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Transgender Individuals' Thoughts and Experiences Regarding the Transition Process: An Interpretative Phenomenological Analysis

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Abstract

This study utilizes Interpretative Phenomenological Analysis (IPA) to gain an in-depth understanding of transgender individuals' transition experiences and thoughts regarding the diagnostic classification of *Gender Dysphoria* issued by the Diagnostic and Statistical Manual of Mental Disorders (DSM) and *Transsexualism* issued by the International Classification of Diseases (ICD). The study focused upon the experiences and perceptions of six transgender individuals who have had their transition process in Sweden. The diagnostic criteria for Gender Dysphoria and Transsexualism are subject to change depending on the country where they are used, nevertheless most countries follow the guidance of the ICD and the DSM. There is an empirical gap in literature related to transgender individual's thoughts and experiences related to the ICD and DSM diagnostic classifications. Thus, the main purpose of the research is to find out how transgender individuals perceive the diagnostic classification and the transition process they are going through. Following an IPA, the results revealed 11 superordinate themes within 4 master themes: (a) negative feelings due to the process; (b) needs; (c) negative thoughts regarding the diagnosis; (d) negative psychiatric experiences. After analyzing the six participants' accounts, this study suggests that the DSM and ICD diagnostic categories of Gender Dysphoria and Transsexualism, as well as their experience of transition, were evaluated by the participants in predominantly negative terms. How these findings address gaps in the literature are discussed. Finally, recommendations for the future research and clinical implications are presented.

Keywords: gender dysphoria; transsexualism; transgender; transition process; DSM; ICD

Introduction

In social psychology the concept of gender is significant in the way of assessing individual's social status. American Psychological Association defines gender as "socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for boys and men or girls and women" (APA, n.d.). Yet, this definition is insufficient in the way of describing genders only in two binary categorizations. A person can identify their gender as male or female; as neither male nor female; as both male and female; or dispute the idea that only two genders exist (Richards et al., 2016). The participants in the current study are transgender individuals. Transgender is an umbrella term which is defined by the American Psychological Association as "persons whose gender identity, gender expression or behavior does not conform to that typically associated with the sex to which they were assigned at birth" (APA, n.d.). Furthermore it is defined as follows:

People who were assigned female, but identify and live as male and alter or wish to alter their bodies through medical intervention to more closely resemble their gender identity are known as transmen (also known as female-to-male or FTM). Conversely, people who were assigned male, but identify and live as female and alter or wish to alter their bodies through medical intervention to more closely resemble their gender identity are known as transwomen (also known as male-to-female or MTF). Some individuals who transition from one gender to another prefer to be referred to as a man or a woman, rather than as transgender (APA, n.d., "What does transgender mean?" para. 1).

Current Clinical Definitions

The Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, APA, 2013) is published by the American Psychiatric Association and is used worldwide as method for defining mental health disorders. The DSM first recognized transgender individuals within the category of *Gender Identity Disorder* in 1980. In 2013, DSM-5 changed the name and definition to *Gender Dysphoria*. The disorder comes under the section of "Gender Dysphoria" which includes classifications of "Gender Dysphoria in Children", "Gender Dysphoria in Adolescents and Adults", "Other Specified Gender Dysphoria", and "Unspecified Gender Dysphoria." (APA, 2013). The current study will draw on the definition of the secondly stated classification. The criteria of the *Gender Dysphoria in Adolescents and Adults* are as follows:

Gender Dysphoria in Adolescents and Adults 302.85 (F64.1)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. (DSM-5; APA, 2013, pp. 451-453)

On the other hand, the 10th Edition of the International Classification of Diseases (ICD) is the international standard for reporting all diseases and health conditions, not just mental health, and is published by the World Health Organization (WHO, 2016). The ICD-10 classifies transgender identities with a code of "Transsexualism" under the section of "Gender identity disorders" which is a sub-section of the "Disorders of adult personality and behavior." *Transsexualism* is defined as follows:

A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex (WHO, 2016).

The diagnostic classifications published in the DSM-5 and ICD-10 are consistent with each other. The codes that have been listed in the DSM-5 have ICD codes (APA, 2017). The DSM-5 is a tool that represents diagnostic criteria which are corresponding ICD-10 codes. Whereas the ICD provides a listing of disease names and their corresponding codes (ibid.). For some people, it is inappropriate to diagnose and in turn pathologize transgender identities (Butler, 2015). So then the diagnostic classifications of the transgender identities are asked to be eliminated (APA, 2017). On the other hand, for some, the existence of the diagnosis is essential in the way of accessing to the medical care (APA, 2017). That is to say, the pathological condition is considered beneficiary in the way of providing financial support for the transition process. On the other hand, those who stand against the pathologization argues that transgender people pay the price for establishing their gender identities (Butler, 2015). The latter argument questions if gender variant people “distressed by their condition, and if so, what is the source of their distress? Or do they become distressed when they are told that they cannot be what they are sure they are? Or are they distressed because of the social ostracism they must endure?” (Mallon & DeCrescenzo, 2006, pp.226).

Rationale for Undertaking the Research Project

The definition of gender dysphoria includes the following statement: “The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA, 2013 pp. 451-453). This definition is questionable in terms of its use the term “distress.” The main issue here is that the potential source of the distress is not specified in this definition. According to the minority stress theory, sexual and gender minority populations experience chronic stress due to discrimination and prejudice in societies which leads marginalized individuals to experience emotional and behavioral issues (Meyer, 2003). When the dichotomy of pro-pathologization and anti-pathologization arguments are read with the minority stress theory, the question, then, arises: what is the source of transgender individuals’ distress? Bartlett, Vasey, and Bukowski (2000) conducted a cross-cultural and historical series of longitudinal case studies about the association between the sense of discomfort of the biological sex and the diagnostic category of Gender Identity Disorder (GID) in children. According to the findings, only a minority of the children diagnosed with GID were found to have a sense of discomfort with their biological sex. The overall data suggests that gender nonconformity cannot

be interpreted as an inherent dysfunction or disorder. Rather it is argued that the main reason of the experienced distress in children was resulted from a conflict between self and societal expectations (Bartlett et al., 2000). That is to say, the diagnosis was found to derive from a conflict between the individual and the society rather than from individual's own mental health. In this regard, when the distress of transgender individuals is read with the minority stress theory (Meyer, 2003) it becomes reasonable to argue that the source of distress that transgender individuals experience are stigma, prejudice, and discrimination.

Considering the definition of gender dysphoria, the question then arises why stigmatized, prejudiced and discriminated subjects are classified in the DSM-5 and ICD-10? If discriminated subjects are not inherently stressed, rather experience stress as a result of society's expectations, then what is the rationale of pathologizing transgender individuals and why is the diagnostic classification a precondition for legal gender recognition? However, the current research is not aiming to find answers for these questions, rather it focuses on how pathologizing impacts transgender individuals' well-being. The findings of the study conducted by Bartlett et al. (2000) suggests further research on how diagnostic classifications influence self-identified transgender adults' well-being.

The growing number of studies on the diagnostic classifications will facilitate an enclosing evaluations on whether the diagnostic categories should appear in the future editions of the DSM/ICD. Therefore the main motivation of the current study is to investigate whether maintaining the very diagnosis is favorable in terms of the psychological well-being of transgender people. The current research aims to examine transgender individual's thoughts about the two diagnostic classifications and their own psychotherapeutic experiences, the latter being a main component of the transition process in Sweden. According to the regulations, transgender people in Sweden can apply for the hormone therapy and sex change surgery within the public health care system but only with a referral from a local psychiatric clinic and only after the person has undergone several psychiatric assessments (Johansson et al, 2010).

Aim of the Research

According to the Swedish laws, legal gender change can only be obtained with the permission of the National Board of Health and Welfare (Olsson & Möller, 2003). In January 2017, Sweden's National Board of Health and Welfare announced that Sweden will stop applying

the “gender dysphoria” diagnosis to transgender people in connection with a decision made by the World Health Organization which offers removing the diagnosis of *transsexualism* from the mental health section of its diagnostic guide (“The Local,” 2017). Yet, the ICD-11 beta draft (WHO, 2016) which is not yet approved by the WHO and expected to be published in 2018 proposes a new section as “conditions related to sexual health.” Differently from the previous edition, it suggests a new coding for transgender identities called “gender incongruence” which is defined as “a marked and persistent incongruence between an individual’s experienced gender and the assigned sex. Gender variant behavior and preferences alone are not a basis for assigning the diagnoses in this group.” (ibid.). Even though the definition of the diagnosis was suggested to be changed, transgender identities will remain to be pathologized unless the WHO decides to drop it completely from the ICD-11.

The existing research has focused on general psychotherapeutic experiences of transgender individuals, however very few of those studies focused on psychotherapeutic experiences specifically during their transition process. Even though the findings of the previous research demonstrate transgender individuals’ thoughts on the diagnostic classifications, none of those studies focused on this phenomenon to a large extent. Moreover there is a research gap in the Swedish literature related to the perceptions of transgender people on the diagnostic classifications. The purpose of the current study is to fill in the existing research literature and to contribute with a more comprehensive view at what the diagnostic classification of transgender identities means to transgender individuals along with their psychotherapeutic experiences. The main purpose of this study is to investigate the following research questions:

- How do transgender individuals think about *gender dysphoria* and *transsexualism* which are issued as diagnostic classifications by the DSM and the ICD?
- How do these diagnostic classifications affect individuals’ psychological well-being?
- How do transgender individuals experience the transition process?
- How do transgender individuals experience therapeutic meetings throughout their transitioning process?

Literature Review

The research topic on transgender individuals’ psychotherapeutic experiences has recently started to be investigated. The following review of the psychology literature discusses self-

identified transgender individuals' psychotherapy experiences and their thoughts regarding the diagnostic classifications issued by the DSM and the ICD. Even though a considerable number of psychological research has been investigated lesbian, gay, bisexual and transgender populations from various aspects, there is limited research which addresses transgender individuals' experiences and thoughts regarding psychotherapeutic services and the diagnostic classifications (Benson, 2013; Bess and Stabb, 2009; Elder 2016; Rachlin, 2002). Given the fact that psychotherapy is a precondition for legal gender recognition (Lev, 2005) it is critical to evaluate previous literature concerning transgender individuals' evaluations on these issues in order to gain a clear understanding of the subject.

Transgender individuals' psychotherapy experiences

Elder (2016) conducted a qualitative study related to transgender individuals' experiences in psychotherapy. Results of the semi-structured interviews with 10 participants shows various outcomes. One of the prominent findings includes a participant's declaration that their psychiatrist did not know what transgender means. On the other hand some participants reported that therapy had made them feel worse about themselves. Besides, one participant declared that they got very ill due to psychiatrists' attempt to cure the patient's gender diversity for 10 years. Another study conducted by Bess and Stabb (2009) reveals both positive and negative experiences of transgender individuals with their therapists. In this study, the participants' accounts were described by two themes as "supportive and affirming relationships" and "less positive experiences." The most important, one of the main reasons of the negative experiences was attributed to the therapists' lack of knowledge on gender diversity. Furthermore, therapists may assume that transgender clients seek therapy only for addressing their gender identity, yet it is not always the case. Benson (2013) conducted a research in which experiences of transgender clients in therapy was investigated. The results of the interviews with seven self-identified transgender individuals represented that transgender clients are tend to be viewed through the narrow lens of gender identity disorder by the psychiatrists. Similar with the findings in Elder's (2016) study, participants stated that therapists were not well-informed about transgender issues.

In addition to qualitative studies, several quantitative studies were conducted related to the phenomenon. Rachlin (2002) conducted a quantitative research in which transgender individuals' experiences in psychotherapy were investigated. According to the survey results, transgender

individuals reported that their therapists were flexible in treatments and respectful for the patient's gender identity when they did seek help for gender-related concerns. Moreover, a considerable number of participants reported that psychotherapy led positive change in their lives. Similar with aforementioned studies above this study also found that the participants had negative experiences in therapy resulted from the lack of knowledge regarding up-to-date transgender issues. Likewise, a phenomenological study conducted by Scarpella (2010) found that all participants in the study declared the need for more educated and trained therapists. Besides, participants were found to express their negative experiences resulted from the fear of possibility that therapists may reject their referrals for the needed medical care. In another research, Jokić-Begić, Korajlija and Jurin (2014) found that participants experienced negative feelings due to the lack of understanding of health professionals.

Johansson, Sundbom, Hojerback and Bodlund (2010) conducted a longitudinal research in which transgender individuals' satisfaction with the process of sex reassignment was evaluated. Differently from the previous research, this study evaluated not only transgender individuals' thoughts but also clinicians' evaluations. Results of the study showed that clinicians reported most transgender clients as globally improved, while some of them were reported as became worse at the end of the process. On the other hand, almost all transgender clients in the study reported positive evaluations regarding the outcomes of the transition process. Moreover they reported extreme satisfaction related to the sex reassignment process as a whole. Similar results had found in other quantitative research in which most of the participants reported positive evaluations related to their hormone therapy (Newfield, et al., 2006) and sex reassignment surgery results (Lawrence, 2003; Smith, et al., 2005; De Cuypere et al., 2005). In a more recent study, well-being and general health of transgender individuals living in Sweden was investigated. According to the results, negative self-rated health and low quality of life had found to be resulted from negative health care experiences including trans-incompetence and/or transphobia (Zeluf et al., 2016). Moreover, transgender individuals who had been living in Sweden between 1973 and 2003 were found that after going under sex reassignment surgery, they became having higher risks for mortality, suicidal behavior, and psychiatric morbidity than the general population (Dhejne et al., 2011). The frequency of the suicidal attempt among transgender individuals living in Sweden was previously reported in the literature (Landén, Wålinder & Lundström, 1998). The results of such studies raise the question of why this risk is higher among transgender individuals and what are the factors

make them attempt suicide. More research is needed to understand the reasons of suicidal thoughts. Accordingly, therapy sessions need to be evaluated in the way to develop more effective prevention of suicide attempts.

Transgender individuals' thoughts regarding the diagnosis

One of the most important outcomes of the research conducted by Elder (2016) is the declaration of three participants related to the psychology literature and the DSM. According to the participants, the psychology literature is biased, derogatory, or outdated and may be traumatizing; while the diagnosis in the DSM is considered as a main reason for being pointed by other people as those who have something wrong with them. Besides, Benson (2013) found that some transgender individuals visit a therapist solely for obtaining a therapist report which is a precondition for an access to the medical care and the transition process. One participant declared that it was annoying to convince somebody for writing a letter which would state that they were transgender. According to the study conducted by Bess and Stabb (2009), most participants were found as declaring their objection of the diagnostic labels issued by the DSM and the ICD. Moreover participants stated that they view their own transgender identities as one aspect of the human diversity rather than as a symptom of a disorder. It is worth noting that the participants stated that their therapists were also disagree with the pathologizing classifications, yet they have to use such classifications since it is required for the transition process. On the other hand Scarpella (2010) found that transgender participants were questioning the necessity of getting permission from a therapist in order to have a surgery. It seems this requirement, which is a pathological reference, is not taken for granted by all transgender individuals. Besides, the study suggests that misinformation of health professionals might cause trauma in transgender individuals lives (Scarpella, 2010).

Summary

According to the existing literature, transgender individuals' experiences range from dominant negative evaluations to modest positive evaluations. All studies has addressed the research question of psychotherapy experiences of transgender individuals and satisfaction between transgender individuals and their therapists. The previous studies share similarities with the current research in terms of the methods used. Some of the studies used semi-structured

interviews with 10 transgender-identified participants and were analyzed with a thematic analysis (Elder, 2016); some conducted a qualitative and heuristically based study in which the therapeutic alliance and satisfaction between seven transgender individuals and their therapists was explored (Bess and Stabb, 2009); moreover a feminist phenomenology with seven people who self-identify as transgender was conducted as well (Benson, 2013).

One of the quantitative studies conducted a survey in order to investigate psychotherapeutic experiences (Rachlin, 2002). One of the strengths of this quantitative study is that it consisted of a large number of samples which make the results generalizable across transgender individuals to explain the phenomenon. On the other hand, it lacks to investigate more details related to the responses of participants. For instance, in a study which conducted a phenomenological research provided detailed explanation regarding transgender individuals' experiences and thoughts regarding the transition process (Scarpella, 2010). This study consisted of a small number of participants, thus the results cannot be generalized to larger samples. On the other hand, according to Scarpella (2010) this study represents transgender individuals' voices and provides deeper understanding of the phenomenon. What's more, as previously aforementioned in this paper the bias of people in a given society was considered as a reason behind the negative feelings that transgender people experience. Nevertheless, it is evident that the language used in previous studies shows there is a bias in psychology literature as well. In one of the research the following statement was used: "The treatment for transsexualism is sex reassignment" (Dhejne et al., 2011). This statement is problematic in the way to refer transgender people as sick who need a treatment, also it implies that the treatment is possible only by the sex reassignment surgery. Moreover, it uses the statement of "persons with transsexualism" as if being transgender is not a gender identity rather it is a disease people live with it.

Another key fact to remember is that the updated terminology for people who would like to change their gender is *transgender* instead of *transsexual*. The term transgender is preferred to be used by LGBTI+ (lesbian, gay, bisexual, transgender, intersex, and any other marginalized gender identities/sexual orientations) organizations and also by individuals themselves in order to point the fact that gender expressions are heterogeneous, thus gender depends on the ways in which each person express masculinity and femininity. Moreover, a wish to change gender does not necessarily mean that a person wish to go under surgery, rather, as the word transgender represents an umbrella understanding, some transgender individuals do only prefer to change their pronouns,

and some of them would only like to use hormones. All things considered, biased language in the research literature have a huge potential to create stigmatizing perceptions among health professionals, counselors, psychologists and psychiatrists towards transgender individuals. Therefore there is need not only for a development of familiarity with the updated terminology in clinical settings, but also of a language in literature which would reflect the current terminology used to describe transgender individuals.

The Potential Contribution of the Current Study

Very few of the previous studies on transgender individuals' therapeutic experiences had conducted in Sweden (Landén, Wålinder & Lundström, 1998; Johansson et al., 2010; Dhejne et al., 2011; Zeluf et al. 2016). Moreover none of those studies investigated transgender individuals' thoughts regarding the diagnostic classifications issued by the DSM and the ICD. Even though the current research share similar research questions with the previous studies, the main difference of the present research is its nature that focuses on the procedures of the transition process. Moreover the significant research gap is not only in analyzing transgender individuals' experiences and thoughts, but also it is about the lack of cross-cultural investigation because most of the studies were conducted in America. Therefore, the current study aims to contribute to the literature by filling the gap in Swedish context.

Methodology

Qualitative Approach

A qualitative approach was chosen as the research method for this study. Qualitative approach has found coherent with the aim of this research which is to gain an in-depth understanding of the transgender individuals' experiences and thoughts. Qualitative methodologies are exploratory which provide insights into interpersonal issues, meaning, context and culture (Yardley, 2000). In this regard interpreting naturalistic verbal reports is the main concern in qualitative analysis (Smith, 2003). In qualitative studies small sample size is used in order to analyze the phenomenon in depth (Yardley, 2000). The most important, rather than predicting, describing and possibly explain events and experiences is the objective of qualitative research (Willig, 2008). Furthermore, qualitative research necessitates continuous analysis which actually allow researcher flexibility as the study progressed (Scarpella, 2010). Additional themes

emerge during the interviewing process, thus additional questions are formulated by the researcher (ibid.).

Smith (2003) points out the difference between qualitative and quantitative psychology by comparing the definitions of each approach. Accordingly, qualitative analysis is defined as an investigation of the constituent properties of an entity, while quantitative analysis is about investigating how much of the entity there is (Smith, 2003). Besides, qualitative methodologies are believed to provide new understandings in health and illness (Yardley, 2000). Qualitative psychology which is engaged with exploring the phenomenon is not homogenous; it has various approaches (Smith, 2000). Interpretive Phenomenological Analysis is one of those approaches which aims to explore personal and social world of the participant (ibid.). Further details concerning the Interpretive Phenomenological Analysis (IPA) are given in the following section. Furthermore, the rationale of conducting the IPA is described in the same section.

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) which was developed by Jonathan Smith had been conducted for the data analysis of the current study. Considering the fact that it draws on the accounts of a small number of people and five or six is suggested as a sample size by Smith and Osborn (2003), six participants had interviewed for the study. The Interpretative Phenomenological Analysis has found coherent with the research topic in terms of its aims. The study aims to involve the following elements (Smith, 2003):

- Detailed examination of the participant's lifeworld
- Attempts to explore personal experience
- Individual's personal perception
- Asking critical questions of the texts: i.e. 'what is the person trying to achieve here?'
- How individuals are perceiving the particular situations they are facing
- To say something in detail about the perceptions and understandings of the particular group
- Looking for themes
- Finding expressions
- Connecting the themes / cluster together

Overall, IPA was conducted in order to understand what a given experience was like (phenomenology) and how someone made sense of it (interpretation). It also aims to lead to see

things in a new light by encouraging an open-ended dialogue between the researcher and the participants. Besides, the IPA method is used in research which aims to analyze key life transitions (Smith, 1999). Thus, the current study is thought to be analyzed with IPA because it purposes to analyze the transition process of people who are identified as transgender and who had experiences the transition process in Sweden.

Data Collection

Data collection took place in May and June, 2017. Participants chose to have the interviews either in coffee shops or in libraries. All interviews took place in four cities in southern Sweden.

Interviews

Semi-structured interviews were selected to carry out for the research study in order to investigate participants' thoughts and experiences in depth. In semi-structural interviewing, understanding the meaning is the main point (Willig, 2008). That is to say, understanding what the interviewee meant is essential for the analysis (ibid.). Moreover, semi-structured interviews provides flexibility of coverage (Smith & Osborn, 2003) as well as detailed outcome from each participant (Scarpella, 2010). In the current study, interview questions were designed to encourage informants to express their thoughts and experiences freely. The interview schedule was structured into the following three sections:

- Participant's demographics
- Thoughts/experiences about the classification
- Therapy experiences

The demographic questions covered participants' gender identity, preferred pronoun and the duration of their transition processes. Interviews had been carried out in places chosen by the participants. All participants had been given informed consents before interviews were carried out.

Sampling and Selection

Participants was recruited through contacting with LGBTI+ organizations in Sweden. The informed consent forms were provided to people in the events and in meetings organized by those

groups. Informants contacted to the researcher by e-mail and the meeting for interviews was arranged. The two inclusion criteria for the participation were that they had to identify themselves as transgender and have passed through the transition process in Sweden. I did know none of the participants beforehand. All the persons who wanted to be in the study met with the inclusion criteria, therefore, they participated in the interview. Interviews had been held in different cities of Sweden with those who read and accept the informed consent form. Before starting the interviews, consent form was provided to the each participant. Participants were informed that they were invited to take part in this research because their experiences can contribute much to the understanding and knowledge of local health practices. The interviews were held in English and each took around one hour.

Participants

The term *transition process* technically refers to an enduring process. Considering the declaration of the participants that transgender people need to take hormones the whole life, “transition process” will be used in the current study for indicating the time period of each participant’s first and the final meetings with medical professionals. Participant 1 is a transgender woman who has been currently having her transition process since 2015. Participant 2 is a transgender woman who had her transition process in two years. Participant 3 is a transgender man who had his transition process in two years as well, while Participant 4 is a transgender woman who had the longest transition process among other participants which lasted eight years. Participant 5 is a transgender man who had it in three years. Finally Participant 6 is a transgender man whose process lasted four years. All participants are referred based on their preferred pronouns.

Data analysis

Interpretative Phenomenological Analysis was conducted for the data analysis. Accordingly, I transcribed each interview during the data analysis. After transcribing, I conducted coding with an aim to gain insights into the accounts of participants. Then I identified themes in the text by finding out similarities and differences of the accounts. The next step was to interpret the data.

Validity and Quality

Validity and quality are believed to have important roles in qualitative research (Smith, 2003). Yet for some, qualitative research loosely establish truths (Merrick, 1999). Qualitative researchers exhibit wide variation in the definition and criteria of the quality (ibid.). More importantly, an appropriate criteria must be chosen to evaluate the qualitative research study (Smith, 2003). According to Yardley (2000), truth and knowledge is not possibly established by the fixed criteria since the very both concepts are created by the communal construction and negotiation of meaning. That is to say, truth and knowledge cannot be defined as objective appraisals. For Yardley (2000), characteristics of a good qualitative research are comprised of (a) sensitivity to context, (b) commitment and rigour, (c) transparency and coherence, and (d) impact and importance. Each criteria has been applied to the current research and discussed further in the discussion section.

Ethical Considerations

An Ethics Committee at the Department of Psychology, Lund University, has corroborated that the present research protocol follows the research ethics guidelines established by Swedish authorities.

Informed Consent

Informed consent letter was consisted of information about the researcher, explanation of the study and confidentiality. Participants were informed that their participation was voluntary and they were not obliged to answer all questions. They were aware that the entire interview would be tape-recorded, but no-one would be identified by name on the tape. Also, participants were informed about confidentiality. They were aware that the information that had been collected would be kept private. The information recorded was confidential, and no one else would have access to the tapes. The transcription process would be entirely anonymized. Each file would be marked with anonymous codes and the all material would be kept strictly confidential. The audios and the transcriptions would be stored in a personal computer of the researcher and would not be shared with anyone else. Any information about them would have a number on it instead of their name. They were aware that only the researcher will know what their number is and the information would not be shared with or given to anyone except the researcher. The tapes would

be destroyed after this process. Also, participants were informed that each participant would receive a summary of the results.

Results

Table 1: Master themes and superordinate themes

Number of Participants with Themes	Master Themes	Superordinate Themes
6	Negative feelings due to the process	Isolation
		Stress
		Depression
		Frustration
6	Needs	Need for a change
		Need for an autonomy
	Negative Thoughts regarding the diagnosis	I am not ill
		It is stigmatizing
5	Negative Psychiatric experiences	Lack of knowledge
		Lack of experience
		Lack of empathy

Negative Feelings Due to the Process

This master theme aims to capture the idea that participants' transition processes resulted in having negative feelings; all participants experienced isolation, stress, depression, frustration and anger.

Isolation

Almost all participants in the study described their transition process as made them feel isolated from society. Participant 1 replied her sense of isolation as in the following interview quotation:

"I don't think people know about it. People don't know about this, like everyone I talked to. I do some lecturing, everyone I talked to who isn't super involved in this kind of thing have no idea. They shock of the lines and waiting time it takes and, because trans people are so invisible. I don't think it affects it, because they don't even know about this. We don't get space to express ourselves."

Participant 2 also described her sense of isolation at the work place she used to work. She also talked about the changing diagnostic classifications:

“I was a gay man, back then heterosexual people see us as ill. Then it had changed. When I started my process, I realized that I was ill again. And now they’re going to change it again in 2018 when it comes to putting it onto a psychiatric label. I feel like it would happen again during lifetime...I didn’t come out I felt through I just couldn’t keep it in me anymore. I had quit my job.”

Participant 3, who started their transitioning 12 years ago, referred these period as a rough time, and explained his sense of isolation at the school. He gave details about the support he got. Besides he compared past and present in terms of the existence of a community he could get help from:

“At that time it was quite hard to cope actually since I wasn’t out at school. I had one friend who was cisgender but he was gay so I could talk to him. I had support from my family. But there wasn’t really a community I could go to. There was an internet community but it wasn’t that strong at all as it is today.”

It seems that Participant 3 refers lgbti+ as an umbrella term for people who share similar experiences. This was reflected in his comment stated above, *“I had one friend who was cisgender but he was gay...”* Here, connecting the two expressions with the conjunction of “but” gives us a clue that the participant highlights the need of being understood to be able to avoid of isolation. The understanding, for the participant, seems possible/easier among lgbti+ people. This is also reflected in his following comment regarding the psychiatrists he met during his process:

“...it is obvious that they lack the experience of being trans themselves.”

Participant 4 gave a great deal of descriptive information regarding how the transition process results in making transgender people isolated:

“You get kind of isolated through the process because it is hard for trans people to get jobs. If you have a job, the meeting take place regular days mid-day and if you have a

job it really hard to hang on to it. Because you need to leave and travel kind of long distances, kind of often. So you risk losing your job if you actually have a job. So it's isolating us."

Participant 5's account of himself reflects how he felt isolated due to the failure of his need to talk to a psychiatrist during the process in which he started to take hormones:

"When I started hormones I tried to contact her but had removed her job, and they haven't hired the new one so, I was quite lonely and exposed and therefore in the beginning of the process."

Stress

Some of the participants associated their transition process with the feeling of stress. Participant 2 described how stressful the process was for her. Accordingly, she expressed that support from her husband and leaving her job made her coping with the stress.

"I was miserable person. I also had high stress level. I had quit my job which of course diminish my stress a lot. My husband, my gay husband had stayed with me which made me so much stronger."

Participant 4 presented criticism towards the very process. She attributed her stress to the miscommunication between herself and the doctors.

"I was really stressful to not know any dates whether anything should be decided or whether the process will be over or don't get any feedback from the doctors, what do you think, how do you feel about that and never get anything back... During my transition I felt really really stressed and I got the point that I couldn't function."

Participant 6 was more likely not to criticize the process yet he implied that he got affected by the process:

"I'm not blaming my transition but it plays a part in it but I haven't able to work for 3 years and when I tried to work I can only 25 percent because... I was stress related, tired all the time."

Depression

Two participants described their experience of depression as it stemmed from the waiting period of the transition process. Participant 1's account suggested that the transition process did not make her feel good, rather it worsened the depression she already experienced:

“Waiting so much time worse my depression.”

She mused for a while, even though she seemed uncertain as to what is the real reason of her depression, she gave an account of the negative effect upon her of the diagnosis she was subjected to:

“But also, almost, maybe, even because of the diagnosis itself or the criteria they put.”

Participant 4 described how isolated she was since she couldn't go out of her house during the transition process:

“I couldn't go out. I couldn't pay my bills, I couldn't function. Because I was so depressed. And finally I got evicted from where I lived because I couldn't pay.”

When asked what made her feel so depressed, she implied that she has not been considered as a person who can decide by herself, rather the medical authorities do it for you:

“When you're not considered a person who can decide things you feel very alienated. I felt really really bad I was really depressed, then when I got the decision and then the permission from the authorities I felt a lot better and then just had to wait until the surgery. Long way but I felt much better.”

Frustration

Similar with Participant 4, Participant 3 gave an account related to his negative feeling resulted from the waiting time within the process:

“I was extremely frustrated and extremely angry and waiting for their final judgement and approval”

Differently from the transition process, Participant 5 described how he feels frustrated when he encounters with people who have negative attitudes toward transgender people:

“People who think negatively about transgenderism and think that it is sick and unnatural and it shouldn’t be allowed to exist, that’s hurting people. And that’s what making the feeling of frustrating to see those opinions and beliefs anything able to do about it.”

Participant 6’s account was more similar to Participant 5’s in the sense that he seemed get frustrated concerning society’s attitudes:

“I feel very frustrated and invisible. That feeling of being invisible... They don’t know, even if they don’t have bad intention they don’t know that my particular gender exists. It’s a bit strange because it’s a big part of me.”

Needs

This master theme addresses participants’ accounts of expressing themselves as in a need of change regarding the transition process in Sweden. Also, a need for an autonomous decision making was represented by all participants.

Need for a change

All participants commented upon having trouble with at least one regulation within the whole procedure of the transition process. Participant 1 talked about the problem of queues which makes transgender people to wait for a long period of time in order to start their transitioning:

“I think the problem is the availability of it. If the trans health care would work, health care rules say it should, and queues work reasonable and this kind of things, the diagnosis wouldn’t be the problem.”

For Participant 2, psychiatric diagnosis is not necessary. She implies that a change is needed since it is not about a mental issue:

“It doesn’t have to be a psychiatric diagnosis. Maybe some kind of physical diagnosis instead. There has to be some kind of deciding point but not psychiatric. Because I don’t feel I’m mentally disturbed. Some kind of gate you have to go through within the health care system.”

As Participant 1, Participant 3 talked about the need for a change of a long waiting time of the transition process:

“If the investigation was quicker and took shorter amount of time, it could really help people and transitioning faster and safer. The issue is how long you have to wait”

Similar with the Participant 2, Participant 3 talked about the need for a change of a diagnosis from psychological to physical:

“I think in general they should be a positive attitude towards helping people and it should be more regarded as a physical problem so that you can get health in physically transitioning once you decided with right help and support that you want to. But it definitely shouldn’t be built up this way as a test/testing your gender identity. They can choose not to approve your transition which could have a potentially a deadly outcome for lot of people.”

Participant 3 also gave an account related to the diagnosis and accordingly commented upon the transition process which is, for him, needs to be changed by considering the individual differences:

“I don’t see it as necessary for everyone, I think it is very individual and I think the medical system should also needs to be changed so it suits every individual since everyone is like, not everyone enter this process. They’re at the same stage and their own process. Some are sure, some has just recently found out. So it is sad that everyone should have to wait for the same amount of time.”

Participant 4 expressed her need for a change with this sentence:

“I think they need to really revise the Swedish trans care.”

She also gave a great deal of descriptive information about the transition process in Sweden. The content in her description suggests that she is feeling a lack of fairness, thus it seems she is in need of a change which would bring equal and well-organized transition process:

“We have a law from 1974 that states we should get an (psychological) investigation. There’s nowhere anyone said how that should be done. It’s up to the

doctor. And I think there are 6-7 centers in different parts of Sweden. And those centers doesn't make the same judgements and they don't follow the same procedures. That's not how it supposed to be. You have to have the same medical aid wherever you live in Sweden I think. You shouldn't be denied servicing in Lund and get it in Stockholm, the same kind of person. I'm really against that. Because in some parts you get the hair removal just for the face, in some places you get hair removal everywhere if you need it. And in some places you can't get any, you have to pay that yourself and that's not fair."

Participant 4's account of herself was the most defensive of transgender rights:

"I feel like, I really can't stay out the ... it needs to be fair. I can't just shout up out the things that are unfair. And human rights... Trans rights are human rights in my point of view. And I always fights for it, and fight for everyone who's depressed and feels bad about the process"

She also gave an account regarding the dilemma between psychological treatment and physical treatment:

"I want it (diagnosis) to be removed totally. In Sweden we're now in a process of changing it from a mental disease to a physical disease, and that is so weird. To not say we're mentally ill but to say we're physically ill?! It doesn't really change anything I think"

Participant 6 described his need for a change regarding the physical examination he was subjected to:

"My doctor was ok most of the time but he wanted to make a physical examination which today I refused to do, because he was like checking my tits and is like ok, this can't be possibly necessary as part of a physical examination! It's part of the process I guess but he could have done it much better or just skipped that particular body part cause he didn't make me feel better! I tell you I felt much worse during that particular examination."

He felt discomfort during the physical examination, thus he gave more account related to this issue. For him, it would be better if the physical examination would be done by someone else who wouldn't be the same person whom he shared his personal information with:

“Also because we talked a lot about personal stuff I was not comfortable having physical examination done by somebody, I also, I would like to separate it in 2 so I can have something for myself, you knew me too. I think, if you know everything about my psychiatric I don't want them to see me naked as well.”

Need for an autonomy

This theme aims to address the participants' sense of a need for an autonomous decision making about their gender. This theme is represented by the all participants. Within Participant 1's account there was a very powerful theme addressing the defense mechanism she experienced when talking with the psychiatrists. Her expression highlights a communication issue between a client and a therapist:

“I didn't feel I can be honest with them. Because they're the ones who decided... I prefer not to tell about everything when I felt worse.”

Participant 2 talked about the gender binary. Then she described how her views about her own gender identity evolved by time. Her account reflects the autonomous decision on the way of describing her gender. Rather than let the binary gender system to place her within a specific category, she seems to have her own definition:

“If you're born a boy you're hundred percent man. I think the views on this has changed. It is not like define as either man or woman, but you could also be somewhere on the scale of binary gender system. That is a change. I am now I should put it I am now happily confused about my gender identity whereas before I was so frustrated if you say I'm a man I didn't want to be a man. Now I feel I, my identity is a woman but it doesn't mean that I have rejected everything that I felt of being a gay man. So happily confused is perhaps the best thing for me.”

Participant 3's perception on gender identity was similar with Participant 2. His account was about the clash between the idea of his non-binary gender identity and the doctors' expectations which were about the gender binary:

"For me as masculine person, there was this idea that I should go to the gym for my physical ability, to get more muscles... the expectations that I should be into those kind of activities, rather than activities that I actually enjoy like theatre, writing, being with friends and being an activist."

Participant 4's account was overwhelmingly that doctors have the power to decide about one's body:

"We can't make decisions about our lives, ourselves. We have to ask doctors first to get a diagnosis. Then we have to ask the state to do what we want to do and it's kind of weird actually. I got very very angry."

Her account suggested that she was engaging in a great deal of anger due to the lack of autonomy on her own body:

"If a doctor and me think my left arm is bad for me and want to remove it they can just do that. But if I need to do something with my genitals me and my doctor together thinks that's the best way but then we have to make this process with the investigation and council. But not if you need to get your arm. So weird. Genitals are special parts of the body that the state have some kind of interest in keeping in kind of natural states. So weird."

Similar with Participant 2 and 3, Participant 5 seemed to have an idea that his gender identity does not have to fit into the gender-binary system:

"... she was very supportive when I said do you have to be 100% male to identify as male she said of course not."

Similar with Participant 1, Participant 6 implied how he used defense mechanism in the therapeutic environment in order to protect his gender identity. He described how he presented himself to the psychiatrist for convincing him that he is "man" enough:

“You’re just a confused little girl. He could have said that. He probably wouldn’t have said that because of the way I presented. And it’s a way for me to protect myself. So I’m good at protecting myself.”

He seemed he see himself lucky in comparison with other transgender people since he knew how to behave and present himself to the psychiatrist:

“But the person who isn’t good at protecting themselves might not know how to present male, convincing enough.”

Then he admitted that he was not reflecting his real self while presenting the male image to the doctor. His account suggested that he did not behave in an autonomous way since he had to protect himself from humiliation. He also compared himself with other transgender patients who does not fit into masculine ideals yet being seen by him as healthier than himself:

“And that person would probably healthier than me because this person is being himself but would encounter problems, because of not convincing enough presentation. But I’m a control freak, as I said I had a partner who is a drag king instructor who can teach me all the details to make sure I will not be humiliated in this guy’s office.”

Negative thoughts regarding the diagnosis

This master theme addresses participants’ accounts of expressing the diagnostic classification in a negative way. The theme was represented by five of the six participants but was a strong one. Participant 6 was the one whose account did not include this theme. For participant 6, the diagnosis is an inevitable step for the transition process to start, therefore it is not problematic:

“I don’t have a problem with it. Not in any way. For me personally I don’t care if I have a psychological diagnosis, because, well... it’s ok if this is used for the time being as a psychological problem. It really doesn’t matter to me. So you need to have a diagnosis of some kind otherwise it’s not a disease and if it’s not a disease there will be no treatment.”

I am not ill

Participant 2's account of herself suggested that she rejects the diagnostic classifications which label transgender people as ill in the medical area. She emphasized the label of "human being" as opposed to medical definitions of transgender identities:

"I of course don't feel I am ill. I only feel I'm a human being. From my point of view I want to remove it. We're not sick in any way. I don't want to keep it."

Participant 4's account of the diagnosis was the most pervasively negative. She stated:

"I think it (diagnosis) is problematic some ways. Because we are not sick. To have a diagnosis you need to have some problem physically or mentally. We don't have any. So I find it troublesome."

Then she compared transitioning with pregnancy:

"I think also pregnant women. That's not a diagnosis, that's just being a pregnant. And they're not denied any medical aid. Because on the assumption it's not a disease. So I think there's many things that it's not a diagnostic disease/sickness/illness that actually people get medical help for in Sweden today."

In a similar way, Participant 5 gave an account which was about a rejection of the diagnostic classifications:

"I don't think something is wrong with me this is just the way I am."

It is stigmatizing

Participant 1 highlighted the potential individual differences. Accordingly, she considered the potential negative effects of the diagnosis on personal identity. Besides, she compared herself with other transgender people and implied that not every person could get over it as she did:

"Bad in a way that it's still diagnosis in some way some people take it harder than the others. It didn't affect my identity so much but I can see that it affects others more."

Participant 3 spoke of his thoughts regarding the diagnostic classifications as having bad intentions towards transgender identities:

“They contribute to stereotypicalization of trans experiences, trans identities and also disqualify a lot of trans identities.”

When asked what kind of stereotypes it constructs, he replied as:

“Classification is so stigmatizing, it gives more validation to the idea of trans being a mental illness. I assume most people think trans people are mentally ill.”

Negative Psychiatric experiences

This master theme aims to address the participants’ psychiatric experiences, more specifically, their evaluations concerning the medical professionals they met during their transition process:

Lack of knowledge

Participant 1 gave an account as illustrated in the following quote, in which she is talking about insufficient knowledge of the medical professionals:

“Nonexistent knowledge. It’s not about being against it, it’s just not knowing anything at all.”

Even though he started his evaluation with positive words, Participant 5 stated his negative experience regarding the psychologists:

“Psychiatrists that I met there have been very well informed, do their job. But the psychologists did not specialize in that area, don’t have so much knowledge”

Participant 6 gave an account related to a doctor who has not updated his knowledge on gender issues:

“Some were good some were not good at all... one was, I spent most time with, he was ok in many ways but also very old fashion. It’s good he’s retired because the young generation will not agree with his ideas...”

He also described how some medical professionals made him feel bad:

“I met so many crazy people also. I mean people working with the mental health issues who have huge mental health issues themselves obviously and seeking a cure

and become professionals and they sit there and you feel like ‘oh I’m feeling very bad.’”

Lack of experience

Participant 3’s account on the evaluation of the medical professionals was the most striking in a way to make a point regarding being trans and highlighted the importance of the experience of being trans:

“It is obvious that they lack the experience of being trans themselves. All the information they could possibly have gotten at the time when they’re in school is old and today we know it’s wrong. This affects their attitudes in ways that destructive and negative”

Lack of empathy

According to Participant 2, it is not about having a lack of knowledge, instead it is a matter of care that they lack:

“I think they don’t give a shit. Of course they know information, if they work in a health care system they know”

Similar with the Participant 3, Participant 4’s account mainly suggested a need of an empathy and familiarity that would come from the doctors who work in the gender transitioning processes:

“(Doctors) are lack of empathy because they don’t personally know trans people, and there’s no one there work and there’s no one in the scientific society who makes this kind of psychological, there’s no one trans who does that. And that’s kind of weird/ you wouldn’t have someone making, taking care of everyone whose black, and everyone who does that is white. It would be really strange. Because they don’t have any experience about meeting the daily problems and so on.”

Discussion

The purpose of this study was to investigate transgender individuals’ perceptions of the diagnostic classifications and the transition process they are going through. The following

discussion will focus on evaluations of the findings, comparisons with previous research, significance of the study, limitations of the study and clinical implications.

Understanding the findings in relation to the research questions

One theme that emerged from all accounts was negative feelings due to the transition process. This was specifically associated with experiences of isolation, stress, depression, frustration and anger. Another notable finding evolved around the theme of two needs: need for a change and need for an autonomy. All participants implied that they have problems with at least one regulation of the transitioning process. Besides, everyone in the study declared their need of an autonomous decision making regarding their gender identity. Another theme emerged from almost all accounts was a negative evaluation of the diagnostic classifications. Participants expressed their negative thoughts with expressions of “I am not ill” and “It is stigmatizing.” The final theme was negative psychiatric experiences which was emerged from almost all accounts. Those experiences were consisted of the ideas that some health professionals have lack of knowledge and experience towards transgender issues and lack of empathy towards transgender individuals. The semi-structured interviews provided two-way communication in which insights into an issue was identified handily. The research questions were addressed not necessarily in order. This flexibility provided freedom for participants in the way to express their experiences readily in their own terms.

Comparisons with previous research

The current study presented similar results with previous studies conducted by Benson (2013), Bess and Stabb (2009), Elder (2016) and Rachlin (2002). The negative psychotherapeutic experiences including distress and depression which were attributed to the therapists’ lack of knowledge on gender diversity are consistent with the negative feelings of individuals described previously (Benson, 2013; Bess and Stabb, 2009; Elder 2016; Rachlin, 2002). The findings of the study are also related with the previous literature in the way of demonstrating transgender individuals’ accounts on diagnostic classifications. The participants’ accounts such as “of course don’t feel I am ill”; “we are not sick”; “I don’t think something is wrong with me”; “I only feel I’m a human being” and “this is just the way I am” are related to the accounts of participants in previous research where they stressed that their transgender identities are one aspect of the human

diversity rather than as a symptom of a disorder (Bess and Stab, 2009), and the diagnosis causes them to be perceived as they have a problem (Elder, 2016). Also, participants from previous studies shared similarities in terms of support from family members and friends (Jokić-Begić, Korajlija & Jurin, 2014).

In previous research, it was also found that transgender participants feel satisfied with their decision to undergo genital surgery (Jokić-Begić, Korajlija & Jurin, 2014) and with their surgical results (Johnson, 2001). Similarly, the present study demonstrates an account in which a participant declared her good feeling resulting from the permission of authorities. According to Participant 4, it was depressing to wait permission for hormones and surgery. She expressed this waiting time as “long” but at the end she said she felt “much better.” She was not the only one who criticized long lasting waiting time. Participant 1 emphasized negative effects of the long queues and according to Participant 3, shorter amount of waiting time would be more helpful for transgender individuals. In contrast, Jokić-Begić, Korajlija and Jurin (2014) found that lengthier process of transition made transgender individuals feel and adjust better to the transition process. This study was conducted in Croatia, where, according to the researcher, transgender individuals are not tolerated. Considering this, it could be argued that the outcome of the longer duration of gender transition is context dependent. Individuals might need more time to adjust the transitioning process in societies where being transgender is not tolerated. Further research is needed to illuminate the role of social context in regulations of the transition process.

On the other hand, an old research found that some transgender individuals avoid being honest towards their therapists and one of the reason behind it was the fear of not being able to receive a report which permits clients to start taking hormones (Walworth, 1997). Participants in the present study shared similar defense mechanisms when asked about their therapy experiences. For instance, Participant 1 stated that she was not honest with her therapist because they hold the power to decide whether transgender clients’ can start hormone therapy or go under the surgery. Similarly Participant 4’s account was a critic towards the therapists’ power in deciding the future of one’s body. She also expressed her anger of not being able to decide in an autonomous way. Also, Participant 6 admitted to use defense mechanism in order to convince his therapist that he is masculine enough. Thus, he presented himself as someone who did not reflect his real self. According to him, using this mechanism was not healthy for him but he had to use it in order to avoid any rejection from the therapist. In a quantitative research conducted by Rachlin, Green and

Lombardi (2008), it was found that most of the participants evaluated their medical care positively, while some of them reported that the provider's sensitivity was poor. This study was conducted among transgender individuals who attended to a gender conference. In this regard, the study has weakness in terms of its method of data collection, because the participants were consisted of those who were able to attend conferences with their openly transgender identities. At the same time, further research is needed to collect data of those who have visibility problems.

The current study is consisted of a small number of participants as is the case in all qualitative studies. This nature of the qualitative studies raise the question of *representativeness*. In contrast with quantitative studies, qualitative studies are not able to generalize their results to a larger population (Willig, 2008). Nevertheless, a given experience that emerges in a research has potentially reflects a universal phenomenon (Haug, 1987 in Willig, 2008). That is to say, themes that have identified in this study are available in Swedish society, therefore, as Kippax (1988) cited in Willig (2008), each experience is potentially generalizable. Furthermore, accumulative technique which is applied across cultures in the way to illuminate more generalized themes (Willig, 2008) was conducted in the current study. In this regard, the study represented the findings of both qualitative and quantitative studies which are related to the findings of the current study.

Significance of the study

The purpose of the study was to explore how transgender individuals perceive the transition process they go through and the diagnostic classifications issued by the DSM and the ICD. Such exploration is significant because there is a gap in understanding the needs and sensitivities of transgender individuals related to the transition process they go through. There are few studies focused on investigating transgender individuals' perceptions on procedures of the transition process which is consisted of the diagnostic classification and psychotherapeutic seasons. Nevertheless, sensitivities of transgender individuals continues to be underrepresented in the literature. For this reason, it is crucial to conduct research in which transgender individuals' experiences and needs are reflected. That way, wider understandings related to the phenomenon could be represented. Also, growing number of such studies is essential in the way to provide a guideline for psychologists and psychotherapists. Additionally, the findings of the current study provide a deeper understanding of the transgender individuals' thoughts and experiences by representing their own accounts related to the phenomenon. The findings also indicate that some

emerged themes share similarities with the previous literature. Therefore further research is needed to investigate whether the situation in other contexts are related with the existed findings. Moreover it would be interesting to take a deeper look at the effects of pathologizing on transgender individuals by conducting longitudinal research methods.

Validity

Sensitivity to context

This criteria comprises various elements. First of all, *the context of theory* refers to the sensitivity to the existing literature and theory. Discussing different perspectives is important in the way that it provides more profound and far-reaching analysis (Yardley 2000). This criteria is demonstrated in the *Literature Review* section. Secondly, sensitivity to the *socio-cultural setting of the study* refers to “the normative, ideological, historical, linguistic and socioeconomic influences on the beliefs, objectives, expectations and talk of all participants” (Yardley, 2000, p. 220). This criteria is demonstrated in the *Interviews* section.

Commitment and rigour

The criteria of commitment is about a degree of an engagement with the research topic. Yardley (2000) states that the prolonged engagement with the topic does not have to be as a researcher. In this regard, it is worth noting that I have been an activist of lgbti+ rights for more than six years. Lgbti+ is an abbreviation for lesbian, gay, bisexual, transgender and intersex. The plus refers to all other marginalized sexuality and gender identities. My aim of work on this topic is to make transgender individuals’ voices heard, because it is essential to approach this issue from the perspectives of transgender individuals themselves. The rationale for undertaking this research topic is described further under the subheading of *Rationale for Undertaking the Research Project*. Rigour refers to the completeness of the data collection and a comprehensive analysis, as well as the completeness of the interpretation which attends to the variation and complexity observed (Yardley, 2000). Further information regarding data collection, participants and data analysis are addressed under the section of *Methodology*.

Transparency and coherence

Transparency is also known as “reflexivity” which refers to a presentation of a detailed data collection process and the rules of coding the data. To put it in a different way, it is a discussion concerning how participants were recruited, what equipment was used and how such factors may have influenced the product of the research investigation (Yardley, 2000). Coherence is about the “fit between the research question and the philosophical perspective adopted” (Yardley, 2000, p. 222). Those information could be read in the *Methodology* section.

Impact and importance

This criteria reflects the usefulness of the study. The value of a research can be considered important only if it opens up new ways of understanding and if it provides the applications it was intended for (Yardley, 2000). This principle is discussed under the subheading of *Significance of the study* section.

Limitations of the Present Study

Interpretative phenomenological analysis suffer from several limitations including *the role of language, the suitability of accounts, and explanation versus description* (Willig, 2008). Before representing the discussion of each limitation, the overall weaknesses of the present study will be considered. First of all, the small number of participants characterize less generalizable results of the study. Nevertheless experiences that emerged in the current research are appreciated due to their potential nature of being generalizable (Kippax, 1988 in Willig, 2008). Another limitation is that my activist identity as an lgbti+ rights defender might affected not only the participants’ accounts but also my interpretation of those accounts. Therefore I did interviews with those whom I did not know beforehand in order to avoid bias. Furthermore, my long term inclusion in lgbti+ activism and my existed knowledge concerning transgender identities might influenced the questions I addressed. That is to say, my previous knowledge might resulted in reflecting inside perspective of the issue therefore I might miss addressing basic questions concerning the transgender identities.

The role of language

Language plays an essential role in phenomenological analysis since the very analysis is based on the validity of language, yet, language is argued as being a reflection of a particular

experience within a particular context instead of expressing the experience itself (Willig, 2008). That is to say, the words have a characteristic to reconstruct experience, thus, language is questionable in the way to understand how much it expresses the very experience itself. In the current study, participants expressed their experiences either in a library or in a coffee shop which might influence their word choice to verbalize a specific experience due to the fact that their subjective account had been experienced in a place and time which are quite different from the time and context of interviews being taken.

Suitability of accounts

This limitation is concerned with the question of how efficient language is to express rich texture of the experience for the analysis (Willig, 2008). In other words, participants' accounts are questionable in terms of their success in producing the experiences in words that would be suitable for an analysis. In the current study, interviews were prepared in English in the way of conducting an inclusive research which would also reflect non Swedish-speaking individuals' experiences with Swedish trans care. Therefore all the interviews were conducted in English, yet, the participants consisted merely of Swedish-speaking individuals. In this regard, the choice of preparing the questions in English might result in lack of efficiency in linguistic expression of the participants' experiences since they do not use their first language in their verbalizations.

Explanation versus description

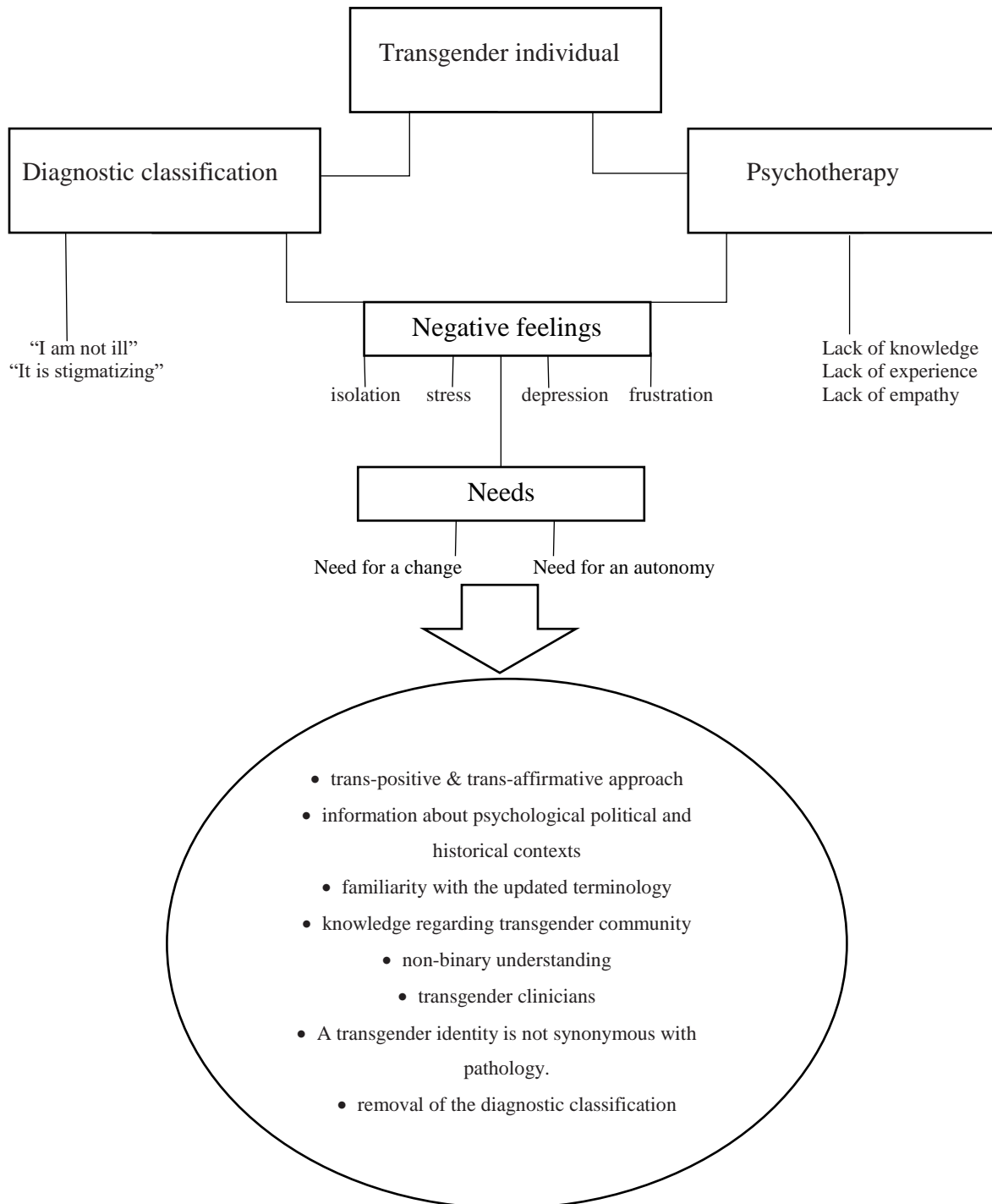
Another limitation is the failure of qualitative studies to explain the reasons behind the facts. Even though such studies provide rich descriptions, they do not explain those explanations (Willig, 2008). In the current study, each emergent theme had been described by participants and also the reasons behind the emergent feelings were represented. For instance, the feeling of depression was attributed to the transition process by the participants. Even though the current study focused on representing emergent themes, there are also explanatory facts behind such experiences. As Willig (2008) argues, qualitative research describes and possibly explains events and experiences. Nevertheless, such explanations encounter with the issue of generalizability.

Clinical implications

Considering the fact that transgender individuals reported negative thoughts towards the diagnostic classifications and psychotherapeutic sessions, this section aims to provide a guidance for the clinicians whose role have been reduced to provide medical treatment (Lev, 2005). Carroll, Gilroy and Ryan (2002) suggest that transgender consciousness could be achieved if the focus will be on transforming the cultural context rather than to transform the transgender clients. To put in a different way, the main purpose needs to focus on raising awareness of transgender issues, eliminating discrimination and stigma in cultures rather than to focus merely on changing transgender individuals' gender. Likewise, it is also important to evaluate to what extent the medicalization of transgender identities disempower transgender individuals (MacDonald, 1998). It is also important to acknowledge that transgender people may seek psychological help related to the other issues than gender identity (Meyer, 2001). Carroll, Gilroy and Ryan (2002) highlighted some clinical implications for clinicians including the needs in (a) trans-positive and trans-affirmative disposition which refers to advocating rights of transgender individuals and educating people in society; (b) gaining information not only about psychological context of transgender clients but also political and historical backgrounds of them; (c) familiarity with the updated terminology; (d) gaining knowledge related to support networks of transgender community. Aside from these suggestions additional progress could be made in the way to progress non-binary understanding in clinical settings which could help transgender individuals to not feel that they have to fit the male or female ideals. In other words, the view which defines gender identity in binary terms needs to be evolved in order to open possibilities for wider gender expressions that would provide individuals to feel more freedom and comfort with their gender performances. In this regard, clinicians need to acknowledge that gender cannot reduced to anatomical body. Accordingly, it is important for clinicians to adopt gender neutral language and also to attach importance to the preferred pronouns of transgender clients. Moreover, as it is found in the current study transgender individuals are criticizing the approaches of clinicians in terms of the lack of experience of being transgender themselves. In this regard, not only clinicians with transgender conscious but also transgender people themselves working as health professionals is a necessity. The most important, clinicians need to acknowledge that a transgender identity is not synonymous with pathology (Korell & Lorah, 2007) thus, removal of the diagnostic classifications needs to be considered importunately. In conclusion, the diagnostic classifications needs to be evolved by the

health authorities carefully with the consideration of the impact of societal expectations on gender identities.

Figure 1: This scheme aims to present the outcomes of the study and the summary of clinical implications.



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