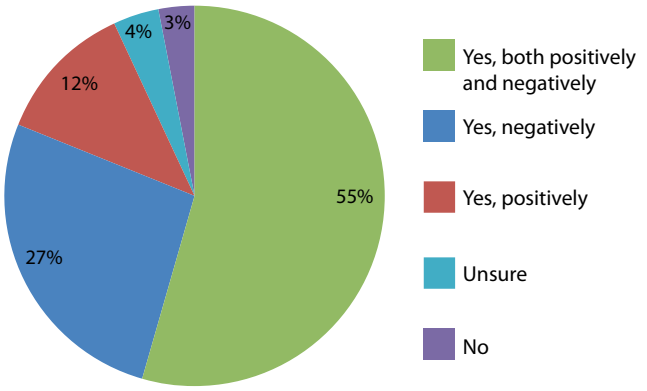
"I find it difficult to be my true gender because of society's lack of acceptance of trans people".

Mixed experiences:

"Sometimes it feels like a blessing, sometimes a curse – I appreciate that it gives me a broader perspective on life… but on a personal level it can be a burden".

"I love being trans, I just hate that people judge me badly for it".

Figure 6.1: Effect of Being Trans on Life Satisfaction (N=151)



Coming Out (N=150)

For the majority of participants (65%), coming out to others as trans led to an improvement in life satisfaction. Only 6% were less satisfied as a result of telling others that they were trans. These findings suggest that being supported to talk to others and be honest about their identities could enable the majority of trans people or those with a trans history to feel more satisfied with their daily lives.

Transition (N=81)

In addition to simply telling others that they were trans, many participants felt that undergoing some form of transition had improved their life satisfaction. Of the 81 participants for whom transitioning was applicable, 84% were more satisfied with their lives post-transition. Only 5% were less satisfied, with some experiencing no change or being unsure as to the impact of transition (6% and 5% respectively).

Table 6.4: Life Satisfaction After Transition (N=81)

	%
More satisfied with life now	84
No change	6
Less satisfied with life now	5
Unsure	5

General Life Satisfaction

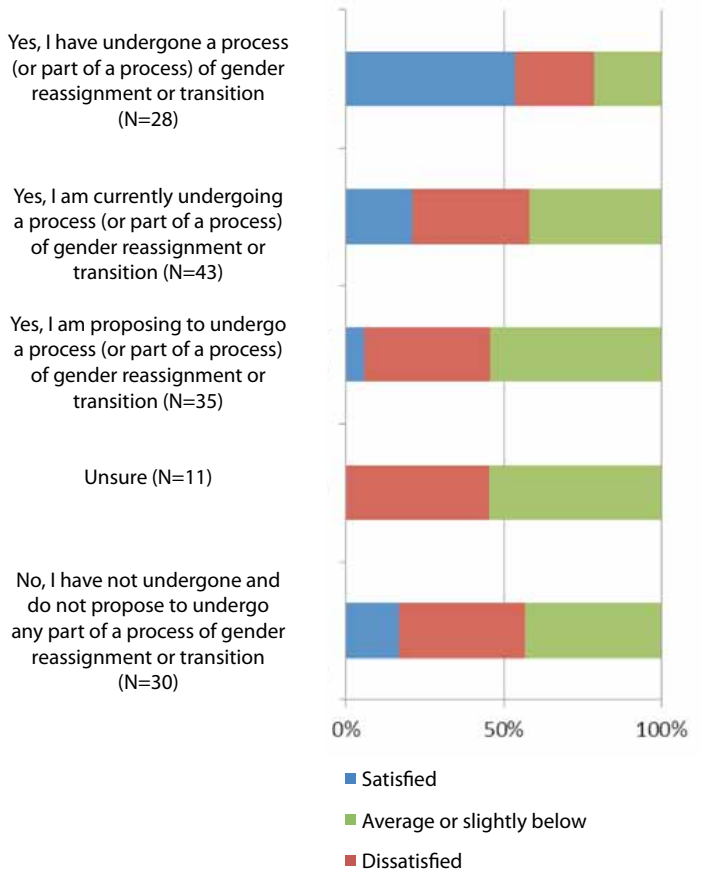
When asked about their levels of life satisfaction, more participants were satisfied with their lives (42%) than dissatisfied (36%).

Table 6.5: General Life Satisfaction (N=151)

	%
Very dissatisfied	11
Dissatisfied	25
Neither satisfied nor dissatisfied	22
Satisfied	26
Very satisfied	16

As a more objective and standardised measure, the Diener Life Satisfaction Scale was incorporated into the survey. Higher scores represent greater life satisfaction. For the 148 participants who completed this scale, there was a tendency for greater levels of dissatisfaction with life than satisfaction.

Figure 6.2: Diener Life Satisfaction Scale (N=148)



The sample was further separated by gender identity and by stage of transition. Small numbers in some of these groups, however, made comparisons problematic. Unlike amongst the UK participants, here there were no statistically significant differences between participants in terms of gender identity, though the findings were different for different stages of transition. When separated by this dimension, the only participants who experienced more satisfaction than dissatisfaction with life were those in the group who had undergone a process of transition. Post-hoc statistical testing confirmed that members of this group were indeed significantly more satisfied with life than those who were proposing to undergo some form of transition ($p<0.001$), those who were currently undergoing some form of transition ($p=0.019$), and those who did not want to undergo any form of transition ($p=0.021$). This replicated the UK findings in some ways; however, those who had no intention to transition in that data set were also significantly more satisfied with their lives.

Table 6.6: ANOVA: SLS by Stage of Transition SLSscores

	Sum of Squares	DF	Mean Square	F	Sig.
Between Groups	1281.873	4	320.468	6.015	.000
Within Groups	7406.127	139	53.281		
Total	8688.000	143			

Body Satisfaction (N=143)

The research explored the participants' satisfaction with their bodies in relation to their gender. Of 143 participants, 47% were dissatisfied with their bodies, in comparison to 31% who were satisfied. There was a broadly even distribution of scores between satisfaction and dissatisfaction when participants were separated by gender identity, suggesting that this had little impact on their body satisfaction (N=143). There were, however, clear differences in body satisfaction between the participants at different stages of transition. Once again, the group with the greatest level of satisfaction consisted of those who had undergone some process of transition. The only other group within which the number of those satisfied exceeded those who were dissatisfied was the group of those who did not wish to undergo any transition (N=142). The impact of transition on body satisfaction seemed to be much greater in this sample than with the UK participants (92% compared with 77% in the UK).

Interestingly, clear differences were seen between participants when they were separated by how they felt they were perceived by others (N=106). Only those who were seen as the gender that they identified as were more satisfied than dissatisfied (57% compared to 21%). For those who were seen as a trans person or those seen as the sex they were assigned at birth, their levels of satisfaction compared to dissatisfaction were dramatically different (8% vs. 70% and 8% vs. 68% respectively).

6.4. Physical Interventions (N=150)

When asked about physical interventions, 85% of the participants said that they had made, or had wanted to make, gender-related physical changes using hormones or surgery. Only 11% had not, whereas 4% were unsure.

Hormones (N=150)

Fifty-four percent of participants had not taken hormones in relation to their gender identity, as compared to 43% who were currently receiving hormone therapy and 3% who had historically used hormones. Those respondents who were currently taking hormones were asked a number of additional questions concerning their use. Seventy-nine percent had begun taking hormones at least a year ago, with 44% starting hormone therapy over five years previously. Eighteen percent had begun taking hormones less than a year ago (N=63).

Table 6.7: Body Satisfaction and Transition Status (N=142)

	Dissatisfied (%)	Neither satisfied / dissatisfied (%)	Satisfied (%)
Has not undergone and does not intend to undergo any part of a process of gender reassignment or transition (N=30)	30	33	37
Unsure (N=13)	83	17	0
Intends to undergo a process of gender reassignment or transition (N=34)	74	27	0
Currently undergoing a process of gender reassignment or transition (N=39)	60	18	23
Has undergone a process of gender reassignment or transition (N=26)	0	8	92

Seventy-nine percent of the participants were satisfied with the results of their hormone therapy, with only 9% being dissatisfied. Eleven percent were neither satisfied nor dissatisfied. In addition, the majority of respondents felt that their hormone usage had led to changes in their mental health or emotional wellbeing (77%; N=64). The responses here were overwhelmingly positive, with participants reporting significant improvements to their mental health and wellbeing as a result of initiating hormones. For many, the benefits were linked to the physical effects of the hormones. The hormones induced secondary sex characteristics, which were greatly welcomed by respondents for helping them to be seen by others as their felt gender:

"I am much more comfortable in my own skin and my self-esteem and self-confidence are much higher".

Others described themselves as calmer and more balanced since starting hormones. The emotional effects were, in the main, greatly welcomed:

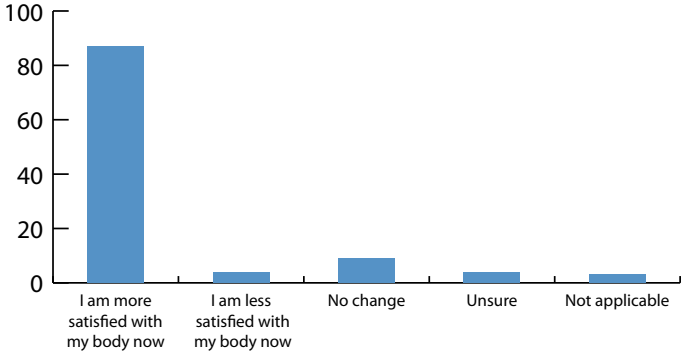
"They have released me to feel life in a freer and more connected and emotionally involved way. Very important to me, no matter what the emotions are".

However, whilst some respondents reported that hormones had stabilised their moods, others reported suffering mood swings since starting hormones. Respondents highlighted the importance of getting the right hormonal levels:

"It depends a lot on what the levels of hormones are. When my levels are good, I feel 'at home' in my skin. When they are bad, I feel 'off', and I'm quick to anger. And when my levels are rising, I am quick to cry".

There were also mixed responses for those taking the feminising hormone oestrogen. Some reported feeling relieved by the decreased sex drive they experienced, whilst others felt disappointed by this result.

Figure 6.3: Body Satisfaction and Hormones (N=63)



In addition to changes in mental health and wellbeing, hormones had a number of other effects. An overwhelming 87% of participants taking hormones said that they were more satisfied with their bodies due to hormones, as compared to 2% who were less satisfied (N=63).

Furthermore, 90% were more satisfied with their lives in general as a result of taking hormones, compared to only 7% who were less satisfied (N=60).

Surgery (N=144)

Participants were asked a series of questions about their experiences of surgery. Eighty percent had wanted to have, or had undergone, some form of surgery to either remove gendered characteristics or to create new ones, with only 20% not wanting to undergo any surgeries.

Of those who wanted to have or who had already undergone surgery to remove male characteristics or to create female ones, the most common was removal of testicles, with creation of a vagina also ranking highly (N=70). In relation to each type of surgery participants had undergone, they were never more dissatisfied with the results than satisfied. Due to small numbers, however, it is not possible to draw any substantial conclusions relating to satisfaction with surgical outcomes. Some respondents chose multiple responses or did not provide answers for all surgery types as reflected in the percentages in Table 6.8 (overleaf).

Of those who wanted to have or who had already had surgery to remove female physical characteristics or to create male ones, by far the most common was chest reconstruction/breast removal, with no participants feeling that they did not want or need this. No participants had undergone any form of phalloplasty, and more participants did not want or need these procedures than those who wanted or were considering them. This was also the case for vaginal closure surgeries. Again, for those who had undergone surgery, participants were more satisfied with the outcomes than dissatisfied. It is important to note, however, that only very small numbers of men reported having had any surgeries, or provided details of these. Some respondents chose multiple responses or did not provide answers for all surgery types as reflected in the percentages in Table 6.9 (overleaf).

Table 6.8: Surgery to Remove Male Physical Characteristics or to Create Female Physical Characteristics (N=70)

	Have had (%)	Would like (%)	Considering (%)	Don't want/ need (%)
Removal of testicles (orchidectomy)	20	20	17	16
Creating a vagina (vaginoplasty)	21	17	20	17
Creating a clitoris (clitoroplasty)	21	7	21	23
Removal of penis (penectomy)	16	13	16	21
Creating external appearance of female vulva/vagina but not a vaginal cavity	9	13	16	23
Breast augmentation	11	16	31	24
Reshaping brow, nose, jaw and/or other parts of face (facial feminising surgeries)	9	13	26	30
Making voice higher by surgically altering vocal chords	1	1	21	31
Removal of facial hair using laser or electrolysis	41	1	10	30
Reshaping Adam's apple (tracheal shave)	11	1	13	30
Hair transplants	4	0	14	30
Other gender-related surgery	1	9	6	26

Table 6.9: Surgery to Remove Female Physical Characteristics or to Create Male Physical Characteristics (N=41)

	Have had (%)	Would like (%)	Considering (%)	Don't want/ need (%)
Making breasts smaller (breast reduction)	45	20	7	51
Chest reconstruction removing breasts, i.e., 'top surgery' (double mastectomy)	24	54	15	0
Removal of uterus (hysterectomy)	7	34	24	27
Removal of ovaries (salpingo-oophorectomy)	7	29	27	29
Releasing the clitoris (metoidioplasty)	2	12	34	39
Lengthening of urethra to change where urine is excreted from	0	22	32	37
Creation of scrotum (scrotoplasty)	2	22	29	39
Insertion of testicular implants to create testicles	2	27	24	42
Closure or removal of vaginal cavity (vaginectomy)	0	22	17	51
Creation of a penis using tissue from belly (abdominal phalloplasty)	0	2	27	54
Creation of a penis using tissue from arm (radial artery forearm phalloplasty)	0	2	32	51
Creation of a penis using tissue from thigh (anterolateral thigh phalloplasty)	0	2	32	51
Creation of a penis using tissue from back (musculocutaneous latissimus dorsi phalloplasty)	0	0	29	51
Insertion of erectile device (rods/pump) to enable erection of penis	0	15	34	44
Other gender related surgery	0	2	5	51

Surgery and Body Satisfaction

For the small numbers who reported undergoing surgery, the impact on satisfaction with their bodies was substantial. Eighty-three percent were more satisfied with their bodies following non-genital surgery (N=29), with 90% of those undergoing genital surgery (N=19) finding that it led to an increase in body satisfaction:

"Yes I feel more at peace with myself and my body. I am more confident and happier in my daily life and with my life in general".

"Prior to surgery I had severe social anxiety, which post-surgery became negligible, and I am also less depressed".

However, whilst one respondent was happier as a result of the surgery, they felt that a lack of support post-surgery had a negative impact on their mental health:

"Going through it – especially with the non-existent aftercare – was a nightmare, but I've pretty much recovered from that now".

A number of respondents who had not yet had surgery but who were intending to highlighted the negative impact that waiting for surgery was having on their mental health:

"Not having my mastectomy yet has negatively impacted my self body image. I wear layer upon layer of clothes to hide my chest which is extremely uncomfortable, I can't go jogging or swimming and can't try on tops in the shop. I will only buy jumpers and t shirts in large and XL which is too big. I won't allow my girlfriend to touch my chest".

"I have not undergone surgery and find it a real struggle to leave the house on a day-to-day basis...I've fallen in and out of depression for years and my dysphoria has added to this considerably".

6.5. Gender Identity Clinics

Unlike in the UK, gender services in Ireland are not provided by a small number of specialist clinics known as Gender Identity Clinics (GICs). Instead, at the time of undertaking the data collection for the study, there was only one endocrinology clinic in Ireland that was willing to provide services for hormone therapy. Access to this was generally via one of two private psychologists in the country who worked with trans clients. The protocols followed by each psychologist were different, and access could in some cases be achieved through an Health Service Executive (HSE) psychiatrist. Following endocrinology therapy, trans people could then access some surgeries in Ireland (e.g., top surgery for trans men) or be referred to the UK (via a GIC) or another EU country for other surgeries. It would seem that where questions in this survey asked about participants' experiences of GICs, some conceptualised the endocrinology service as a GIC, whilst others referred only to their experiences in UK GICs. Thus, in some cases responses refer to Irish endocrinology services and in others, UK clinics.

Eighty-two percent of participants (N=118) had at some point sought help for their feelings around being trans. Interestingly, just under a third of those did so between the ages of 11 and 20, with a further third doing so between 21 and 30 years of age. These numbers have implications for organisations providing youth and young people's services, in terms of awareness of the difficulties a younger trans person may face in coming out and accessing support. The remaining third were spread across age groups with a gradual tailing off, although one participant reported seeking initial support after the age of 71. Most participants who took part in the study had accessed support initially after 2005 (70%, N=93). Forty-six percent of participants stated that they had been seen at a GIC (N=125), whilst 9% were still on a waiting list (N=123).

The 57 participants who had been seen at a GIC were asked further questions about their experiences of accessing gender services. Fifty-five percent had waited for less than a year from the time they first asked a health professional for support to the time of being seen at a GIC. Twenty-one percent had waited between 1 and 2 years, whilst 25% had waited longer than 2 years. Worryingly, 6% reported waiting for longer than 10 years for an initial GIC appointment (N=53). The majority of participants felt that this wait for an appointment had a negative impact on their mental health or emotional wellbeing (46%), with only 13% stating that these conditions improved during the wait (N=54). Most participants (78%, N=55) had been seen at a GIC within the last 12 months, with 22% being last seen over a year ago.

Of concern was the finding that 55% of the participants (N=53) had experienced difficulty in accessing the treatment they felt they needed from a GIC, 9% more than in the UK data set. Only 45% felt they had experienced no difficulty. The participants gave details of the sorts of issues that they had encountered:

"The therapist insulted me a lot, made me feel bad, so I decided to get hormones online instead of depending on people like him. He told me 'I should try girls or date other trans guys because no gay guy would like me', also 'That I passed till I spoke, then he knew I was 'not a guy'".

"Hasn't been easy to contact them between appointments, not open to discussion about alternative treatment plans either".

"No advice given on changing names, voice work, hair removal or any other aspect of transitioning. Refusal to diagnose. Refusal to prescribe hormone blocker".

"They are still trying to 'fit me in' even though I am suicidal".

"[Name of GIC removed] refused to prescribe hormones until I had frozen sperm. I received no advice on where to go to do this apart from 'We don't know'. This delayed taking hormones for nearly a year while I fought with various Irish hospitals over the matter and was refused for 'ethical reasons' several times. I eventually had to pay for a private clinic in London".

A trans man reported being prescribed hormones which were not approved for use in female-to-male gender reassignment, while a trans woman described being put on the wrong hormone dosage.

A small number of participants felt that whilst attending a GIC they were uncertain about their gender identity (15 people; 27% of N=55). The majority of those (N=9) stated that they had not felt able to talk about this at the GIC, and provided many reasons for this. Fear of having treatment delayed or terminated was common, especially for those with a non-binary identity:

"It seemed that they were only interested in transition, a one-way ticket, all the way, I was afraid to express too many doubts for fear of being denied treatment".

Respondents also articulated their lack of trust in the clinician allocated to them or felt that they could not be entirely honest with the clinician about how they were feeling in case their treatment was stalled:

"It's natural to be scared but I felt if I voiced it then the whole process might take even longer".

A number of participants were also emotionally distressed or worried about their mental health whilst attending a GIC (25 people; 46% of N=54). Of those, the majority (N=18) did not feel able to discuss this in the clinic. Many respondents feared that their treatment would be stalled or discontinued if they revealed any mental health concerns to their gender identity specialist. In the words of one respondent, "I was afraid they would think I was not mentally fit to carry it through". Respondents felt that they had already waited a significant period of time for treatment. Added to this, many trans people are aware of their gender identity from a young age and may have already struggled with gender dysphoria for many years prior to seeking a referral to a GIC. As such, trans people will try to navigate the system as best as they can in order to avoid any further complications and delays with regards to accessing treatment. In other cases, respondents did not trust their clinicians or felt let down by the lack of support that they received:

"Because the feeling I have always gotten from them is they simply don't want to know. This is in no small part due to the fact that aside from an occasional meeting with the consultant in charge of the clinic I NEVER see the same doctor twice and thus have no chance to build up a rapport and thus trust with them".

"He wasn't being very understanding about anything. I felt I needed to hide any hint that I was suffering other than typical trans suffering for him to give me what I needed".

"I rang 4 times when the Zoladex provided left me suicidal and never had a phone call returned. I have not returned to that clinic since".

Interestingly, 31% of the participants reported that they had not been honest within a GIC. Nineteen percent stated that they had withheld information, and 12% said they had actively lied about something. The qualitative details participants provided highlighted fears of being denied treatment as a leading reason for this, with sexual orientation, non-binary gender identities and mental health being commonly withheld information:

"I did not disclose fully the sexual relationship I am [in] because I felt it might lead them to believe I was not suitable for hormone treatment".

"I have never explained my true sense of gender, because there is no sense that there is any acceptance in the clinic for anything but binary genders. For example I often feel hassled for only wanting castration. I also admitted once to my therapist that I use my phallus with my partners. His reaction has left me shaken to this day (four years later)".

"I said that I had always from an extremely young age felt trans and was uncomfortable from a young age because I wanted to access hormones. After I told this lie, the doctor remarked that there are two types of trans people, 'those who aren't really trans and need to be monitored carefully and those who know from birth like me and can be given hormones'. I lied to ensure I would get on hormones

as soon as possible which I knew I needed. I withheld information about my sexuality (my answers could have suggested I exclusively liked women though I am bisexual). I did this to get on hormones as soon as possible".

"Lied about not having suicidal thoughts to get treatment".

"That I believe that gender is non-binary, however I do want to be a woman, and my chosen gender is female, however I lied about wanting SRS [sex reassignment surgery], to make sure I got my hormone treatment".

Just under half of participants felt that attending a GIC had positively affected their mental health or emotional wellbeing. Thirty-three percent felt that the impact had been mixed, whilst 9% felt it had been wholly negative (N=55). Positive experiences included the following:

"After each appointment I knew I was getting closer to my goal of surgery, hence I was more and more excited and positive".

"It was the first time I was taken seriously and not treated like I had something mentally wrong with me for being trans".

"I felt like I was doing something towards transitioning and I had an input into my treatment so I felt like I had some control over it. This always helped to improve my mental state and give me hope that I would get through".

Participants also gave examples of negative experiences:

"The delays and the waiting and general unhelpfulness or apathy of medical professionals can be a frustration. I once had to go and collect letters myself and drive them to [name removed] because [name of clinic removed] seemed to be incapable of posting a letter without losing it when the doctors actually finally wrote it".

Having timely access to gender reassignment treatment – namely, hormones and surgery – can be seen as a protective factor for respondents' mental health. In addition, having their gender recognised and being in contact with helpful and supportive health professionals was also seen as positive. However, experiencing delays or having their treatment refused contributed to poor mental health among respondents.

6.6. Health Care (N=115)

Of 115 participants, many reported having never used different types of health services:

- 44% had not used Gender Identity Clinic (GIC) services
- 26% had not used mental health services
- 20% had not used general health services

Of those participants who had used a particular service, the following percentages experienced at least one negative event:

- 60% had at least one negative experience at a GIC
- 69% had at least one negative experience at a mental health service
- 74% had at least one negative experience at a general health service

As can be seen from Table 6.10, some of those experiences were extremely serious.

In GICs, where trans people should feel safe to have their gender respected and supported, 11% of respondents had experienced someone using the wrong pronoun for them on purpose, and 12% had been asked questions which made them feel like they were educating the clinician. Eight percent had been told that a clinician did not know enough about a particular type of trans-related health care to provide it.

When accessing mental health services, 26% had been discouraged from exploring their gender, and 9% had been belittled or ridiculed for having a trans history or being trans. Nineteen percent had been told that they weren't really trans.

Finally, rates of negative experiences were higher in general health services. Seven percent of respondents had been asked to show their genitals when they felt it was inappropriate or unnecessary; 38% had been told that a clinician did not know enough about a certain type of trans-related health care to provide it; and 19% had experienced a clinician refusing to discuss or address a particular trans-related health concern. Across all these areas, many people had experienced clinicians who were unable or unwilling to address trans-related health needs, in addition to many more forms of overt discrimination. Although lowest in GIC services, these experiences were prevalent there too. Many trans people experienced barriers when trying to access the services other individuals can routinely expect to receive.

At the time of data collection, top surgery was available in Ireland for trans men, as was access to endocrinology services. Laser therapy, voice therapy and counselling are currently generally available on a private basis. Direct referrals to the endocrinology clinic are difficult to obtain, with the main route available being for a new person's details to be taken to an existing patient's appointment to be passed on.

Table 6.10: Experiences of Negative Treatment from Health Care Professionals (N=115)

	GIC (N=65) (%)	Mental health (N=85) (%)	General health (N=92) (%)
Refused to treat or ended care because of the trans identity of patient	3	6	11
Used hurtful or insulting language about trans people	8	8	16
Belittled or ridiculed patient for being trans or having a trans history	2	9	15
Refused to discuss or address a particular trans-related health concern	8	14	19
Told trans patient were not really trans	5	19	1
Discouraged patient from exploring their gender	5	26	19
Told trans patient they didn't know enough about a particular type of trans-related care to provide it	8	29	38
Thought the gender listed on patient's ID or forms was a mistake	5	12	21
Used the wrong pronoun or name on purpose	11	14	16
Used the wrong pronoun or name by mistake	12	22	42
Used terms to describe patient's gender-associated body parts (e.g., genitals, chest, etc.) that made patient uncomfortable	9	11	22
Showed unprofessional levels of curiosity about what patient's gender-associated body parts look like	5	7	10
Asked to see/examine patient's genitals, where the patient felt this was unnecessary or inappropriate	3	1	7
Asked questions about trans people which made patient feel like they were educating their healthcare professional	12	32	30
None of the above	40	31	26

The following excerpts highlight the mixed experiences involved in obtaining gender reassignment treatment:

"Initially positive, felt like things were finally moving in the right direction and so on. Negative due to…still having recieved no actual help from them after 7 months".

"The hormones I've got from them have had a positive effect, but the clinic itself only ever has a negative effect".

Importantly, 13% of those who had previously had contact with a GIC or health service had wanted to injure themselves in relation to or because of that involvement (N=51). Of those that wanted to injure themselves in relation to or because of involvement with a GIC or health service, reasons included the following: frustration at delays and prolonged waiting times to access hormones or surgery; being denied access to gender reassignment; experiencing negative treatment from psychologists and psychiatrists and dealing with unhelpful doctors who lacked awareness and understanding of trans issues. One respondent reported feeling suicidal after being prescribed Zoladex, a hormone blocker. Another respondent reported feeling suicidal when told by a health professional that they were not trans, and they came away from the appointment feeling like they were not being listened to.

Overall, 36% of the participants were dissatisfied with their experiences of GIC services; 16% were neither satisfied nor dissatisfied; and less than half (47%) were satisfied (N=55). When asked if anything could improve the participants' experiences of GIC services, they made a number of suggestions: more GICs in order to reduce travel and waiting times; alternative treatment plans; trans awareness training for GPs, psychiatrists and clinicians; better understanding of non-binary identities; direct referrals and treatment from GPs; consistency with regards to seeing the same specialist throughout the treatment process; better communication between GIC and GP; and better communication between endocrinology, surgery and gender identity services.

6.7. Mental Health Services (N=119)

Over half of the respondents (58%) had used mental health services for reasons other than access to gender reassignment medical assistance (for example, speaking to their GP about stress, being prescribed anti-depressants or seeing a community psychiatric nurse). Those participants went on to answer further questions regarding their experiences of accessing mental health services (N=66). The most commonly used interventions or services for mental health issues were anti-depressants (23%), a family doctor (20%) and psychiatry (15%). In terms of lifetime usage, the most commonly used were anti-depressants (67%), a family doctor (56%) and psychology (44%). See Table 6.11 (overleaf).

The participants were asked how satisfied they had been with their experience(s) of using mental health services. Overall levels of satisfaction and dissatisfaction were similar (37% and 34% respectively; N=67). Some respondents had an entirely positive experience of mental health services and "never felt judged" and, elsewhere, felt that professionals were "caring people doing a great job for the people nobody else cares about. If it wasn't for them I'd quite simply be dead". Others found counselling helpful for uncovering and defining the source of their issues and difficulties. However, one of the main barriers that respondents identified was a lack of trans awareness training and subsequent knowledge among mental health professionals: "Very little education on dealing with trans issues, especially within inpatient services". In some cases, this led respondents to avoid returning for follow-up appointments. One respondent had a particularly negative experience:

"Psychiatrist in Accident and Emergency room. Within the last year. The first time, the doctor asked me some very strange questions about being trans. I got the impression that he didn't 'agree' with 'that sort of thing'. He was supposed to give me a follow-up appointment because I was suicidal, and he never did, I received no communication from the hospital. The next time I was suicidal I got a different psychiatrist, an appointment with a psychiatric (in a month's time) and I got a phone call the week after to check that I was okay".

Experiences were mixed. According to one responsdent:

"I have been to many different psychologists, psychiatrists, counsellors etc., on and off since I was 18 years old. At best they have been good people who lacked adequate knowledge/ability of how to help me, at worst they were extremely arrogant, condescending, inappropriate, rude, judgmental, ill-educated, dismissive, self-righteous and controlling and only contributed to my problems, or in a few cases made them much worse than they ever would have been had I never gone to them for help in the first place".

Another respondent had mixed feelings, finding that:

"counsellors and other health professionals have always been very polite and respectful and done their best to help but none of them had any knowledge of transgender people or their issues. If they had I might have figured out the problem several years earlier and been able to transition much sooner than I did".

However, one respondent pointed out that knowledge and consequently services: "are improving over the decades".

One respondent felt that some of the questions asked by psychiatrists about sexual behaviour were either "irrelevant or a bit invasive". Elsewhere, respondents described a range of unacceptable scenarios during which counsellors exhibited ignorant and prejudicial attitudes with regards to trans identities:

"They told me I wanted to be a woman because I was a gay man who hated his sexuality".

"I'm a survivor of childhood sexual abuse, and that was presented to me as a potential cause of my trans issues".

"I was told that I dress as a female as a reaction to extreme stress in my life".

However, one respondent reported a positive experience and stated:

"My consultant psychiatrist was very accepting. She admitted she did not know much about the subject, but that she would become informed".

Only 27% of respondents had felt able to be completely open with a mental health professional about being trans or having a trans history (N=68). A further 37% were 'sometimes' open, 18% 'rarely' open and 12% 'never' open about their trans identity or history. This suggests that these participants felt a need to modify their behaviours or disclosures in mental health settings, which has implications for how fully able they are to engage with and thus benefit from any suggested interventions. To elaborate on this apparent lack of willingness to discuss their trans identity or history, an exploration of what happened within mental health services was necessary. The participants were asked if they had ever experienced certain negative events within mental health settings due to being trans (N=63). Over 30% had been given advice or suggestions by a practitioner which they thought were inappropriate and had been asked questions about their sexual behaviour which were seen as irrelevant and resulted in the person feeling uncomfortable.

Table 6.11: Services/Treatment for Mental Health Issues (N=119)

	Currently using this (%)	In the past (%)	Total lifetime prevalence (%)	Have never used this (%)
Anti-depressants	23	44	67	23
Anti-psychotics	6	7	14	52
Other medication	12	14	26	35
Some form of therapy from health service	9	24	33	29
Some form of therapy – private	6	24	30	33
Community Mental Health Team	12	9	21	42
GP/family doctor	20	36	56	14
Psychology	8	36	44	24
Psychiatry	15	23	38	27
Crisis Team	2	9	11	47
Early Intervention for Psychosis Team	0	0	0	56
Drug and/or Alcohol support	2	6	8	52
Inpatient mental health support	0	8	8	52
Charity	5	9	14	47
Helpline	2	20	21	38
Social Worker	6	11	17	44
Spiritual Leader	6	5	11	52
Other	3	6	9	35

Thirty-seven percent of participants had their gender identity treated as a symptom of ill mental health rather than as a genuine identity, and conversely, 11% had their mental health issues treated as a symptom of being trans or having a trans history when they felt this was unrelated. Only 48% had never experienced any of the negative events which were enquired about in the survey.

Table 6.12: Experiences with Mental Health Services (N=63)

	%
Given advice or suggestions by a mental health provider that patient felt was inappropriate	32
Told that mental health issues were due to being trans when patient felt that they weren't	11
Given treatment that patient thought was inappropriate	14
Asked questions about patient's sexual behaviour that patient felt were irrelevant and that made patient uncomfortable	32
Asked questions about patient's body that patient felt were irrelevant and that made them uncomfortable	21
Asked questions about patient's gender identity that patient felt were irrelevant and that made them uncomfortable	22
Patient's gender identity was treated as a symptom of a mental health issue rather than their genuine identity	37
Other	5
None of the above	48

Some participants felt judged by health professionals or, elsewhere, that health professionals would not understand trans issues and therefore would not be able to help them: "They don't know anything about trans issues, I always ended up having to teach them about it when I needed help, if I didn't explain I felt like I was a freak to them". Other respondents reported being in denial about their trans status and therefore unable to get help in order to deal with linked issues. Some respondents did not feel that they could disclose their trans history either to professionals or to other members of their peer mentoring support group for fear that "it will just make matters worse". One respondent described a previous clinical encounter: "My current psychologist would always focus on the fact I was transgender and drag up and get side-tracked by my past, whether or not it had any relevance". That experience had put them off from accessing psychological services in the future. Concerns over an excessive preoccupation with a patient's trans status, and the consequent conflation of issues and misdiagnosis by health professionals, was a concern shared by other respondents. One respondent stated, "I don't trust doctors or hospital staff to respect my gender identity so I would never go to a hospital even after severe self-harm", whilst another revealed that they were "treated badly by paramedics and doctors after a suicide attempt and now [they] won't go anywhere near doctors or hospitals unless [they] really really need to".

Forty percent of respondents avoided seeking urgent help or support when distressed because of their trans status. When asked about their past experiences, respondents highlighted what had been unhelpful and why:

"Would not contact medical practitioners for fear of not being granted hormones".

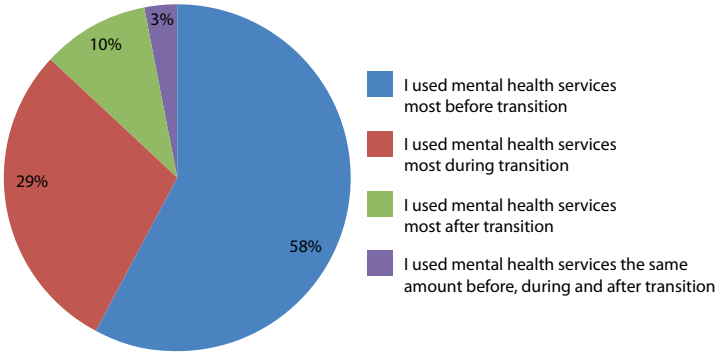
"Not respecting my identity, ignoring me when I insisted on my name and pronouns".

"The fact that even in an absolute emergency when I was moments from killing myself they still insisted on making me jump through hoops. And then blamed my feelings on my being transgendered".

"Unhelpful, when they do not know what to do or how to treat me, how to help me or what to tell me, because they had no experience".

Transition had a clinically important impact on those participants who reported using mental health services and undergoing some form of transition process (N=31). Only 10% used mental health services more after they had transitioned, compared to 58% who used them more beforehand. Importantly, 29% used services most during their transition, which has implications for services to be proactive in engaging with trans people who are undergoing some form of transition.

Figure 6.4: Transition and Mental Health Service Utilisation (N=31)



One respondent reported using mental health services more prior to transition "due to the much higher levels of anxiety and depression I felt before beginning the transition process". Similarly, another respondent said, "I am happy in my post-transition body and feel stable and calm, I no longer needed mental health support". One respondent who reported using mental health services more after transition claimed that this was unrelated to being trans: "I've had a lot of other issues to deal with". Elsewhere, one respondent viewed counselling as a wellbeing resource – on par with yoga or life-coaching – rather than a medical intervention, implying that it was a useful aid for coping with life events rather than specifically in relation to dealing with trans issues/transition per se. This sentiment was echoed elsewhere. Lastly, one respondent attended counselling only as a requirement for obtaining gender reassignment treatment – namely, to be declared as having the capacity to consent for medical treatment.

Twenty-seven percent of respondents (N=118) either would not, or were unsure as to whether they would, use mental health services in the future if they needed to. Thirty-one percent had concerns about doing so due to being trans or having a trans history, whilst a further 13% were unsure. Respondents who were concerned about accessing mental health services in the future cited a lack of trust in professionals' ability to understand trans issues and treat trans people in a dignified, respectful and appropriate manner. Some felt anxious that professionals would pathologise them on the basis of their trans identity and consequently conflate and misinterpret other issues that they may face. In the words of one respondent:

"As a trans person if I had to access mental health services that adopted a medical model I would (have) serious concerns because in my experience the vast majority of such still see a transgender person as having a disorder".

"Attitudes to transgender people in most mental health services are like attitudes were to gay people 80 years ago".

In keeping with this idea, some respondents were worried that their trans identity would be negated or dismissed and that, consequently, their needs would not be met:

"I worry that, if I mention my gender identity, the person I speak to will focus upon that rather than the issue I am there to discuss, or that they will treat my trans identity as a disorder which is having an influence on the issue I am there to discuss, even if I know that and tell them it is not".*

Inpatient Experience (N=117)

A small minority of participants (12; 10% of N=117) had been inpatients in a mental health unit at some point; 4 of those 12 had been more than once. Fifty percent (N=10) had experienced difficulties in relation to being trans or having a trans history, for example around single-gendered areas as well as staff lacking knowledge and awareness of trans issues and the needs of trans patients.

6.8. Mental Health

Overall, participants rated their mental health as more positive than negative. On a scale of 1 to 7, with 1 being very poor and 7 being excellent, the average score was 4.8 (N=114). There were no significant differences in scores when participants were separated by gender identity, nor by stage of transition. Only 27% of respondents felt that there may not be or was not any relationship between mental health and being trans. Twenty-seven percent of participants felt that being trans had a negative impact on mental health, whilst 12% felt it had a positive impact. Almost half of participants (46%) felt that it both positively and negatively affected their mental health (N=113).

In terms of specific mental health issues, those identified most often by participants were stress 83% (N=100), depression 82% (N=107) and anxiety 73% (N=100), with the values encompassing the respondent having either received a diagnosis or believing that they have or had this issue. These findings almost exactly replicated those in the UK survey, where stress, depression and anxiety were the most common issues, with prevalence rates of 80%, 88% and 75% respectively. See Table 6.13 (overleaf).

Table 6.13: Mental Health Issues

	Not applicable (%)	Currently/Previously Diagnosed (%)	Believe have/ had but not diagnosed (%)
Depression (N=107)	18	37	45
Anxiety (N=100)	27	28	45
Obsessive-Compulsive Disorder (OCD) (N=88)	75	8	17
Post Traumatic Stress Disorder (N=84)	76	5	19
Addiction (N=85)	74	6	20
Bipolar (Manic depression) (N=87)	86	6	8
Schizophrenia (N=84)	98	2	0
Eating disorder (N=89)	72	6	23
Borderline personality disorder (N=86)	91	6	4
Other personality disorder (N=78)	97	1	1
Stress (N=100)	17	30	53
Insomnia (N=87)	46	13	41
Relationship issues (N=87)	52	7	41
Anger management problems (N=88)	69	7	24
Grieving or bereavement (N=83)	58	13	29
Dissociative identity disorders (N=82)	98	1	1
Other (N=59)	95	3	2

In order to obtain an objective and comparable snapshot of mental health, the Center for Epidemiologic Studies Depression Scale (CES-D) was incorporated into the survey as an externally validated psychometric scale, giving a measure of depression amongst the participants over the last 7 days prior to survey completion. Eighty-nine participants completed all questions of the CES-D, the results of which demonstrated that 44% did not appear to be depressed, 24% could be considered mildly depressed, and a further 33% could have major depression. Thus, over half of the participants could have some level of depression. Again, these findings were very similar to those in the UK sample. No significant differences in CES-D score were found when participants were split by gender identity, although they were found by stage of transition. However, post-hoc testing failed to confirm this finding.

Table 6.14: ANOVA: CES-D by Stage of Transition CES-D score

	Sum of Squares	DF	Mean Square	F	Sig.
Between Groups	2545.576	4	636.394	3.622	.009
Within Groups	14582.504	83	175.693		
Total	17128.080	87			

Crisis Support (N=116)

Over half of respondents (55%) felt that they had been in crisis at some point, needing to seek help or support urgently, with a further 9% being unsure. Of those who may have been in crisis at some point, 51% felt that they had or may have avoided seeking urgent help due to being trans or having a trans history (N=73). Participants highlighted a number of possible reasons for avoiding seeking help such as religious pressure, unwillingness to engage with issues, previous poor experiences and, most commonly, a fear of being judged:

"Afraid of judgement from health providers, unsure if it will just make matters worse, have avoided mentioning it in a group support context for about a month".

"Because at that time my current psychologist would always focus on the fact I was transgender and drag up and get side-tracked by my past whether or not it had any relevance".

"Because I did not know what was happening to me, who to go to or what to discuss".

"Because the problems I was experiencing were related to being trans and I knew this, but at the time was unwilling to confront it, and so didn't see how I could ask anyone for

help, or if there was any point, if I already knew I wasn't going to actually be honest enough to deal with real issues".

"I don't trust doctors or hospital staff to respect my gender identity so I would never go to the hospital even after severe self-harm".

"I felt like having to disclose my trans history to a person who does not know anything about it would make me feel even worse".

"They don't know anything about Trans issues, I always ended up having to teach them about it when I needed help. If I didn't explain I felt like I was a freak to them".

When participants did seek help the most common strategies they used were to contact friends (both trans and non-trans, 36% and 38% respectively), their GP (33%) or their partner (25%). A small number of participants added that they contacted their private counsellors when in crisis. Worryingly, very few contacted any other health service or mental health organisation, instead getting in touch with trans groups either by phone or online. Given that those who work or volunteer within such groups often have little or no mental health training or background and rarely have service protocols for referring on into statutory services, these individuals may not be in receipt of the services that they need the most. Twenty-one percent also reported doing nothing when in crisis (N=72).

Table 6.15: Support Behaviours (N=72)

	%
Contact non-trans friends	38
Contact trans friends	36
Contact GP	33
Contact partner	25
Call a non-LGBT helpline	22
Contact family	22
Contact a trans online group	21
Nothing	21
Call a trans helpline	17
Contact named person	14
Contact a local trans group	14
Contact other health service	13
Contact a national trans group	11
Other	11
Call an LGBT helpline	10
Call a health service helpline	10
Contact A&E	10
Contact a mental health charity	8

Abuse (N=112)

A little over half of respondents reported experiencing some form of abuse before the age of 16 (54%). The most common form was emotional abuse, which 46% had experienced. For other forms of abuse, rates ranged between 13% and 19%. These high levels have implications for those supporting trans people, as there is a substantial chance that they have experienced and require support surrounding abuse in childhood.

Table 6.16: Experiences of Abuse Before 16 (N=112)

	%
Physical abuse	15
Emotional abuse	46
Sexual abuse	19
Neglect	13
Other	13
No experience of abuse or neglect	46

Self-Harm (N=113)

A substantial number of the participants reported having self-harmed at some point in their lives (44%), with 6% currently self-harming. Participants reported engaging in a variety of self-harming behaviours simultaneously. The most common form of self-harm amongst those that had done so was self-cutting, with 84% having engaged in this. Other common methods of self-harm included punching objects/walls (65%), punching self (55%), biting self (43%) and banging head against objects/walls (37%). More passive methods of self-harm such as overdosing were also present, although less prevalent (N=51).

Table 6.17: Methods of Self-Harm (N=51)

	%
Cutting self	84
Punching objects/walls	65
Punching self	55
Biting self	43
Banging head against objects/walls	37
Burning self	24
Pulling own hair out	20
Swallowing non-prescription medications	18
Other	18
Asphyxiation/choking self	12
Swallowing prescribed medications	10
Swallowing other dangerous substances/objects	6

Further exploring the relationship between being trans and self-harm, 57% of respondents felt that there were trans-related reasons for their self-harm. A similar number, 63%, felt that there were non-trans-related reasons for their self-harm (N=51).

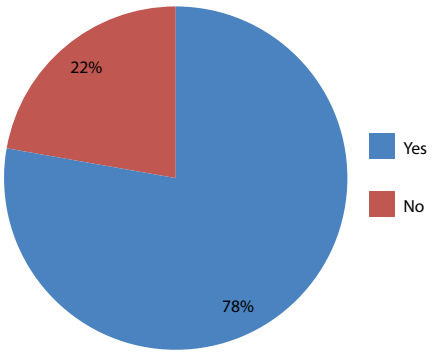
Trans-related reasons for respondents' self-harm included gender dysphoria, not having their gender recognised, being frustrated with treatment delays, lacking access to treatment, being rejected by family, being bullied, feeling different but not knowing why, trying to suppress their identity, feeling guilty about their identity or having their identity misunderstood by health professionals. In relation to the last point, one respondent stated that their self-harming occurred "usually after the doctors told me [I was] confused and just homosexual and having sexuality problems".

Non-trans-related reasons for self-harm included childhood abuse, rape, family issues, bullying, isolation, relationship problems, school stress, job stress, bereavement, conflict between religion and sexual orientation, frustration with society/societal pressure and lack of help and support.

Suicide (N=113)

The participants reported a lifetime prevalence of 78% in relation to thinking about ending their lives.

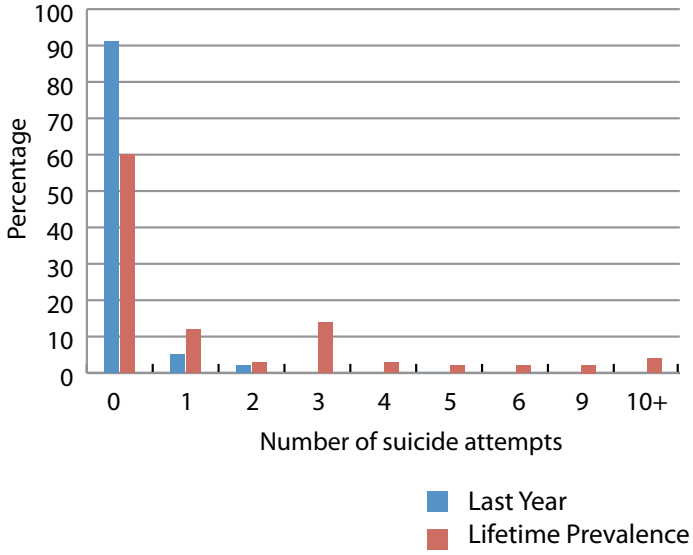
Figure 6.5: Thoughts of Suicide (N=113)



Those who answered that they had thought about it were asked further questions about their experiences. Twenty-eight percent had thought about taking their lives in the last week, with 2% thinking about it daily (N=87). In the last 12 months, 63% thought about taking their life at least once, and 2% thought about it daily (N=87). These rates almost exactly replicated those found in the UK sample.

In terms of actual suicide, 40% of those who had thought about it had made an attempt at least once, with 8% of these attempts being in the last year. In the last year, some participants had attempted suicide up to 2 times, whereas across their lifetimes, some had attempted suicide more than 10 times (N=77 for last 12 months; N=85 for lifetime prevalence).

Figure 6.6: Suicide Attempts (Last Year vs. Lifetime Prevalence)



When those people who had never thought about attempting suicide were factored back into the data, the lifetime prevalence rate of suicide for those who completed the initial question was 30% (N=113). The participants reported that there were trans-related reasons (71%; N=87) and non-trans-related reasons (50%; N=86) for wanting to end their lives.

Trans-related reasons for thinking about or attempting suicide included gender dysphoria, family rejection or non-acceptance, relationship breakdown, self-denial/not wanting to live as a trans person, ignorance regarding gender identity or stigmatisation of trans status by others, uncertainty regarding whether they would ever 'fully' or 'successfully' transition, not transitioning sooner and feeling like they had lost time, feelings of being an embarrassment to their family, inability to find a partner who could accept their body, and harassment. Some reported feeling apprehensive about transitioning and/or losing the support of family and friends, particularly in the early stages, whilst others felt suicidal when they were not able to get medical help at the beginning of their transition or did not feel that they were getting enough support from GICs. This respondent highlighted the particular difficulties experienced by non-binary-identified people:

"The feelings of being incomplete as a person, neither female or male and being trapped in limbo between social groups...Excluded from female society but not fitting into male society simultaneously is very isolating".

Elsewhere, respondents described a downward spiral which led them to suicidal thoughts:

"The uninhabited life, the pointlessness, the prejudice, the jokes, beatings, accusations, lectures, eventually you start to be all the things they hate and say you are, so when you hate yourself suicide is inevitable".

"Years of dealing with doctors, therapists and then the public during a transition seemed like so much effort for something that would surely end badly anyway, right? Easier to just be dead no doubt".

Many participants felt that if they did not transition they would no longer be alive. For these respondents, transition was literally life-saving. Some reported that their suicidal ideation was the result of more than one factor, and it was often shown to be a combination of both trans-related and non-trans-related triggers.

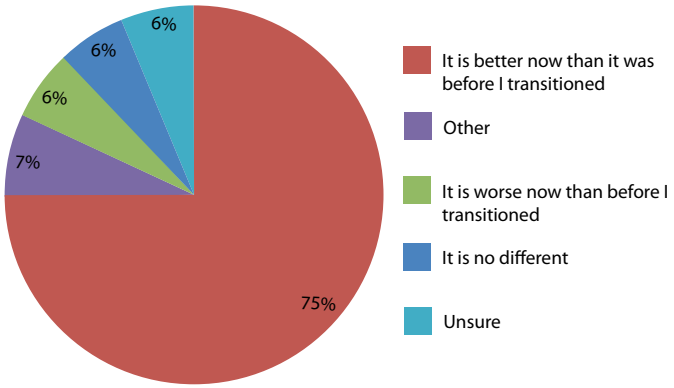
Non-trans-related reasons for thinking about or attempting suicide include childhood abuse, bullying, relationship breakdown, family problems, loneliness/isolation, stress and exhaustion.

Finally, 15% (N=87) of respondents, when asked if they were actively planning to take their own lives soon or in the near future, said that they were unsure. One person said that they were.

Impact of transition on mental health

Seventy-five percent of the respondents felt that their mental health had improved, compared to 6% who felt it was worse since transition (N=51). Six percent felt that it was no different.

Figure 6.7: Mental Health and Transition (N=51)



For the majority who reported that their mental health had improved since transition, the reasons cited included the following:

"I feel I have become physically who I always felt I was within, thus my overall mental health has improved".

"Much better since transition. Happier with my body and my mind is much calmer".

Others felt more mixed:

"At the beginning felt better than I have in years but the longer I wait for surgery and the longer we wait to be in any way legally recognised makes me feel hopeless".

"Anything positive about my transitioning has also been equally balanced by the stresses of having to endure the process itself".

"So much has happened since transition, lost 3 jobs, suffered transphobia, domestic violence, sexual abuse, none of this happened before".

Impact of transition on rates of self-harm

Participants reported having self-harmed more prior to transition (76%), as compared to no participants who reported self-harming more after transition (N=29).

Figure 6.8: Self-Harm and Transition (N=29)

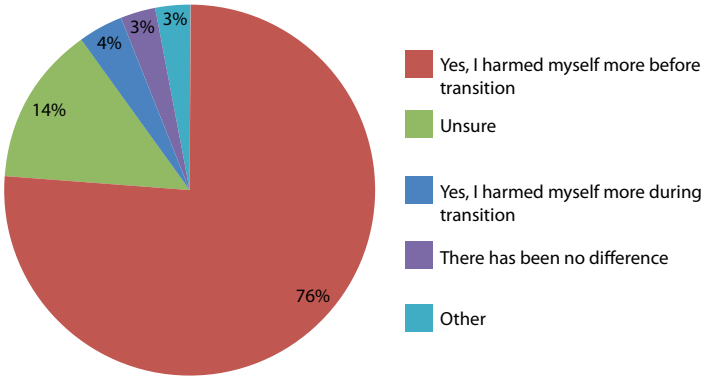
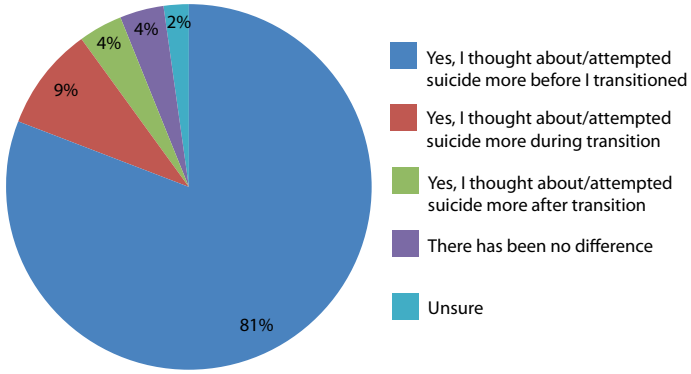


Figure 6.9: Suicide and Transition (N=87)



The importance of transition cannot be overstated. Respondents here highlighted the beneficial effects of transition, stating that they rarely self-harm or that they have stopped self-harming altogether since transitioning:

"I have not self-harmed at all since I started transition".

"I stopped when I was old enough to learn that I can transition one day".

"Once I started transition/the doctor listened to me, I never felt the need to self-harm again".

Impact of transition on suicidal ideation/attempt

Again transition had a substantial impact on the participants, with 81% thinking about suicide or attempting suicide more before transition, and only 4% doing so after transition (N=87).

The majority of respondents thought about or attempted suicide less after transition:

"I couldn't live anymore as male, however that has changed during and post transition. I love life and I love being able to enjoy it".

"Moving through life is easier for me now".

"The further into transition I go the happier I am with myself and my situation".

Those who reported no difference or that the thoughts/attempts increased after transition stated that this was not related to their transition per se but was, instead, the result of other issues, such as bereavement, family issues, social stigma or continued gender dysphoria.

6.9. Substance Use

Non-Medical Substance Use (N=114)

Thirty-four percent of participants reported that they had used drugs for non-medical reasons in the last 12 months, a little higher than the rates in the UK (24%). These individuals were asked for more information about their drug use. The most commonly used drug was cannabis, with 91% using this. Ecstasy was the second most common (27%), with prescription narcotics also being used (18%; N=33). Forty-nine percent of the participants were engaging in poly-substance use. None of the participants reported using heroin, opium, crystal meth, crack or other amphetamines.

Table 6.18: Drugs Used in the Past Year (N=33)

	%
Marijuana/hashish/dope	91
Ecstasy	27
Prescription narcotics, other than for medical use (e.g. Codeine, Oxycodone)	18
Poppers or nitrites	12
Legal highs	12
Cocaine	9
PCP (angel dust)	3
Special K	3
GHB (G)	3
LSD (acid)	3
Other	21

Only 5% felt that their drug use was a problem, with the others either feeling it was not, or reporting that they were not using at this time (N=33). No participants reported injecting drugs in the last 12 months.

Smoking (N=114)

Forty-three percent of the participants reported that they had never smoked cigarettes, whilst 37% were ex-smokers and 20% were current smokers. Of the current smokers, 91% (N=23) reported smoking daily, with 45% smoking 20 or more cigarettes each day (N=20).

Alcohol (N=113)

113 of the participants completed the AUDIT-C, a commonly used scale of alcohol dependence and damaging levels of drinking. A score of 3 or more suggests some form of issue with alcohol such as dependent drinking. Sixty-five percent of respondents scored above 3, suggesting that there may be harmful levels of alcohol use in this community. This finding is very similar to that amongst UK participants (62%).

6.10. Daily Life

In this section of the survey, being a trans person or having a trans history was explored in terms of how it related to an individual's daily life experiences.

Participants were provided with a list of situations and asked if they avoided any of them. Eighty-three percent of respondents avoided at least one place or situation due to a fear of being harassed, read as trans or outed, which was very similar to the 81% of UK participants who avoided some situations. The most commonly avoided places were public toilets (40%), with gyms (39%), clothing shops (33%), clubs or social groups (33%) and other leisure facilities (33%) also scoring very highly. These high levels of avoidance are concerning in that it would seem that day-to-day activities (such as using public transport) are restricted for many trans people, which could be expected to reduce their ability to engage in positive and meaningful activities. This situation in itself can affect mental health and wellbeing. Of those who did avoid situations, 95% avoided multiple places or situations, with 17% avoiding 10 or more (N=128).

Table 6.19: Avoidance of Public Spaces (N=128)

	%
Public toilet facilities	40
Gyms	39
Clothing shops	33
Clubs or social groups	33
Other leisure facilities	33
Public transport	27
Travelling abroad	26
Restaurants or bars	21
Cultural or community centres	20
Schools	20
Supermarket	17
Religious institution	15
Pharmacy	15
Cinema	13
Public spaces	13
None of the above	17

When the sample was divided by gender identity, those with a constant and clear non-binary identity avoided the fewest situations, whereas those who were unsure of their identity and those with a constant identity as a woman avoided the most. In general, more people avoided situations than did not, regardless of group (N=128). It could be hypothesised that those with a robust non-binary identity are happier to adapt their presentation to their situation thus leading to fewer conflicts, whereas those who are more visibly trans are more likely to experience difficulties and so avoid more situations. To explore this further, the data was also split by stage of transition (N=127). Again, for all groups, more people avoided situations than did not; however, this difference was much less for those who had no intention or desire to transition and those who had undergone some form of transition, when compared to other groups. A higher amount of those who were unsure of whether they wished to transition, were proposing to, or were currently undergoing transition avoided situations than did not avoid them.

Finally, the data was split by how respondents felt they were usually perceived by others (N=103). Substantially more participants who felt they were perceived as trans avoided situations than did not (85% compared to 15%). This difference was not as great amongst those who were seen either as the gender they identified as or the sex they were assigned at birth (22% did not avoid situations compared to 78% who did). Although the numbers of participants were too small to form any robust conclusions, the general trends do seem to suggest that it is visibility as a trans person (or perceived visibility) which is linked to avoidance.

As discussed, many trans people were already avoiding certain places or situations through fear. This trend continued when participants were asked whether they felt they would have to avoid any social situations or places in the future, with 45% saying they would have to avoid places and 22% being unsure. Only 33% said that they did not anticipate having to avoid places or situations in the future (N=129).

Thus, the participants' current and anticipated future behaviours were affected by their levels of fear. With this established, it was important to explore where this may have originated from – whether the fear was based on actual negative experiences or a worry that they may happen. Participants were provided with a list of different negative experiences, including hate crimes, and were asked whether they had ever experienced each one because of their trans status or history (N=129). The most common experiences reported were hearing that trans people were not normal (84%), silent harassment (72%) and having to pass as non-trans to be accepted (71%). In terms of hate crimes, in addition to silent harassment, many other forms were evident in the sample. For example, being made fun of or called names (64%), being physically intimidated (36%) and being physically assaulted (16%). Sexual violence was also evident amongst participants, with 36% having experienced sexual harassment, 12% sexual assault and 6% rape because they were trans. For all of the listed events, many participants had experienced them more than once. Of concern, 12% had experienced police harassment due to their trans status, which could be expected to impact their willingness to engage with the police to report such incidents in the future.

For most experiences, more participants reported them to have occurred in the last 12 months than longer ago. Rates for some experiences, however, were reported as being higher over 12 months ago. These were:

- Being hit or beaten up
- Having to move from family or friends
- Experiencing police harassment
- Experiencing physical intimidation
- Experiencing domestic abuse
- Being sexually assaulted
- Being raped

Table 6.21 demonstrates rates of fear of future experience, with those where experience is more frequent in italics.

Table 6.20: Daily Lived Experiences (N=129)

	Total who experienced this (%)	More than once (%)
Heard that trans people are not normal	84	83
Experienced silent harassment	72	69
Had to try to pass as non-trans to be accepted	71	70
Felt their trans identity hurt and embarrassed their family	70	67
Worried about growing old alone because of trans identity	64	61
Been made fun of or called names because of trans identity	64	56
Been objectified or fetishized sexually because of trans identity	50	43
Feared they would die young because of trans identity	41	40
Experienced physical intimidation and threats because of trans identity	36	29
Experienced sexual harassment because of trans identity	36	33
Had to move away from family/ friends because of trans identity	33	12
Suspected they have been turned down for a job because of trans identity	29	18
Experienced domestic abuse because of trans identity	20	19
Been hit or beaten up because of trans identity	16	8
Been sexually assaulted because of trans identity	12	5
Experienced some form of police harassment because of trans identity	12	8
Been raped because of trans identity	6	1

Table 6.21: Fear of Negative Experiences (N=120)

	Fear in future (%)
Been made fun of or called names because of trans identity	56
Been hit or beaten up because of trans identity	49
Heard that trans people are not normal	63
Been objectified or fetishized sexually because of trans identity	44
Felt their trans identity hurt and embarrassed their family	63
Had to try to pass as non-trans to be accepted	51
Suspected they have been turned down for a job because of trans identity	56
Had to move away from family or friends because of trans identity	34
Experienced some form of police harassment because of trans identity	29
Worried about growing old alone because of trans identity	57
Feared they would die young because of trans identity	37
Experienced silent harassment	54
Experienced physical intimidation and threats because of trans identity	58
Experienced domestic abuse because of trans identity	24
Experienced sexual harassment	38
Been sexually assaulted because of trans identity	43
Been raped because of trans identity	35

Table 6.22: Knowledge of Other's Experiences (N=105)

	%
Silent harassment	96
Verbal harassment	93
Physical intimidation and threats	71
Attempted suicide	71
Sexual harassment	67
Physical violence	64
Sexual assault	44
Rape	22
Suicide	22
Been killed	9

Some of the increased fear of future experiences may be explained in part by the large percentages of trans people who personally know others who have experienced negative events. Over 90% of the participants (N=105) know people who had experienced silent and verbal harassment. Over 20% know other trans people who had been raped or who had committed suicide and 9% reported knowing others who had been murdered due to being trans.

6.11. General Wellbeing

Participants were asked about their self-esteem on a 7-point scale, with 1 being very low and 7 being very high. The scores were fairly well spread with most clustering between 3 and 5 (N=111).

The Rosenberg Self-Esteem Scale was also incorporated into this survey as an objective and validated measure of self-esteem. Scores range between 10 and 40, with higher scores suggesting higher self-esteem. The mean score for the whole sample was 28.5, with scores ranging from 10 to 40. Scores between 25 and 35 are within the normal range. Scores below 25 suggest low self-esteem. Thirty-one percent of the sample (N=32) had a score below 25 (N=104).

Initially there appeared to be a statistically significant difference in self-esteem score when the participants were separated by gender identity; however, this was not evidenced in post-hoc testing. Interestingly, however, there was a statistically significant difference in self-esteem when stage of transition was used to split participants. Post-hoc testing confirmed that those who had undergone a process of transition had significantly higher self-esteem than those who were proposing to undergo transition (p=0.024).

Very few participants felt that being trans had no impact on their self-esteem (13%). Twenty-nine percent felt that the impact was entirely negative compared with 14% who felt it was positive and 38% who felt it was mixed (N=112).

Ways in which being trans had a mixed effect on self-esteem largely centred around experiences of negativity from others, or internalised transphobia. Some of these issues were highlighted by the following participants:

"The positive support from the people I surround myself with impacts my self-esteem positively. Yet negative comments, actions (whispering, pointing, laughing) would TEMPORARILY lower my self-esteem".

"[Being trans impacted me] Negatively, around people, being self-conscious, somewhat paranoid and constantly second-guessing everything I do around them. Positively, because it has taught me the value of knowing myself and made me a better person overall as a result. I have an abundance of self-esteem insofar as my thoughts and opinions go; whether I share them or not is another matter".

"Will I ever find a partner? Will I ever get my chest surgery? I get a unique perspective on life having experienced both female and male life".

"It's great feeling more like a guy, but it feels as though I can't match up to other guys".

"It's given me a very useful set of skills and perspectives, but it also means that I'm exposed to pervasive systematic institutionalised discrimination all over the place, and that affects me – more because of its pervasiveness than because of its actual day-to-day impact on my life".

"I'm dissatisfied by my form, my physical shape. I'm very unhappy with my body – I don't know whether I ever will be happy with it. I'm happy though with the fullness of my emotional life – these are not contradictory! I hope my self-esteem improves, I'd like to find someone whom I can be physically relaxed with".

"I am proud of what I reached, but still feel shame whenever I need to come out to a new person, especially to girls".

"Being trans has allowed me to accept myself, so that brings an improvement in self-esteem and gives me an identity I sorely missed in the past when I didn't accept myself. However it negatively affects me in that I know I have a hard road ahead of me".

Explanations of how being trans negatively affected self-esteem included the following:

"Society tends to view trans people as freaks due to ignorance which eventually wears on your self-esteem".

"It's hard, I have a male-sounding voice and I cannot afford to have surgery or voice therapy. I need help but the clinic will not help".

"It meant my true identity didn't get validation when I was growing up as a kid. I also sometimes sense that the world hates who I am, and that I don't have the right to exist as I want to".

"It makes me hate the way I look. Media makes me think of being trans as a fetish or something..."

The positive influence of being trans was explained in the following ways:

"It's who I am, so really I am the potential inside, the mental, physical, emotional attributes of me, and they are all good. I don't understand how being trans can influence how I feel about them".

"I've decided that I'm awesome, and anyone who thinks otherwise is an idiot".

"Being trans has affected it somewhat negatively in the past but now I feel that my trans* identity positively affects my self-esteem. I am happy being trans* and accept myself completely despite how society may or may not view or accept my experience".*

The participants were also asked about the amount of stress in their lives, as this can have a substantial impact on general wellbeing. Of the 113 who answered this question, 19% felt that most days were either very or extremely stressful. Thirty-seven percent felt that most days were quite stressful, and 44% said that most days were either not very or not at all stressful.

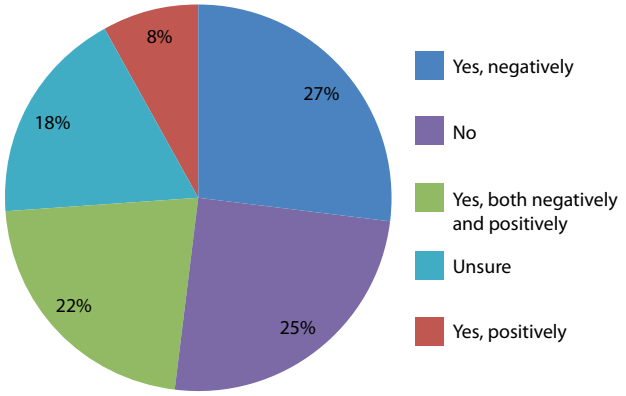
Life Orientation Test - Revised (N=106)

The Life Orientation Test - Revised was incorporated into the study as a measure of optimism and pessimism, both of which may have an impact on health and wellbeing, with optimism having a generally positive effect on health and wellbeing and pessimism, a generally negative one. Higher scores on this measure indicate optimism, with between 14 and 15 being average. The mean score for the participants was 12.9 (N=106), with scores being generally well spread. There were no statistically significant differences between participants when separated by gender identity or by stage of transition.

Other substantial factors which can affect wellbeing are feelings of control or lack of control. It was hypothesised that those participants who had not undergone transition but wanted to, or who were currently doing so, may experience a lack of control in their lives, due to being engaged with the medical system. When asked about amount of control participants had in their lives, on a 7-point scale, scores were generally well spread, perhaps a little greater on the positive side. No statistically significant differences were found between participants when separated by gender identity; however, partly in accordance with the hypothesis, statistically significant differences were found for stage of transition ($F=4.671$, $df=3$, $p=0.004$). Post-hoc testing indicated that, on average, those proposing to undergo some form of transition rated the amount of control over their lives as significantly lower than did those currently undergoing and those who had undergone some form of transition (N=111).

This trend was explored further, and participants subjectively reported that being trans did have an impact on the amount of control they had over their lives (75% as compared to 25% who felt it did not; N=113). Twenty-seven percent felt that being trans had a negative impact on control, with only 8% feeling it was a positive relationship. Twenty-two percent of participants felt that being trans both positively and negatively affected the amount of control they had over their lives.

Figure 6.10: Trans Identity Effected Control Over Life (N=113)



There were many ways in which participants identified being trans as limiting the amount of control they had over their lives. Some of these included having limited access to resources, having to negotiate a medical process, encountering barriers from society and family, experiencing employment issues and being reliant on others. Some examples follow:

"All the decisions I make are my own, however it's the means to make those decisions I feel unsure about. I'm not sure I have the strength, the support, the financial means, the security etc., to make the decisions I know are correct".

"Being male is not what I want and so I feel that I'm lagging behind no matter what I do...so I really need to get on in life as female".

"Being trans makes it more difficult to change jobs, make career steps".

"I am often afraid to look for work in case I have to show my passport. Once, after a successful interview, because I had to bring my passport the next day, I never showed up. Nowadays, many people do not have jobs, but seems like being trans dissuades me from trying to find one. Of course, when it comes to dating people, the same thing".

"I feel I am very much in control of my life but I don't have control of how others respond to me as a trans person, sometimes prejudice or ignorance can lessen opportunities and the control I have in my life".

"I feel that others are in control of my life because I don't believe that I would be accepted if I came out publicly as TG in the town I live in".

"I have to go spend a large amount of money to look right, I have to go through a process of having my head checked for mental illness and to see if I'm making the right decision".

"I'm dependent on having the proper levels of hormones in my body for the rest of my life".

"I'm part female but can barely express it or lose marriage/job/family possibly".

"It limits where I go in my free time, because I can't always present as female everywhere I want to as I'm scared of what will happen. It makes it more uncertain for me in terms of finding work, future etc., and makes relationships very difficult at least at the moment".

"I've always been trans, I've nothing to compare it to but at least when you're not trans you don't have to get hormone treatment, a mental diagnosis to access health care or apply and be approved for surgery. It almost puts your life on hold and makes your entire life revolve around being trans when you have so much to concentrate on in regards to being trans".

"No control over how my body develops physically as a result of puberty".

"The issue of who actually has control over my life becomes apparent when I engage with State or society agencies or actors that do not recognise my trans identity and existence. I am currently challenging a number of agencies to recognise and respect my non-binary identity and in that way trying to take back some control over how, and on what terms, I wish to be engaged with by others".*

For others, being trans meant taking back control where they'd previously felt that they had none:

"I know who I really am for the first time of my life and can confidently make my own decisions".

There were also some participants for whom being trans was unrelated to their sense of control. Other issues such as being a carer or having medical problems affected their control much more for some participants, whilst others felt in control all the time regardless of trans status:

"In my opinion, whether I was trans or not wouldn't make a difference on how much control I have on my own life as either way, I am the one in control of my own actions".

Being trans affected the participants' lives in a number of other complex ways. Thirty-two percent felt that they had lost something, with a further 46% feeling that they had missed out on something as a result of being trans, transitioning or expressing their gender identity (N=112).

Respondents felt that they had missed out on the following due to being trans: a good childhood and adolescence, socialisation and experiences in preferred gender, a positive relationship with family and friends, long-term partner, an intimate relationship, a good social life, being 'normal', not having to worry about 'passing' or how people would perceive/treat them, a life, employment and career progression, education, participation in sports, having biological children of their own, their home, being able to travel and their children. Reasons included respondents withdrawing or holding back from opportunities and experiences because they feared that they would be treated negatively, or else experiencing rejection and discrimination when they did reveal their trans status. Some respondents described losing family and friends because of transitioning or, in the case of the following respondent, being forced to suppress their gender expression altogether due to family relationships:

"As a married transvestite whose wife can't accept my trans desires I have had to suppress these and missed out on opportunities to fully express myself".

In addition, however, 78% felt that they had gained something as a result of being trans, transitioning or expressing their gender identity (N=108). Gains included resilience, defiance, independence, self-knowledge, freedom, self-esteem, self-respect, self-reliance, patience, strength, acceptance, a sense of belonging, wisdom, insight into gender, a new life/a reason to live, self-expression, open-mindedness, honesty, inner peace, confidence, assertiveness, improved mental wellbeing, new/improved friendships and relationships, community, happiness, empathy and tolerance.

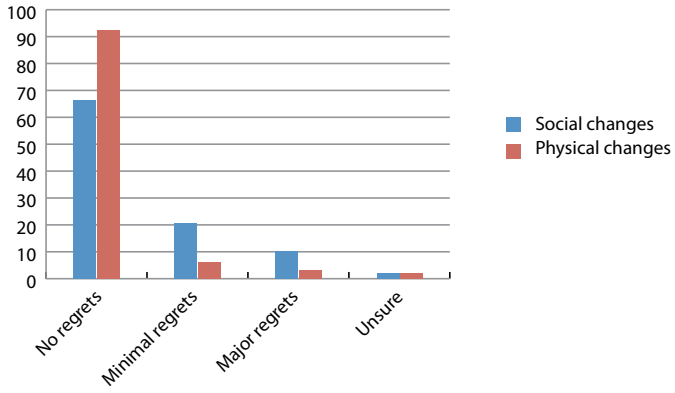
Sixty-seven percent of respondents who had made social changes reported that they had no regrets about changes they had made in relation to being trans or having a trans history (i.e., coming out, living in their felt gender, telling parents or a partner). Twenty-one percent experienced minimal regrets and 10%, major regrets (N=101). Of those who had made physical

changes (e.g., hormones or surgery), 92% had no regrets, as compared to 6% who had minor regrets and 1% who had major regrets (N=72).

Table 6.23: Regret of Social and Physical Changes

	Social changes (N=101) (%)	Physical changes (N=72) (%)
No regrets	67	92
Minimal regrets	21	6
Major regrets	10	1
Unsure	2	1

Figure 6.11: Regret of Social and Physical Changes



In relation to both the social and physical changes made in relation to being trans or having a trans history, respondents regretted the following: losing family and friends, losing their sex drive, gaining weight, and being less employable. A few respondents regretted telling others that they were trans because of negative and prejudicial reactions that they had received and the subsequent impact the revelation has had on relationships. A common regret was not coming to terms with their identity sooner and transitioning at an earlier age. The following statement sums up the sentiment of many respondents who stated that they regretted the fallout that their transition precipitated – largely as a result of social stigma – but they did not regret the transition itself:

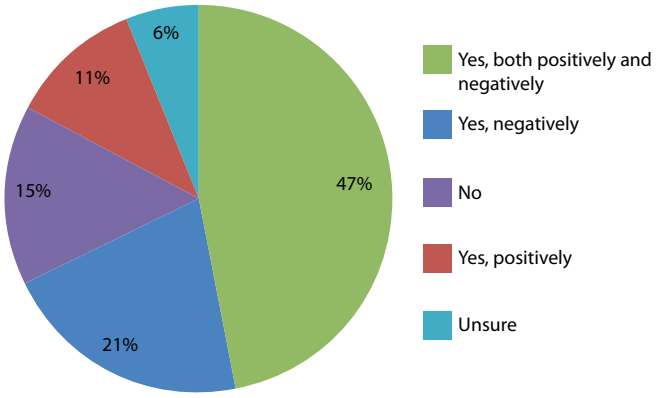
"I would not change transitioning, I needed to with every fibre in my body and mind".

6.12. Quality of Life

Quality of life was measured using a 7-point scale, with 1 being the worst it could be and 7 the best. Scores were fairly evenly spread and slightly more positive (52%) than negative (30%; N=106).

The majority of participants (47%) felt that being trans or having a trans history had both a positive and negative impact on their quality of life. A further 11% felt that it had a solely positive effect whilst 21% felt that it had a negative effect. Fifteen percent stated that it had no impact whilst 6% were not sure (N=107).

Figure 6.12: Trans Identity Effected Quality of Life (N=107)



The following comments highlight the positive impact:

"Happy with my life and able to deal with society's lack of understanding and awareness in a positive way".

"It makes me feel better about myself that I can now identify as the gender I am".

"I am on the right path now and learning new things everyday".

Others felt more ambivalent:

"Positively in that I am the real me now and negatively in the way society stigmatises trans people".

"Overall I feel grateful for my experience while, at the same time, feeling like I have missed out on many things in life".

Elsewhere, respondents highlighted the negative impact:

"Navigating a cis world as a trans person has been hard to say the least".

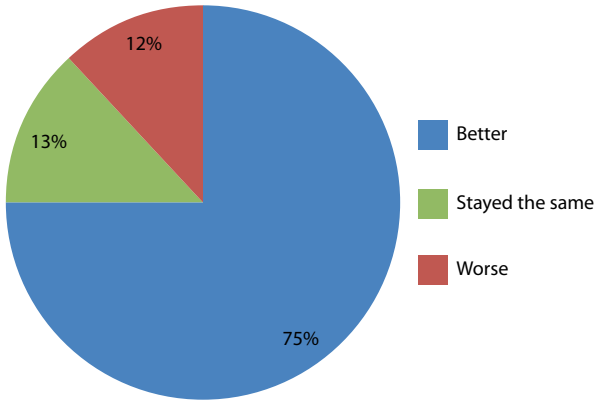
"I can't get a job in my chosen career, I have a fantastic work history up until the point when I came out as trans, now no one will employ me, this means I can't afford my transition in full which is really hard on me".

One trans man reported the following in a matter-of-fact way:

"Being on testosterone automatically shortens my life expectancy, makes me more at risk for diabetes and heart disease and surgeries puts my body under more strain".

Transitioning dramatically improved quality of life for those who had transitioned in some way. Although 12% felt it had decreased, 13% felt it had stayed the same, and 75% stated that their quality of life had improved (N=98).

Figure 6.13: Effect of Transition on Quality of Life (N=98)



6.13. Being T

In general, participants rated their experience of being trans or having a trans history as slightly more positive than negative. While 25% felt that their experience was more negative, 30% felt it was neutral, and 45% felt it was more positive (N=106). Being trans or having a trans history was also seen as being an important part of participants' identities, with only 21% stating it was not important, 23% feeling neutral, and 57% reporting that it was an important part of their identity (N=106).

Many participants reported feeling part of a trans community (39%); however, a greater number did not (47%; N=104). Statistically significant differences were found between groups when participants were separated by gender identity ($F=6.974$, $df=3$, $p<0.001$). Those who were unsure about their gender identity or had no gender identity were significantly less likely to feel part of a trans community than those with a constant and clear binary gender identity as a man or a woman. In contrast, many more participants felt part of mainstream society (47%) than not (36%; N=106). However, gender identity made little impact here, with statistically significant differences being found for stage of transition ($F=4.157$, $df=3$, $p=0.008$). Those participants who were proposing to undergo some form of transition were significantly less likely to feel part of mainstream society than those who had undergone their transition.

In answer to the question "What does the term 'trans community' mean to you?", respondents answered with the following:

"A caring community that looks after each other, gives advice, gives information, support and friendship. A kinship and understanding of shared experience".

"A network of trans people...working towards social change and equality for all".

"People with very unique and diverse gender presentations, identities and experiences united in our desire to live and be accepted as ourselves".

"It seems to me more a concept than anything else...quite often there are divisions and squabbling among us. I find that very depressing. We should be presenting a united front to the world, but we don't".

"Fluid! People come and go through the trans community. A lot of trans people spend time in the community when they are accessing support or going through transition but move on to living a normal life once transitioned. Many do not come back into the community after transition".

"The term 'Trans community' is a loose-knit group of people with a trans identity or history. It is a kind of imagined community more than actual but it consists of peer support and shared experiences".

In terms of isolation, the participants' scores were evenly spread across a scale of 1 to 7 (with 1 representing never feeling isolated, and 7 representing feeling isolated all of the time). Similar numbers of respondents felt isolated more of the time as did less (41% compared to 45% respectively; N=105).

Finally, the respondents were asked about the range of situations in which they felt able to be out as a trans person (N=103). The majority were out with their friends, whether they were lesbian, gay, bisexual and/or trans or not, and with close family. Only 4% were not out to anyone.

Table 6.24: Where People are Open About Being Trans (N=103)

	%
With trans friends	85
With LGB friends	79
With close family	69
With friends who aren't LGB or T	65
With sexual partner(s)	63
With extended family	34
At social groups	25
At work	23
At religious centre	6
Other	6
Not out to anyone	4

6.14. Employment

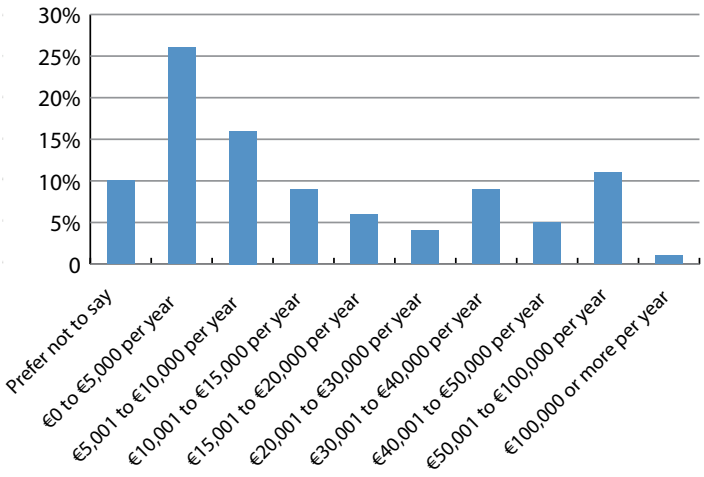
Of the 106 people who provided details about their qualifications, around 40% had a Bachelor's Degree or higher qualification. Eight percent had no educational qualifications at all.

Table 6.25: Highest Level of Educational Qualifications (N=106)

	%
High School qualifications	31
Bachelor's Degree or equivalent	23
Master's Degree or equivalent	18
Certificate of Higher Education or equivalent	10
Diploma of Higher Education or equivalent	9
No qualifications	8
Doctoral Degree	2

Despite being generally well-qualified, relatively few (37%) earned over 15,000 Euros per year, with even fewer earning over 20,000 Euros annually (31%; N=104).

Figure 6.14: Current Personal Income (N=104)



Only 51% of participants were employed either part- or full-time, with 24% being unemployed but seeking work (N=106). These rates were similar to those found in the UK sample, where 44% of participants were not working for various reasons.

One potential contributing factor to the high rates of unemployment and low earnings could be that 43% of respondents reported experiencing problems in work due to being trans or having a trans history (N=103), with a further 16% being unsure as to whether any difficulties were related to being trans or not. Fourteen percent of respondents reported experiencing harassment or discrimination, with 14% also believing that they had been unfairly turned down for a job on the basis of being trans. Nine percent reported being unfairly dismissed or laid off, with another 9% leaving a job early despite having no other job to go to, because of being harassed or discriminated against for being trans. Other issues which were reported included avoiding applying for jobs or declining job offers due to fear of harassment or discrimination, and being unable to provide references from past jobs due to gender history.

Table 6.26: Negative Experiences at Work Due to Trans Identity (N=103)

	%
No negative experience	57
Unsure	16
Believe they have experienced workplace harassment or discrimination	14
Believe they have been unfairly turned down for a job	14
Believe they have been unfairly fired, dismissed or laid off	9
Have left a job due to harassment or discrimination, with no other job to go to	9
Have not applied for certain jobs due to fears of workplace harassment or discrimination	8
Have not provided references from a previous job because of gender history	7
Yes (other issue)	6
Have declined a job offer due to fears of workplace harassment or discrimination	3

Respondents gave further details of the types of issues which had arisen for them in employment:

"I have felt unable to reveal that I am trans because I really need my job and feel that it would put my employment in jeopardy".

"Feeling I can't look for another job due to my gender history as regards a reference".

"One incident of direct abuse at work. Another in an inappropriate e-mail widely circulated. My then employer took both incidents very seriously".

"Last 3 jobs I suffered discrimination, finally taking the last employer to Employment Tribunal (which I wish I had done previously as well)".

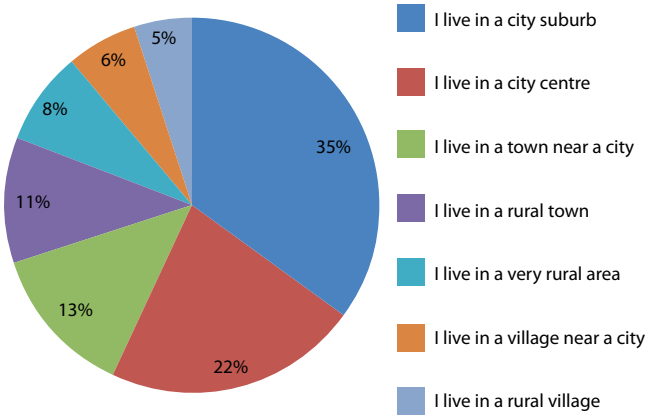
"People are generally very polite and I get on well in work situations but I have experienced some exclusion from some company public events or have not been invited to front projects because it was not seen as wise to have a trans person be the public image of the project. This has

been politely explained to me in private as the person tells me it's not them or the company that feel that way".

6.15. Accommodation

Most of the participants reported living in a city (57%), with a further 19% living in a town or village near a city (N=107). Twenty-four percent reported living in rural areas.

Figure 6.15: Locality (N=106)



The majority of respondents were in relatively stable housing, with 30% living with parents or family. Twenty-eight percent owned their own homes, with 30% renting privately either alone or as a joint tenant (N=107).

Table 6.27: Current Housing Situation (N=107)

	%
Live with parents or family	30
Own a house/flat/apartment	28
Rent as a single tenant a house/flat/apartment from a private sector landlord	17
Rent as a joint tenant a house/flat/apartment from a private sector landlord	13
Live in subsidized or public housing	8
Live in a student residence	2
Couch-surf or stay at a friend's house	1
Rent a single room as a lodger from a resident private-sector landlord	1

Many participants reported that they had been in a position where they had had to leave a housing situation due to others' reactions to their trans status or history. Of those (N=43), 37% had left a parental home, and 35% a home they'd shared with their partner. These figures are substantially higher than were found in the UK sample, where 7% had needed to leave a parental home, and 6% had left a home shared with their partner. Fifteen percent of respondents had been homeless at some point, with 5% being homeless on more than one occasion (N=106). Respondents gave more detail about their experiences of being homeless:

"I was made homeless because I lived with my Mum and she disowned me when I transitioned".

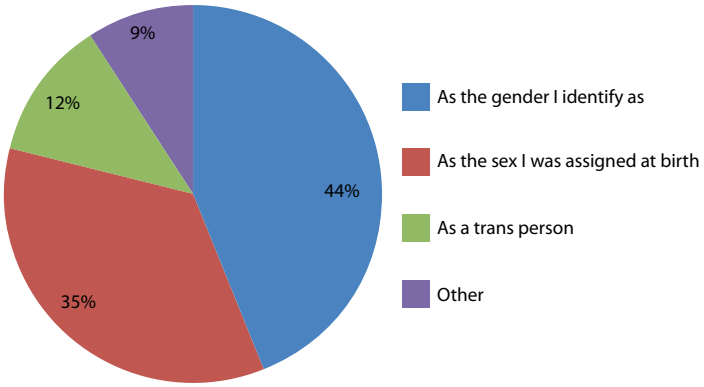
"I lost my job for being trans, it was a live-in job so I lost my home as well, the owners threatened me saying I was a freak and had an hour to leave, this happened twice, only the second time it was company security instead of the owners".

"Before transition I came home to find all my things on the doorstep after my landlady found my female clothes and makeup...in my bedroom while I was out, with a letter saying she didn't want perverts living in the house".

6.16. Social Support

Socially it was extremely important to the participants that others respected their gender identity. Only 10% felt that it was not that important, compared to 84% who felt it was (N=107). Although it was extremely important to the participants, only 44% felt that they were perceived or seen by others as the gender by which they identified. In contrast, 35% felt that they were seen as the sex they were assigned at birth and 12% felt that they were seen as a trans person. Nine percent felt that they were perceived as something else (N=106).

Figure 6.16: Perception of Gender Identity by Others (N=106)



Most participants felt that others would very rarely or never know that they were trans without being told (44%), compared to 24% who felt others would know at least half of the time (N=106). Given how important it was to participants to be recognised as their identified gender, it could be expected that the lack of recognition evidenced here may have an impact on their wellbeing.

In general, the participants felt that more people were supportive of their gender identity or expression than were unsupportive. The only exception to this, however, was the category of faith groups, where equal numbers of participants reported receiving support as did not.

Table 6.28: Level of Support

	Not applicable (%)	Not at all supportive (%)	Not very supportive (%)	Somewhat supportive (%)	Very supportive (%)
Parent(s) (N=98)	24	20	10	21	25
Sibling(s) (N=96)	26	12	17	18	27
Spouse(s) or partner(s) (N=95)	39	11	4	13	33
Child(ren) (N=88)	79	1	3	11	6
Extended family (N=92)	49	4	10	28	9
Flatmates (N=84)	75	0	2	10	13
Trans friends (N=96)	15	0	1	9	75
Non-trans friends (N=96)	15	1	6	38	40
Church/temple/mosque (N=84)	91	5	0	2	2
Cultural community (N=83)	77	2	7	7	7
Co-workers (N=86)	70	2	4	11	13
Supervisor/boss (N=85)	75	2	2	9	12
Teachers/lecturers (N=88)	72	3	2	15	8
Classmates (N=86)	68	4	5	16	7

The only group that participants reported as being less frequently supportive than more supportive after transition were employers (17% less supportive, 11% more supportive; N=18). Faith groups showed no change (14% less supportive, 14% more supportive, N=7). Other groups were more likely to be reported as being more supportive than less following transition. For all groups, however, most participants stated that there had been no change.

Of the 40% of participants who were parents, only 15% felt that telling their children about their gender was a positive experience. Twenty percent reported seeing their children less after disclosure, and 13% lost contact with their children (N=40). Other negative experiences included losing custody or having custody of children reduced, or losing contact with adult children. Only a small number of respondents (8%) reported no change after telling their children that they were trans.

Respondents who were parents discussed their experiences:

"I felt a huge release of stress after telling my child, who has accepted me quite fully".

"It was a challenge for my 2 kids when I told them in their teens, and although they both accept it, one of them has found it quite difficult to deal with"

"I recently came out to my son, and he was accepting of me. However, I had sole custody of him from the age of 2 until he left home, and during that time I felt it necessary to repress my TG nature because I wasn't sure what the reaction of social workers would be if they knew I was TG".

A further standardised psychometric scale – The Medical Outcomes Study - Social Support Scale (MOS-SSS) – was used in this study to explore the levels of social support to which participants had access. Higher scores in the range of 0–100 represented greater levels of social support. The mean score here was 59, which was similar to the mean score of 67 found in the UK sample. Scores were generally well spread, with greater numbers scoring above 50 than below.

Support Organisations (N=105)

Participants were asked about the types of support or social groups that they might access. In relation to trans groups specifically, the vast majority (69%) of participants accessed internet groups, with 44% visiting local groups in person. Twenty-nine percent visited national groups and 8%, international groups. Sixteen percent did not access any trans groups (N=105). Given that internet groups seemed to be accessed more frequently than physical ones, potential barriers to access in person were explored. The most common barriers cited were groups being too far away (28%) and participants' concerns about a few possibilities: that

they would not be 'trans enough' (24%), that they did not know what they would want to gain from the group (22%) and that others would not like them (20%; N=95).

Table 6.29: Barriers to Accessing Trans Groups (N=95)

	%
Trans groups are too far away	28
Nothing	25
Worry at being not 'trans' enough	24
Do not know what they want to gain from it	22
Worry other people in the group may not like them	20
Trans groups are not relevant enough to their life	17
Worry someone will see them go	16
Worry they may not like other people in the group	13
Other	7
It is not accessible	2
Without regular access to the internet	1

Some of the comments that participants made indicate the types of difficulties that they encountered:

"Fear of someone knowing me, especially when I hear the words admirers – as the fact that they are not themselves trans makes us vulnerable".

"I cannot leave the house dressed, and because I currently have no place away from home where I can dress I'm unable to have any contact with other TG people".

"I have heard horror stories about people being outed or stalked by other members of their trans group".

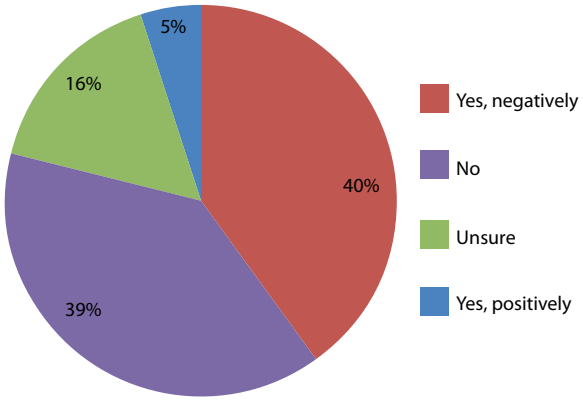
6.17. Media (N=106)

Media portrayals of trans people are frequently criticised for being overly negative or stereotypical. Anecdotal evidence suggests that this kind of representation may have an impact on trans people's wellbeing; however, it was important to explore what impact if any the media actually had.

Seventy-two percent of participants felt that media portrayals of trans people were negative, 16% neutral, and only 12% positive (N=106).

In terms of the potential impact of this, 40% of participants reported that these representations negatively affected their emotional wellbeing or mental health, with only 5% feeling the impact was positive. Almost 40% felt that the way trans people were represented in the media had no impact on their mental health or wellbeing (N=107).

Figure 6.17: Media Representation's Effect on Mental Wellbeing (N=107)



For those who felt that portrayals had no impact on them, they used a number of strategies to distance themselves from what they observed. These included interpreting the representations as demonstrating an issue that other people had (namely those making the programmes) rather than a problem for them, or feeling that the portrayals were not relevant to their lives.

Some examples follow:

"While I see negative portrayals in the media as disgraceful, I personally don't allow it to affect me. And I try to ensure that it doesn't affect those around me by openly discussing it".

"I pay little regard or attention to the opinions of the media".

"I just don't feel part of a group or demographic that can be defined in this way. I feel like me and feel independent of stock representations so it does not bother me whether generic representations are negative or positive. I am not the type to take up a cause so don't feel implied negativity or positivity is necessarily associated with me".

"I find it quite pathetic on the part of those who made the media in question but it doesn't depress me or anything of that sort".

Some participants felt that any media representation was positive, in that visibility was important to helping people who were trans to identify themselves, whilst others felt that media portrayals had the opportunity to be supportive when conducted positively. There was also a sense that times were changing:

"It depends on the media. Books by individuals with trans experience are very helpful, as are some documentaries. Most coverage in tabloids, however, is not helpful".

"If the article is positive it can have a cheering and uplifting effect on me. However if it is negative I can end up quite angry and upset".

"Honestly the main problem was just a lack of any representation, as far as I saw. The first time I heard about transgender people was when I was 23".

"Positively where it shows other people's experiences and inspires me / gives me hope. Negatively because we all know some trans people are portrayed as 'freaks' or a joke on TV, such as on the Jerry Springer Show".

"Because it is both positive and negative in the media it is hard to say, but the trans issue seems to be in the media a lot lately and with so many TV shows coming out with such issues arising I think it's becoming more and more accepted, really".*

For the large number of participants who felt that media portrayals of trans people negatively affected their mental health, many cited a concern that they legitimised stereotypical and harmful views and treatment of trans people, and this led to high levels of fear and isolation:

"Sets a bad work environment if people are discussing big news stories which are negative towards trans people. Makes me feel I could never come out and also makes me feel unwelcome".

"A lot of magazines are sensationalist, they don't treat trans matters with respect, which sets a precedent, a lot of attitudes are derived from the media".

"Most representations of trans people in the media are negative which leads me to believe that people would view me negatively too".

"It's perpetuating negative stereotypes which could lead to ignorant people abusing trans people".

"It makes me so, so angry when I see people mocking trans people on the TV – even when it's 'jokes', it's not funny. The Family Guy episode comes to mind when Brian the dog began vomiting after he slept with a 'man' – but he didn't, he slept with a trans woman. This 'IT'S REALLY A MAN IN A DRESS!' bullshit makes me feel so angry".

"It makes me feel angry and dents self-esteem when I see a negative or unrealistic representation in the media".

"I get angry and frustrated, and I fear for other trans people who are in denial and suffering".

"I don't understand making a mockery of people for who they are, regardless of the group or my membership, it makes me feel pretty bad to be part of a society that thinks it's okay to mistreat different people".

6.18. Sex (N=101)

Participants exhibited high levels of worry in relation to sex. The greatest concern they had was that others would think that their body was unattractive (82%), followed by feelings of shame about their bodies (77%) and worries that there were few people who would want to have sex with them (76%; N=101). Over the course of transition, 62% of participants reported that the quality of their sex lives had changed, with 17% thinking it was worse and 45% thinking it was better. Twenty-nine percent felt it had not changed at all (N=58).

A number of participants reported being asexual, with some others having never had sex. Whilst in some instances they felt that circumstance to be positive, it was frustrating for others. One participant mentioned that they would be unable to comment on sex until they had completed their surgery. Many participants felt that sex either became problematic following transition or had mixed feelings about the topic. In addition, changes in libido, others' reactions and the impact of relationship difficulties led to problems:

"I am unable now to have penetrative sex".

"I didn't transition for sex, though. I don't have a sex life now but I do miss the closeness of a loving relationship".

"Men still have the same issues around me...but it's their issues...in their own heads. Irish men in particular are too hung up on religious teachings which are light years out of date".

"My libido has increased, I am more active and willing to please my partner. However, I'm still experiencing difficulty with pleasure on my part. Now that I am more happy about my body, it seems that the issue lies with my partners. I am trying to experiment and encourage my partner to try new things. Often this does not happen, and I am unhappy. My relationship recently changed mainly due to an unsatisfactory sex life".

"Since operation my sex drive has gone to nothing (though the abuse would also have a factor in this)".

"I've mentally transitioned/matured, but I'm still extremely cautious of relationships. Sex is a frustrating subject (non-existent but semi-happy with that)".

"I feel more comfortable communicating what it is I like and do not like sexually. But I'm also more uncomfortable with my chest now than ever before".

For some, however, sex was a positive part of their lives, and undergoing some form of transition enabled them to enjoy their sexuality more fully than they had previously:

"Before transition I didn't understand the barriers I had to intimacy, particularily revolving around my dislike of certain of my body parts. I'm becoming more at peace with myself now, although would like to wait until further along transition to actually have a physical relationship, when I'm more comfortable with my body".

"More confident and feel better in my body so I'm more 'present' and am better at communicating".

"I'm now able to have sex. I've been effectively a virgin up to now, as I just wasn't able to use the equipment I was born with".

"I'm more at ease with my body and let my partner touch me more".

"I'm me so I don't feel like I'm pretending to be happy having sex as a person I'm not. That can only have positive effects".

7. Conclusions

Impact of Transition on Mental Health

The key finding to emerge from this study was the significance of gender transition in improving mental health and wellbeing. Seventy-five percent of the respondents felt that their mental health had improved since transitioning. Ninety-two percent were more satisfied with their bodies and 84% more satisfied with their lives since transitioning. Both social and physical changes of gender were shown to have a substantially positive impact on trans people's self-esteem, happiness and quality of life. Crucial here was the importance of being able to socially transition towards their felt gender identity and having that identity recognised by others. Alongside and interacting with this was the positive role played by hormonal and surgical interventions, which enabled necessary physical and psychosocial changes to be made. Such changes reduced instances of gender dysphoria and negative body image and, in turn, served to increase confidence, satisfaction and overall wellbeing.

Hormone usage had an extremely high success rate, with 90% of users feeling more satisfied with their lives and 87% feeling more satisfied with their bodies since initiating hormonal therapy. In relation to surgical procedures, 90% of those who had undergone genital surgery reported feeling more satisfied with their bodies, and 83% were more satisfied with their bodies after undergoing other surgical procedures such as breast augmentation or chest reconstruction. Of those who had made physical changes via hormones or surgery, 92% reported having no regrets. However, participants highlighted the importance of having the right hormonal balance and receiving post-surgical care and support. Those waiting for surgical procedures or to start hormones highlighted the negative impact that delays had on their mental health.

Rates of self-harming, suicidal thoughts and suicide attempts were high, with 44% of respondents having self-harmed, 78% thinking about suicide and 40% of those having attempted suicide at some point over the life course. However, gender transition was shown to drastically reduce rates of self-harm and suicidal ideation within this group. Of those who had completed transition, 76% reported having self-harmed more prior to transition, but none of the participants had self-harmed more after transition. In addition, 81% thought about or attempted suicide more before transitioning, but this amount was reduced to 4% after transition among those who had already transitioned.

Whilst transition has been shown to significantly reduce rates of self-harm and suicidal ideation, it follows that those who would like to transition but who are unable to or who are experiencing significant delays or set-backs within the health care system will be at risk of increased self-harm and suicidal behaviour. Six percent of respondents reported currently self-harming at the time of completing the survey; 28% had thought about taking their life in the last week; and one person said they were planning to commit suicide soon or in the near future. Trans-related reasons for participants' self-harm and suicidal ideation included gender dysphoria, not having their gender recognised, social stigma, frustrations with treatment delays, lack of access to treatment, worry that they would never 'fully' or 'successfully' transition, having their identity misunderstood by health professionals and not feeling supported by gender identity specialists.

Accessing Health Care Services

Whilst treatment for gender dysphoria was shown to have a beneficial impact on mental health, the process endured by respondents in order to gain access to that treatment was more mixed. Experiencing significant delays in obtaining an initial appointment at a gender identity clinic or for hormone therapy, and being unsupported during that time, had a negative effect on respondents' mental health in 46% of cases. Thirteen percent of those who had previously had contact with a GIC or health service had wanted to self-harm in relation to or because of that involvement. Reasons for this correlation included frustration at delays and prolonged waiting times to access hormones or surgery, being denied access to gender reassignment treatment, experiencing negative treatment from psychologists and psychiatrists and dealing with unhelpful doctors who lacked awareness and understanding of trans issues. However, for just under half of participants, being able to eventually transition via gender identity services had a positive impact on their mental health.

The 36% who were dissatisfied with their experiences of GICs made the following suggestions for improving gender identity services:

- Having more GICs in order to reduce travel and waiting times
- Alternative treatment plans
- Trans awareness training for GPs, psychiatrists and clinicians
- Better understanding of non-binary identities
- Direct referrals and treatment from GPs
- Consistency with regards to seeing the same specialist throughout the treatment process
- Better communication between GIC and GP
- Better communication between endocrinology, surgery and gender identity services

Forty-six percent of respondents felt that they were emotionally distressed or worried about their mental health, but 72% of those did not feel able to discuss this in the clinic because they feared that their treatment would be delayed or terminated.

Despite high rates of stress, depression and anxiety over the life course (83%, 82% and 73% respectively), 40% of respondents avoided seeking urgent help or support when distressed because of their trans status. Avoidance of mental health services was common within this grouping and was largely a result of previously negative experiences within this setting. Thirty-seven percent of participants had their gender identity treated as a symptom of mental ill health rather than as a genuine identity; 19% were told that they were not really trans; and 26% were discouraged from exploring their gender. This focus on mental illness among care providers highlighted the need for trans-awareness training with managers and staff working within mental health services in order to promote trans-inclusive practice. That 29% of respondents used mental health services most during transition highlights the need for formal mechanisms of support during this often stressful and turbulent time. The survey found that participants tended to rely on informal support sources – such as friends, partners or trans groups/ organisations – rather than accessing support through recognised routes. As such, the advice and support that trans people may receive might be inappropriate, inconsistent and potentially damaging, as volunteers often lack a mental health training or background and organisations rarely have service protocols for referring on to statutory services.

Within general health care, 11% of participants were refused treatment on the basis of being trans or having a trans history; 15% felt belittled or ridiculed for being trans; and 16% reported hurtful or insulting language being used about trans people. In addition, 19% of participants reported that general health care practitioners refused to discuss or address a trans-related health concern, and a further 7% claimed that health care professionals had asked to see/examine their genitals where this was felt by the patient not to be necessary or appropriate. In keeping with the above, trans awareness training for GPs, nurses and other practice staff was crucial for making patients feel safe and supported within clinics. This practice included respecting a patient's preferred gender identity, facilitating a safe and efficient gender transition (where needed) and treating the patient's body with dignity and care.

Three factors proved crucial for improving respondents' mental health and, as a result, decreasing self-destructive behaviour: having their gender recognised and respected, timely access to gender reassignment treatment, and the support of trans-aware health professionals, especially during transition. Unfortunately, in the time since the data for this study was collected, the services available to trans people living in Ireland have substantially decreased and become harder to access. Given the importance of timely access to the right interventions for maintaining mental health and wellbeing, it would be expected that having to follow a haphazard and inconsistent service will lead to greater rates of distress, anxiety and depression, with a resultant impact on daily functioning and suicidal ideation.

8. Policy Recommendations

The findings of this report mirrored exactly those of the UK study in terms of the recommendations for policy that have emerged. In light of this, the recommendations are largely derived from that study:

Training

There is a significant need for trans health and awareness training for all staff and managers across general health care, 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 health care as other people. Many of the issues that respondents faced related to a simple lack of understanding which could easily be avoided through appropriately targeted, mandatory training.

Suicide Prevention

There is a significant need for suicide prevention research, campaigns and targeted interventions with the trans population. Further research is vital to better understand the complex interaction of factors that 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 into 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 that they can receive.

Exploration of Alternative Health Care Models

There should be a shift towards models of trans health care incorporating informed consent and patient flexibility. This could be within the context of Gender Identity Clinics (GICs), however there are substantial issues with this system as it currently stands in terms of patient experience and outcomes, as with the changes to the Irish system of trans health care in general. Many other models of trans health care are used globally and should be explored as alternatives. For example, the Trans Hormones Informed Consent (THInC) model from Chicago has had very positive outcomes with the communities being fully engaged and involved in decisions around their health care. Informed consent models are easily adapted to the Irish 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 focused on enhancing outcomes, and in the process, reducing costs.

9. 9. Closing Comments: Giving Participants the Last Word

In the final section of the survey, participants were invited to make any closing comments they wanted regarding trans mental health or emotional wellbeing. A selection of these have been included below, without comment, allowing them to make the statements they felt they needed to make:

"A lot done, more to do. :-) We need to really support each other and be more tolerant of our differences".

"Counselling was the best thing I ever did. Went every 2–3 weeks for an hour, talked holistically about life/marriage/gender etc. It was hard for me, (v[ery] introspective) but really helped me. I miss that time a little now and probably need to continue to engage. I wish as a youth I was told/taught about emotional/mental wellbeing (general) about life. My trans issues have been compounded somewhat with an austere Scottish upbringing".

"I hope a time will come when medical professionals will be more educated and well trained, and when a trans individual will receive quality medical and mental care, and the opportunity to undergo whatever means of transition they deem necessary. A trans individual should not feel like a freak, neither should they be forced to undergo any treatment they do not desire".

"I think being trans affects my positivity a lot, but when I'm around people who accept who I am, I feel elated".

"I transitioned in [multiple countries], with surgeries in [another country], very much outside the trodden medical paths, with assistance of GPs and private sector psychologists and endocrinologists. While this was in some ways stressful and definitely expensive, I suspect that I avoided many frustrations, delays and other negative experiences by not relying on the system (as far as one can speak of a system in Ireland)".

"I was/am affected by mental health issues, I think being born trans is quite difficult, however society is changing. The fact of the matter is though I would have liked to be nurtured as a girl, growing into adolescence as a girl, experiencing sex as female, being married as female and giving birth. None of these happened, however I have 2 wonderful sons so I would never deny them. Many things affect being nurtured in a different gender role, it is extremely challenging, but it is what it is. You get one chance of life – make it the best that it can possibly be".

"If you have to transition, time with the rhythm of your life. What you want to do with your life shouldn't be impacted by the fact one is trans".

"I'm not terribly happy right now. I feel my circumstances are difficult. I would like to be able to live under my preferred identity and there are difficulties in the way of doing that. But I am facing them and trying to see how to overcome them. I do have some hope that things will get better".

"[Mental health] is a massive part of trans experience that is not fully or properly addressed in Ireland. Great need to focus resources and policies that are appropriate to people's needs".*

"It is the abuse/negative affirmation that went on and continues throughout my life that has resulted in my ongoing mental health problems. I get treated like this because I'm trans and it affects me to the point of suicide. Sometimes I think I have just continued breathing to spite them all – it's not much of a reason to live but at least it's a reason".

"It is very depressing and I believe that for a cd/tv, talking is not always the full answer – doing is also very important".

"My mental health is often shaky, but I don't think it's because of trans issues, but I think trans issues can trigger it at times. I think there should be a thousand times more support than there already is for trans people – more training for counsellors and such. More acceptance in LGBT groups too as the group I used to be part of was almost fine with calling themselves LGB because they 'had no trans people' – completely ignoring my own gender identity issues. The group now has at least 3 trans people, so groups really need to move with the times".

"The gatekeeping of psychiatrists has to go. They don't understand that nobody would chose to be trans. If there has to be a RLE, have surgery the day after it's complete. It's insulting to drag out assessments for longer".

"The knowledge of mental health specialists of trans people in Ireland is a joke. It's not existent and lives are lost because of this".

"Train the health sector to understand and get help and services in place".

"We're not the problem, everyone else needs to be educated about us and how to treat us!"

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11. Glossary of Terms

Transgender Equality Network Ireland (TENI) offers these general descriptions to help in the understanding, respect and inclusion of trans identities and experiences.

This list was developed through research into current best practice on terminology internationally and consultation with trans people.[1] However, language is dynamic and these descriptions should not be seen as exhaustive or complete. There is ongoing discussion within trans communities about the usage, meanings and the implications of certain terms.

Introduction to Sex and Gender

It is important to clarify the distinctions between sex, gender identity, gender expression and sexual orientation.

Sex:

The designation of a person at birth as male or female based on their anatomy (genitalia and/or reproductive organs) or biology (chromosomes and/or hormones).

Gender Identity:

A person's deeply felt identification as male, female or some other gender. This may or may not correspond to the person's physical characteristics or the sex they were assigned at birth.

Gender Expression:

The external manifestation of a person's gender identity. This is expressed through behaviours and external characteristics that are generally perceived by society to be masculine, feminine or androgynous. Gender can be expressed through mannerisms, grooming, physical characteristics, social interactions and speech patterns.

Sexual Orientation:

Refers to a person's physical, emotional or romantic attraction to another person. Transgender people may identify as lesbian, gay, heterosexual, bisexual, pansexual, queer or asexual (see definition of Transgender).

Main Glossary

Androgynous or androgyne:
A person whose gender identity is both male and female, or neither male nor female. They might present as a combination of male and female or as sometimes male and sometimes female.

Cisgender:
A non-trans person (i.e., a person whose gender identity and gender expression are aligned with the sex assigned at birth).

Coming out:
The process of accepting and telling others about one's gender identity, gender expression or sexual orientation. Many trans people will 'come out' as a different gender to the sex assigned at birth and may begin a social or physical transition (see definition of Transition).

Some trans people choose to 'come out' or be 'out' about their trans identities to raise visibility or acknowledge their experiences. Others do not want to 'come out' as they feel this implies that their gender identity is not valid or authentic (e.g., a trans woman who comes out as trans may be perceived to be less of a woman).

Cross-dresser:
A person who wears clothing, accessories, jewellery or make-up not traditionally or stereotypically associated with their assigned sex.

FTM:
Female-to-male trans person (see definition of Trans man).

Gender dysphoria:
In DSM-V, gender dysphoria is diagnosed when there is a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. In children, the desire to be of the other gender must be present and verbalised. According to the DSM-V, this condition causes clinically significant distress or impairment in social, occupational or other important areas of functioning. This diagnosis is a revision of DSM-IV's criteria for gender identity disorder and is intended to better characterise the experiences of affected children, adolescents and adults.

Gender Identity Disorder (GID):
In DSM-IV, GID is the psychiatric diagnosis used when a person has (1) a strong and persistent cross-gender identification and (2) persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex, and the disturbance (3) is not concurrent with physical intersex condition and (4) causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

In practice, in the current Irish context, a diagnosis of GID or gender dysphoria is required to access hormones or surgery through the public health care system.

Genderqueer:
This term is generally used in two ways: (1) a term that includes all people whose gender varies from the traditional 'norm'; or (2) to describe individuals who feel their gender identity is neither female nor male, both female and male, or a different gender identity altogether.

Gender variant:
People whose gender identity and/or gender expression is different from traditional or stereotypical expectations of how a man or woman 'should' appear or behave.

Hormone Replacement Therapy (HRT) or **Hormones:**
The use of hormones to alter secondary sex characteristics. Some trans people take hormones to align their bodies with their gender identities. Other trans people do not take hormones for many different reasons (see definition of Transition).

Intersex:
An umbrella term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't fit the typical definitions of female or male.

A person with an intersex condition may have elements of both male and female anatomy or have anatomy that is inconsistent with chromosomal sex. These conditions can be identified at birth (where there is obviously ambiguous genitalia), at puberty (when the person either fails to develop certain expected secondary sex characteristics or develops characteristics that were not expected), later in adulthood (when fertility difficulties present) or on autopsy.

Many individuals who are intersex do not identify as transgender or do not consider themselves covered by the transgender umbrella.

MTF:
Male-to-female trans person (see definition of Trans woman).

Sex Change:

Generally considered derogatory; has been replaced by the terms 'transition' or 'surgery' (see definition of Transition and Surgery).

Surgery:

A set of surgical procedures that alter a person's physical appearance or the functioning of their existing sexual characteristics. Other terms include Gender Confirmation Surgery, Gender Reassignment Surgery, Sex Reassignment Surgery, Genital Reconstruction Surgery, Sex Affirmation Surgery and so on.

Some trans people undergo surgery to align their bodies with their gender identities. Other trans people do not undergo any surgery for many different reasons.

Some trans people define themselves by their surgical status such as post-operative (post-op), pre-operative (pre-op) or non-operative (non-op). However, these terms place emphasis on genitals as a marker for gender identity and may be rejected by people who do not see their gender as related to surgical status.

Transgender:

Refers to people whose gender identity and/or gender expression differs from the sex assigned to them at birth. This term can include many gender identities such as: transsexual, crossdresser, androgynous, genderqueer, gender variant or differently gendered people.

Not all individuals with identities that are considered part of the transgender umbrella will refer to themselves as transgender. For some, this may be because they identify with a particular term (such as transsexual or genderqueer) which they feel more precisely describes their identity. Others may feel that their experience is a medical or temporary condition and not an identity (for example they feel they have gender identity disorder but are not transgender).

Trans or trans*:

Commonly used shorthand for transgender. Trans* is a new term that further acknowledges the diversity of gender identities.

Transphobia:

The fear, dislike or hatred of people who are trans or are perceived to challenge conventional gender categories or 'norms' of male or female. Transphobia can result in individual and institutional discrimination, prejudice and violence against trans or gender-variant people.

Transition:

A process through which some transgender people begin to live as the gender with which they identify, rather than the one assigned at birth. Transition might include social, physical or legal changes such as coming out to family, friends, co-workers and others, changing one's appearance, changing one's name, pronoun and sex designation on legal documents (e.g., driving licence or passport) and medical intervention (e.g., through hormones or surgery).

Transsexual:

A person whose gender identity is 'opposite' to the sex assigned to them at birth. The term connotes a binary view of gender, moving from one polar identity to the other in a binary opposition. Transsexual people may or may not take hormones or have surgery.

The term 'transsexual' is hotly debated in trans communities with some people strongly identifying with the term while others strongly rejecting it. Moreover, for some, 'transsexual' is considered to be a misnomer inasmuch as the underlying medical condition is related to gender identity and not sexuality.

Trans man:

A person who was assigned female at birth but who lives as a man or identifies as male. Some trans men make physical changes through hormones or surgery; others do not.

***Trans man** is sometimes used interchangeably with FTM (female-to-male). However, some trans men don't think of themselves as having transitioned from female to male (i.e., because they always felt male). Some people prefer to be referred to as men rather than trans men.*

Trans woman:

A person who was assigned male at birth but who lives as a woman or identifies as female. Some trans women make physical changes through hormones or surgery; others do not.

***Trans woman** is sometimes used interchangeably with MTF (male-to-female). However, some trans women don't think of themselves as having transitioned from male to female (i.e., because they always felt female). Some people prefer to be referred to as women rather than trans women.*

Transvestite:

See definition of 'Cross-dresser'.

Endnotes

[1] Adapted from the following resources: Fenway Institute's Glossary of Gender and Transgender Terms (www.thefenwayinstitute.org); Primary Care Protocol for Transgender Patient Care, Center of Excellence for Transgender Health, University of California, San Francisco, April 2011.