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“I don’t want to say the wrong thing”: mental health professionals’ narratives of feeling inadequately skilled when working with gender diverse adults

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ABSTRACT

Trans, gender diverse and gender questioning adults are highly likely to experience mental health difficulties, for multiple reasons including transphobia or minority stress. However, gender diverse adults often describe having negative experiences accessing mental healthcare in the UK. Concurrently, health professionals have described feeling inadequately skilled, and lacking confidence in their ability to support gender diverse people. There has been limited research exploring the experiences of mental health professionals who provide care for gender diverse people in mainstream mental health services, and even less in the UK. In this study, the accounts of seven mental health professionals from a range of disciplines were analysed with a constructionist narrative analysis, to better understand the nature of stories and positioning of individuals, within the local, social and historical contexts of the narratives’ construction. This paper focuses on participants’ narratives of feeling inadequately skilled when working with gender diverse individuals, which were drawn on and resisted in their stories. Implications for clinical practice and training are suggested.

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Introduction

‘Gender diverse’ is an umbrella term which includes anyone whose gender identity, role or expression is different from the gender they were assigned at birth. This includes people who self-define as trans or transgender, as well as those who have transitioned in some way, but do not identify with the terms ‘trans’ or ‘transgender’. There has been an international increase in representation of gender diverse people in the media in recent years (Koch-Rein et al., 2020), and a growing influence of trans people in the sphere of health (Pearce, 2018). However, examples of transphobia and discrimination against gender diverse individuals are common across the world.

In October 2020, PinkNews reported that transphobic hate crimes in the UK had quadrupled in 5 years (Powys Maurice, 2020), and Reisner et al. (2016) reports on the high burden of violence and victimisation experienced by transgender people globally. Every year, the Trans Day of Remembrance honours the lives of gender diverse people who have been murdered across the world (Transgender Europe, 2020). Mizock and Hopwood (2018) describe the economic challenges faced by gender diverse people, as a result of transphobia, and Pearce (2018) provides several examples of how “anti-trans prejudice can have severe consequences for trans patients” including

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abuse, harassment, sexual violence, and “explicitly negative attitudes towards trans people” experienced from healthcare professionals (p. 54).

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

Gender diverse people may require support from mental health services due to questioning their gender (Ellis et al., 2015), or the minority stress (Meyer, 1995) they may experience as a result of moving through the world as a gender diverse person. Equally, gender diverse people may require mental healthcare for issues completely unrelated to their gender identity. Mental health professionals’ roles can include providing therapy, medication, or care both in community and inpatient settings. However, the links between gender diversity and mental health have been further complicated by the historical requirement that, prior to 2013, trans people were initially assessed by mental health services before being referred to gender identity services (McNeil et al., 2012; Pearce, 2018). In addition, the World Professional Association for Transgender Health (2012) *Standards of Care* require that two mental health professionals approve a referral for genital reconstruction surgery. Although referrals can now come directly from a GP, many gender diverse patients are still first referred to mental health services.

There is a growing amount of literature around gender diverse people’s experiences of mental health care. In the Trans Mental Health Study (McNeil et al., 2012), 63% of British trans people surveyed experienced one or more negative interactions in general mental health services. Similarly, Ellis et al. (2015) analysed survey data from 621 trans people in the UK, a third of whom reported being dissatisfied or very dissatisfied with their mental health care. Participants described experiences such as their clinician not being educated on trans issues, and their gender identity being seen as a symptom of mental illness. Gender diverse adults in Australia also described issues such as misgendering, the need to educate their clinicians, and experiencing discriminatory comments (Riggs et al., 2014).

To further understand the challenges faced by gender diverse individuals accessing mental health care, it is important to explore the perspectives and experiences of mental health professionals who provide this care. However, research in the area is limited (Richards et al., 2014). Canvin et al. (2021) systematically reviewed research into mental health professionals’ experiences of providing care for gender diverse individuals. The authors of all 12 studies included in the review concluded that there is a need for better training for mental health professionals working with gender diverse individuals. Several participants in the studies described their uncertainty working with this population, and some reported stigmatising beliefs or practices, such as imposing moral or religious views, or seeing gender identity as a target for intervention (often referred to as conversion therapy).

Canvin et al. (2021) also noted some limitations in the literature around mental health professionals’ experiences supporting gender diverse people, and areas requiring further study. This included specific research into the experiences of mental health professionals in the UK – a country with free at the point of use, state funded mental health care – as all studies reviewed took place in the USA or Australia. In addition, research which qualitatively explored mental health professionals’ own accounts, as opposed to an assessment of competence, was particularly limited.

This paper presents a subsection of the findings from a larger piece of qualitative research into the experiences of mental health professionals in the UK who have supported gender diverse adults (Canvin, 2020). The broader research project described wider narratives drawn on and resisted by participants, such as narratives of separating different parts of a person (e.g. gender and mental health), and narratives of standing up to higher powers. The findings in the current paper describe mental health professionals’ narratives of feeling inadequately skilled, exploring how mental health professionals position themselves and their ability to support gender diverse adults.

As this research aims to explore the stories mental health professionals tell about supporting gender diverse clients, narrative methodologies were used to analyse the data (e.g. Esin et al., 2014; Riessman, 2008). The analysis explored the stories mental health professionals told about their experiences, as well as the wider narratives, discourses, and social/historical contexts which shape their stories. Attention was paid to the ways gender and mental health were constructed, and the ways participants positioned themselves in their stories, in the interview, and in relation to wider discourses and debates.

Method

Participants

To be included in the research, participants had to be mental health professionals who worked (currently or previously) in the public sector. Relevant professions included community psychiatric nurses, social workers, support workers, care co-ordinators, psychiatrists, psychologists, occupational therapists, or other allied health professionals. The mental health professionals could be qualified, in training, or have no formal mental health qualification. A purposeful sampling approach was used in order to obtain participants from a range of mental health professions, and healthcare settings. Participants were required to have had experience supporting at least one adult in the public sector who self-identified as trans, gender diverse, or were questioning their gender identity. Recruitment primarily took place through social media (e.g. Facebook groups dedicated to mental health professionals), word of mouth, and mental health professionals passing on the research advert to colleagues via email.

The total sample consisted of 7 mental health professionals, aged 27–54. 5 of the 7 participants identified as female, and 2 as male. All 7 participants identified as cisgender, 5 as heterosexual or straight, 1 as demisexual and 1 did not disclose their sexual orientation. 4 participants described themselves as White British, 1 as White, 1 as British, and 1 as Mixed (Caucasian and East Asian). 4 participants were located in the East of England, 1 in the Midlands, 1 in the South West and 1 in London. The sample consisted of 2 Clinical Psychologists, 1 Trainee Clinical Psychologist, 1 Consultant Psychiatrist, 1 Mental Health Nurse, 1 Social Worker, and 1 Art Therapist. The professionals ranged from 1–27 years in their current occupation.

The professionals spoke of their experiences working in a range of different mental health settings such as Community Mental Health Teams, Forensic Mental Health Hospitals, and Single-Sex Inpatient Wards. The Mental Health Care provided included psychological assessment, therapeutic work, and providing care on inpatient wards. 4 participants had only worked with one gender diverse person, whereas 3 had worked with several gender diverse adults.

Materials

Narrative data is typically gathered through a conversation between an interviewer and interviewee (Riessman, 2008; Wells, 2011), designed to elicit talk from the participant in a storied form. The semi-structured narrative interview style used in this research followed the procedure of Jovchelovitch and Bauer (2000), by first introducing the participant to the interests of the interviewer (their experiences working with gender diverse individuals), followed by a phase of uninterrupted narration from the participant, only then asking questions to prompt additional areas of experience and clarification.

The proposed study design and initial draft of the interview guide were commented on by 22 gender diverse individuals through an online survey, and their feedback was incorporated into the materials used for the research. The survey respondents gave largely positive feedback about the design and aims of the study. The interview guide was described as “clear” and “good that it is semi-structured”. Following the survey, the gender ‘non-binary’ was specifically referred to in the interview

guide as one respondent mentioned that they were unsure whether the participants were being asked about experiences working with non-binary people.

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

Other questions relevant to the findings presented in this article included: *Can you share with me an experience that was difficult or challenging?; Can you share with me an experience which you felt went well?; How confident did you feel in your ability to support a trans, gender diverse, or gender questioning person initially? Participants were also asked What additional training, education or resources do you feel you might need?*

Although one interview took place face to face, the majority of the interviews took place online (2) or by phone (4), to maximise time-efficiency for time-poor mental health professionals, and allow for the collection of data across a wider geographical area (Lo Iacono et al., 2016). Participants chose how they wished to be interviewed.

Reflexivity statement

The research team consists of three practicing Clinical Psychologists, two of whom work with gender diverse individuals. There is a mixture of trans and cis people in the research team, with a range of sexual orientations.

As mental health professionals, we the research team consider ourselves as members of the participant group included in this study. We can relate to shared experiences of working with limited resources, the shared language of mental health and illness, and the shared working culture. Our positions as both mental health professionals and queer people/allies in relation to this research, create both strengths and barriers. We may be more attuned to the specific contexts, languages and references made by the participants when telling their stories. However, we recognise that these positions can also create barriers to listening and analysing from an outsider or neutral position.

Ethical considerations

This research was approved by the University of Hertfordshire Ethics Committee (LMS/PGR/UH/03782). The participants' identities were kept confidential through anonymisation. To protect the confidentiality of the gender diverse individuals that the participants spoke of, the participants were asked to change the names and identifying information as they spoke, and further information was redacted in the transcripts. To manage any disclosure of unethical practice, resources were prepared and offered to all research participants at the end of the interview, describing current best practice guidelines for appropriately working with gender diverse people.

Procedure

Immediately prior to the interview, each participant was asked to sign an online consent form as well as consenting verbally. Before the narrative interview began, the participants were reminded of issues of confidentiality for both themselves, and the clients they were about to discuss. Participants were invited to choose pseudonyms for both themselves and their clients to protect anonymity. The interviews ranged from 30 to 60 minutes in length. After the narrative interview had finished, all participants were offered the latest guidelines around working with gender diverse people in mental health care settings from the British Psychological Society (BPS), and World Professional Association for Transgender Health (WPATH). Field notes and reflections were made during and after each interview by the lead author.

The analysis was informed by Constructionist Narrative Analysis (Esin et al., 2014), which attends to the complexities of how people story their experiences: not just what is said, but with attention to how and to whom, attending to different social and historical contexts. Early stages of analysis identified thematic narrative content in each account (Wells, 2011), such as stories of conflict with colleagues, or stories of the team being ill-equipped to support a gender diverse person, which were developed through multiple readings. Further reading then attended to and noted positioning (Harre & van Langenhove, 1999), such as how each participant positioned themselves in their stories, in relation to their clients, and their work context. The analysis also noted *when* participants positioned themselves in certain ways (e.g. as ‘professional’, ‘knowledgeable’ or ‘inexperienced’) – both in relation to narrative content (e.g. stories of first experiences working with gender diverse clients) and in relation to the local context of the interview (Wells, 2011; e.g. presenting the self as ‘professional’ at the start of the interview). Finally, analysis attended to historical and social contexts that could be discerned in talk (Esin et al., 2014), including organisational and professional contexts, broader social and political discourses, and how participants positioned themselves in relation to these (e.g. positioning themselves in line with or in opposition to medicalised discourses of trans identities).

Following this multi-layered analysis of individual accounts, the analysis drew together patterns of convergence (and divergence, or resistance) of wider narratives *across* interviews, with additional attention to the different ways in which positioning, local, social, and historical contexts were drawn on. Of the wider narratives (e.g. separating different parts of a person, standing up to higher powers), narratives of ‘feeling inadequately skilled’ are considered in more detail in this paper, as it highlights an area of particular clinical importance, a barrier to gender diverse people accessing adequate mental health care, as well as identifying an area for improvement.

In keeping with the constructionist approach (Esin et al., 2014) which acknowledges the inevitable influence of researchers in co-constructing narratives and their analysis, authors engaged reflexively with the work throughout the project (e.g. using journal entries, engaging in reflexive conversations with the research team, and others) to develop ideas and to consider the impact of personal motivations and social positions (e.g. in relation to gender, professional experience and other social ‘GRACES’; Burnham, 2018) in project conception, development, data construction, analysis and writing; highlighting possible ‘blindspots’ and alternative understandings which could then be considered. This careful data collection and analysis also contributes to analytic rigour (Tracy, 2010).

Analysis

The analysis below describes a subsection of the findings from a larger study exploring the narratives of mental health professionals who have supported gender diverse adults. In this article, participants’ narratives of feeling inadequately skilled are explored in detail.

Locating narratives of feeling inadequately skilled in colleagues

In the narrative interview, opportunities were opened up for participants to reflect on their own skills and confidence, as well as those of their colleagues. In their stories, many participants drew on and/or resisted narratives of feeling inadequately skilled when working with gender diverse clients. Towards the start of his interview, Dan told a generalised story about his experiences of his colleagues:

Dan: There’s been a lot of hesitation from my colleagues initially . . . who just don’t know how to work with this population, and taking that perspective that that there is something inherently different about trans or gender non-conforming young people, and feeling very deskilled and not able to kind of work with them, that kind of feeling that their more generalist skills don’t fit, or won’t be good enough . . . I think the main one I tend to notice is when a trans person is referred to us, very quickly it’s a “[Dan] can assess them”. It’s a sense that “oh I don’t know this, so I couldn’t possibly”, so to immediately pass on to psychology, or myself as the local gender expert.

In his talk, Dan explicitly speaks to the narrative of feeling inadequately skilled, drawing on ideas of clinicians' feeling that their skills aren't good enough to work with this population. He uses the word "deskilled" – a term commonly used across healthcare settings, to describe a clinician's experience of their skills not proving adequate to a particular situation, new client group, or new and unfamiliar setting (e.g. Alonso, 2000; Billings et al., 2021). Dan positions his colleagues as feeling inadequately skilled, and by describing himself as the "local gender expert", he positions himself as the person *with* the skills. Dan also talks of his colleagues seeing gender diverse people as "inherently different", and this being a potential reason for them feeling inadequately skilled, which is reminiscent of discourses which ascribe an innate pathology to queer identities (Pearce, 2018).

Jenny also drew on narratives of colleagues feeling inadequately skilled. To illustrate, she told a story of attending a training course unrelated to gender identity:

Jenny: I was talking to a bunch of really experienced clinicians who had a lot of knowledge about working with people, working therapeutically, and they just didn't have competence to apply what they already knew, to a new context.

She linked this to how clinicians might feel about working with gender diverse people:

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

Both Jenny and Dan draw on the idea that clinicians might struggle to see how their clinical skills can be applied when working with gender diverse adults, however Jenny challenges this, reminding clinicians that "they're still a person", implying that a person's gender status shouldn't be a barrier to clinicians using their general clinical skills.

These stories were also told in the organisational context of mental health services under financial pressure, with a focus on "turnover" (Jenny). Gender diverse clients might be referred from mental health services to other NHS services, or "signposted elsewhere" (William), in order to reduce waiting times for other patients. Later in his talk, Dan described the Gender Identity Clinic as a "magical clinical" where his colleagues believe other clinicians "should be doing all the digging". The existence of these specialist services may strengthen narratives of feeling inadequately skilled, and contribute to clinicians' difficulty in applying their general clinical skills, as they may see themselves as not having the specialist skills needed to support gender diverse individuals.

Locating narratives of feeling inadequately skilled in themselves

While Dan and Jenny more frequently ascribed feeling inadequately skilled to others (in contrast to their own more expert position), the other participants aligned with feeling inadequately skilled themselves, to a greater or lesser degree. Most of the participants seemed more open to describing their own difficulties in their stories once the interview had progressed, and we had built a rapport. This could also be seen as the speakers taking time to establish credibility as professionals in their narratives (e.g. Edwards & Potter, 1992; Labov, 2010), before telling stories of their own personal challenges or difficulties. Thus, positioning themselves as knowledgeable and thoughtful professionals, though with identified gaps, and understandable uncertainties in their professional repertoire.

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

Elena: I didn't- maybe I didn't have enough experiences at work to make me very, very confident. And I might not be never completely confident because it's just something that I can't relate to completely. I can empathise, and I can see it, and I can advocate for it, but it's not- it's very- it's different to me but- Well, I don't know! But then giving care is giving care. You know, if you're delivering care then it should be- it's the same but it's just the- you just worry for them ... I still get that little like anxiety alert, Oh God, I don't want them to get hurt or do this or do

that or whatever. And, even protecting them from like certain people in the team, you know, like those kind of things.

Elena's talk moves back-and-forward between positioning herself as feeling inadequately skilled if she "can't relate" to a person, and resisting this narrative, saying "but then giving care is giving care". This was then accompanied by an expression of risk and anxiety about gender diverse people on her (acute mental health male inpatient) ward coming to harm, saying "I don't want them to get hurt". She seemed to be speaking to the broader social context of victimisation of gender diverse people (e.g. Reisner et al., 2016), including from mental health staff (Ellis et al., 2015) which she said could also happen on her male acute ward. It seems that this anxiety about gender diverse clients coming to harm may also contribute to her lack of confidence, and feeling inadequately skilled.

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

Jane: So, limited experience, as I said, but I think the first one was very much- I made contact with the local specialist quite quickly to just say, "You know this is- these are my thoughts, what do you think? Am I doing the right thing?" Um, I was asking for supervision quite a lot because it was- it was outside of my experience really

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

Fears of getting it wrong

William drew on the narrative of feeling inadequately skilled when he was asked how he felt working with his gender diverse client:

William: I felt initially slightly, um, uncomfortable in the sense that, you know, I don't want to say the wrong thing, and I don't want to offend them, and I don't want to, um, I don't want to appear ignorant.

William describes initially feeling uncomfortable due to his fears of saying the "wrong thing", or offending his client. William also expressed concern about appearing "ignorant". Similar narratives of healthcare professionals experiencing a threat to their expertise and power when working with gender diverse individuals have been outlined in the qualitative study by Poteat et al. (2013). Towards the beginning of the interview, after mentioning that he'd had some training on gender identity which helped him have some confidence (potentially positioning himself as somewhat knowledgeable, and professionally trying to seek out new knowledge), William described some of the questions that he wrestled with when working with his client:

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

In his talk, William questions his role in exploring "surgery" with his client. As described above, prior to 2013, community mental health professionals had a significant role in assessing gender diverse individuals prior to making a referral to a Gender Identity Clinic (Pearce, 2018), and still have a role in approving some surgeries (World Professional Association for Transgender Health, 2012). This complicated and changing landscape of mental health professionals' role in gender diverse patients' pathways may have led to William's confusion about his role, and may further contribute to clinicians' experiences of feeling inadequately skilled. However, William's narrated worries about "surgery" could also be understood as an example of cisgender people's intrusive curiosity about

genital surgery, and gender diverse people's bodies, which is widespread in popular discourse, and medical communities (e.g. Carabez et al., 2016).

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

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

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

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

Both Anna and Jenny locate this fear of getting it wrong in other people, positioning themselves as people who are cognisant of this problem. They both gave these answers when asked what additional training might have been useful for their service, opening space for them to speak from a de-centred position, the service perspective, rather than an individual one. However, in these excerpts, both Anna and Jenny moved from speaking about "people" to speaking about "we" or "you", thus including everyone (and themselves) as having the fear of getting it wrong. This hesitancy and fear may be coming from a broader context of hesitancy when clinicians talk to clients they see as 'different' from them, for example, those of a different race or ethnicity. This has also been described as "the discrimination of the restraint in risk-taking" (Gunaratnam, 2007, as cited in Nolte, 2007), when people become overly careful not to offend, inhibiting the openness and curiosity they might offer to other clients (Nolte, 2007).

The participants may also be speaking to a fear of being *seen* as 'getting it wrong', when working with or talking about gender diverse individuals, and the potential fear of being judged personally or professionally, if they do 'get it wrong'. Poteat et al. (2013) describe how the lack of training around transgender topics can create uncertainty in healthcare providers, which disrupts the "traditional clinical relationship in which medical providers are expected to be a knowledgeable medical authority" (p. 25). Therefore, medical professionals may experience a professional dilemma around expressing 'not knowing' whilst also maintaining professional credibility (i.e. as someone who 'ought' to know), again leading to hesitancy when working with or talking about gender diverse individuals. This fear of being seen as 'getting it wrong' may be further exacerbated by the currently challenging and highly polarised political climate around transgender rights and healthcare in the UK, as clinicians may worry about how they will be seen if they do 'get it wrong'. Some professionals may be further concerned by examples of healthcare professionals being publicly criticised, or their professional reputations questioned, in the context of their work with gender diverse individuals, again contributing to clinicians' hesitancy, or fears of getting it wrong.

Thoughts on training

All participants were asked if they have accessed any specific training for working with gender diverse individuals, and what additional training, education or resources they felt they might need. Many of the participants spoke of directly challenging the narrative of feeling inadequately skilled, with "proper training" to "just get the facts right" (Elena), covering "the basics" (Dan), and information about gender diverse people's "lived experience" (Linda). The participants may have understood there to be some "facts" and truths about working with gender diverse people, which mental health professionals should be educated in.

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

Language

All the participants drew on medicalised language in their stories, to describe their organisations, operating procedures, and pathways, or to describe their clients' difficulties, diagnoses or treatment. Most of the participants also seemed to use a 'case presentation' style of talking when introducing their clients, and the care they were provided. This may have been due to the shared tacit knowledges and specialist vocabularies available to both the participants and interviewer, as mental health professionals (Wells, 2011), or perhaps as a way for the participants to establish credibility in their narratives (Edwards & Potter, 1992; Labov, 2010), by using 'expert' terminology.

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

Although some participants used dated or gender essentialist language at times (assuming gender is dependent on the sex assigned to a person at birth; Serano, 2007) such as "cross-dressing", or "a man living as a woman", most participants spoke from a constructionist (e.g. Eliason & Schope, 2007) and affirmative (e.g. Keo-Meier & Ehrensaft, 2018) perspective when talking about their clients, respecting their identified genders, and recognising the impact of social contexts on their clients' gender possibilities (Pearce, 2018). Gender critical ideas (e.g. Brunskell-Evans & Moore, 2019) such as questioning whether one should accept a person's gender identity, came up rarely, and were mostly resisted in the participants' narratives. One participant wrestled between critical and affirmative perspectives when trying to understand their client's distress. This is a similar picture to that found in the research literature, that clinicians generally describe affirmative practices, with good intentions (Kawano et al., 2018), and tend to have positive attitudes towards gender diverse clients (Kanamori & Cornelius-White, 2017), as opposed to constructing gender diversity as pathological, immoral, or unnatural. However, gender critical perspectives on gender diversity are re-emerging in the literature, and mainstream culture (e.g. Brunskell-Evans & Moore, 2019), painting a more complex picture of narratives for clinicians to draw on when understanding their clients' experiences.

Discussion

The participants in this study expressed different positions in relation to the narrative of feeling inadequately skilled. Some participants spoke of the narrative explicitly, locating this 'feeling' in other clinicians, and challenging the narrative, saying that clinicians *do* have the skills to support gender diverse individuals. Other participants moved between aligning with feeling inadequately skilled, and challenging this narrative, whereas others aligned with feeling inadequately skilled throughout their talk. Several participants began their interview taking more of a de-centred position, reflecting on, or criticising the actions of their colleagues, before later moving on to reflecting on their own skills, confidence, and decisions, perhaps once they had established credibility in their narrative (Edwards & Potter, 1992; Labov, 2010), or felt safe opening up to a stranger.

Narratives of healthcare professionals feeling inadequately skilled when working with gender diverse people are prevalent in the literature. One of the physicians in Snelgrove et al.'s (2012)

qualitative study into physician-side barriers to providing trans healthcare was quoted as saying that they “didn’t know where to go or who to talk to” (p. 4), which became a centralising theory of the research. Similarly, in Poteat et al.’s (2013) study, most of the healthcare providers mentioned feeling “ambivalent about or unprepared for transgender patients” (p. 26).

Looking at mental healthcare specifically, O’Hara et al. (2013) reported that all the counsellors in their study “initially felt incompetent to work with transgender people because of their lack of exposure and knowledge” (p. 246). Similarly, Rutter et al. (2010) described how two student counsellors in their study “felt worried that they did not know enough information to help the clients” (p. 73). Therefore, the findings from the current study seem in line with the research literature. However, the current study goes further by exploring how mental health professionals position themselves and their abilities when working with gender diverse individuals, and the influence of fears of getting it wrong on clinical practice.

Despite the prevalence of narratives of feeling inadequately skilled in healthcare settings, particularly when working with gender diverse people, some participants challenged this narrative. They argued that clinicians should be able to apply their general clinical skills when working with gender diverse people, and clinicians’ fear, hesitation, or assumption of “inherent difference” are the problem. This could also be described as “the discrimination of the restraint in risk-taking” (Gunaratnam, 2007, as cited in Nolte, 2007) where an individual’s fear of offending inhibits their openness and curiosity with clients. In addition, Poteat et al. (2013) suggest that due to their uncertainty, healthcare providers’ might then stigmatise and discriminate against gender diverse patients, to regain their medical authority and power in the clinician-patient relationship.

Several studies investigating mental health professionals’ experiences supporting gender diverse adults assess clinicians’ ‘competence’, preparedness or ‘knowledge’ for working with this population (e.g. Johnson & Federman, 2014; Lutz, 2013; Riggs & Bartholomaeus, 2016a, 2016b). In these studies, the clinicians’ ‘competence’ is assessed against certain criteria and knowledge. Several of the participants in this study echoed this idea, saying that there are certain ‘facts’ clinicians need to know in order to provide care for gender diverse clients. Salpietro et al. (2019) termed this ‘essential knowledge’, such as awareness of gender concepts and transitioning. However, the participants in the current study also mentioned the importance of having space to have ‘open conversations’ without the fear of being judged or ‘getting it wrong’, when developing skills to provide care for gender diverse clients. This had not been captured in the literature previously.

Implications for clinical practice

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

Limitations

The interviewer’s position as a mental health professional, conducting research with the hope of improving mental healthcare for gender diverse individuals, is likely to influence the stories told by

participants. This position was also made clear in the recruitment materials, which may have attracted people who also have a particular interest in improving mental healthcare for this population. Participants and stories from a more gender critical perspective could be obtained by using more neutral recruitment material, and explicitly mentioning to participants that all perspectives were welcome.

As in previous studies in this area, most of the participants were white, heterosexual, and female. However, this reflects the demographics of mental health professionals in the UK (NHS Digital, 2020). Although it is somewhat expected that the sample would represent these proportions, the research is limited by the paucity of narratives from people outside these demographics. The research would also have been made richer by including narratives of clinicians with diverse gender identities. This also would have avoided the separation of 'trans people' and 'clinicians', which is commonly seen in research into trans healthcare (Richards et al., 2014).

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

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

Further research

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

Additional ideas for further research come from the findings of the research itself, outlining some recommendations for training mental health professionals supporting gender diverse clients. It may be useful to conduct research which explores the helpfulness of training which provides the space for open discussion, as well as the 'essential knowledge' (Salpietro et al., 2019) for working with gender diversity.

Conclusions

Narratives of feeling inadequately skilled have been drawn on and resisted in the stories told by the participants in this study. Some participants mostly located the feelings of being inadequately skilled in their colleagues, whereas others spoke of their own feelings of uncertainty in working with gender diverse clients. Some participants moved between positioning themselves as inadequately skilled, and challenging this narrative, whereas others challenged it throughout their stories, firmly saying that clinicians *do* have the skills to work with gender diverse people. The participants' accounts also describe how mental health professionals' fears of getting it wrong when working with gender

diverse individuals may impact on their clinical work. All participants gave suggestions for improving training for mental health professionals, drawing on both education about 'the facts', as well as opening space for discussion. Although participants often used medicalised, gender essentialist or dated language at times, they mostly spoke from a respectful position, with good intentions and a concern for supporting their clients in the most helpful way. It is important that training for mental health professionals supporting gender diverse adults is improved, for professionals to feel more adequately skilled when supporting their clients, particularly given the high rates of mental health difficulties within this population, and the long waiting times to access gender identity clinics.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Data availability statement

The authors confirm that the data supporting the findings of this study are available within the article, and the original doctoral dissertation: Canvin, L. (2020). Narratives of Mental Health Professionals Supporting Trans, Gender Diverse and Gender Questioning Adults. Doctoral dissertation, University of Hertfordshire (<https://uhra.herts.ac.uk/handle/2299/23422>).

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