Identifying Strategies that Trans and Non-Binary People Use in Response to the Barriers of Mental Health Care in Aotearoa/ New Zealand.

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Abstract

Trans and non-binary (TNB) people have significant mental health disparities in comparison to their cisgender peers. These disparities highlight an important need for research in Aotearoa in order to understand them and work towards their mitigation. General healthcare has received some attention within research, as has gender affirming mental health care, with a gap being identified in research on TNB people's access to general mental health care. The Counting Ourselves Aotearoa New Zealand Trans and Non-binary Health Survey is the only of its kind and the first survey in Aotearoa to have collated data on TNB health and wellbeing. This thesis questioned the strategies TNB people use to navigate the well-documented barriers to mental healthcare (MHC) in Aotearoa. To do so, data were sampled from the Counting Ourselves 2022 dataset, focusing on open-text box responses in relation to sections of the survey that asked about access to MHC services and providers. A qualitative, thematic analysis was completed, chosen due to its positioning of the researcher as a "subjective storyteller" sharing the rich meaning amongst the perspectives and experiences of participants. Guided also by the transformative framework chosen because of its focus on creating equitable outcomes for marginalised communities, transforming oppressive systems and recognising the resilience of the research participants. Control of Disclosure, Provider Selectivity, and For the Future were identified as themes of this study, explaining the overarching patterns of meaning found in the shared experiences of the survey's participants. In response to barriers, to the lack of competent providers, the long waitlists with the public health systems and the worries of gatekeeping or of being discriminated against, TNB people are creating pockets of reactive self-determination, autonomy and resilience for themselves. This involves TNB people; controlling disclosure and choosing not to tell MHC providers (MHCPs) everything about their gender unless they are confident that the provider is

competent and safe, being selective with providers and choosing to only access providers who are trans friendly, affirming, and knowledgeable, and in some situations, choosing to put up with the negative interaction, and challenge them 'for the future' aiming to leave the space better for the next TNB person to come. The identified strategies enable further understanding of what aspects of MHC access and MHCP interactions are creating negative experiences for TNB people. Control of disclosure identifies that the worry of, and actual experiences of uncomfortable, unknowledgeable or discriminatory provider reactions to the disclosure of gender identity is a negative experience leading to the development of strategically not disclosing gender to prevent and/or control the exposure to these negative experiences. Provider selectivity shows that experiencing long waitlists to MHC, as well as providers who are not competent in the provision of MHC for TNB people, is a negative experience and has created the need for strategic selectivity with provider access. By conceptualising negative experiences, we can then formulate that a positive experience would be a safe, appropriate, knowledgeable facilitation of and response to the disclosure of gender and increased provider accessibility and competency. This research builds on current understandings of MHC whilst offering a new angle of inquiry, focusing on the voices of TNB people and their shared experiences, and straying from the often-found discourse positioning providers as the experts on all topics. By doing so, it offers a tool for students and MHCPs to use to direct efforts when working towards equitable MHC access and provision for TNB individuals and the community.

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Table of Contents

Usage of terms

In this thesis, I will use the term trans and non-binary (TNB) to refer to all gender-diverse identities under these umbrella terms, to align with the terminology used in the Counting Ourselves survey (Yee et al, 2025). I recognise that this (or any) term can never encompass the diverse terms that people use to describe their gender and is not meant to minimise the diversity of gender identity. Transgender is a term used by white/English-speaking populations to describe the experience of living within a gender that is non-concordant with the sex you are assigned at birth, whilst cisgender is the term used to describe the experience of living within a gender that is concordant with the sex you are assigned at birth (Oliphant et al., 2018). Transgender identities may be binary-trans or non-binary trans, meaning people may identify as trans women, trans men, trans outside of the gender binary, or as just a man or woman. The term non-binary, specified alongside trans, is to acknowledge that some non-binary people do identify with the term trans and being within this umbrella terminology, but also some non-binary people do not identify with the term trans at all (Darwin, 2020). There are many ways that people may be non-binary (Oliphant et al., 2018), with the term generally meaning outside of the binary of gender, the gender binary being male/masculine and female/feminine. We now know that the gender binary is an incredibly reductive way of viewing the human experience of sex and gender, ignoring the experience of people born with variations of sex characteristics under the umbrella term intersex and simplifying gender down to an incorrect binary narrative.

Other terms often heard in Aotearoa New Zealand are Takatāpui, a Māori term originally used to describe gay and lesbian identities, meaning ‘intimate partner of the same sex’, now used in a similar way as LGBTQIA+ to describe diverse gender, sex and sexuality identities (Hamley et al., 2025). And fa’afafine, a Samoan term meaning ‘in the manner of a

woman'. In Samoan culture, Fa'afafine people are considered a third gender that describes individuals who were born assigned male at birth, but who have personal attributes and roles in the community that society would deem feminine (Kanemasu & Liki, 2021). There are countless terms within different cultures used for trans and non-binary identities, too many for me to list within this thesis, but all are equally important and unique. TNB is being used within this thesis for simplicity only, but I wish for this to be read thinking of all people who live outside of society's normative views of gender and of the gender binary. And for those who do not identify with any gender term, or who play with gender and find joy in the fluid, ever-changing possibilities of gender.

The terms gender queer (Richards et al., 2016) and gender diverse (Coleman et al., 2022) will also be used throughout this thesis to encompass the queering of gender and the diversity of gender identities beyond the binary. These terms act as an umbrella term in my thesis to include everyone. I use this interchangeably with the term TNB when I am discussing all non-cisgender people.

Cisnormativity and heteronormativity are terms that explain the sociological understanding that the society we live in currently functions under a normative view that everyone is cisgender and everyone is heterosexual. Because of this view, our systems are built for and function with the expectation of the 'normal' being cisgender and heterosexual. By positioning these identities as normal and privileged, any other identity is then consequentially treated as abnormal and othered, with systems not built to support or cater to them, which has led to systemic discrimination and barriers within care, education, employment, law and policy (Stallings et al., 2021; Boe et al., 2020; Utamsingh et al., 2016).

Introduction

I will begin this thesis with a review of the current literature on MHC and MHC access for TNB people, examining the history, current standards of care, and barriers to MHC in Aotearoa, New Zealand (hereafter Aotearoa). In this thesis, MHC will be discussed, including both non-gender-related MHC and gender-related/gender-affirming MHC. It is important to involve both forms of MHC access as TNB people seek access to care for non-gender-related mental health concerns, as well as hormone and surgery readiness assessments which are often conducted by MHCPs (Coventry et al., 2025). MHC providers (MHCPs) need to be continuously gender-affirming for TNB people to be able to show up as themselves and disclose safely any topic or concern that has led to seeking MHC (Oliphant et al., 2018; Kattari, 2021).

I want this thesis to be an ode to the strength, pride, continuing resistance and resilience of TNB individuals and the community when interfacing with often transphobic systems (Kattari, 2021). I will share the stories of the participants who shared their experiences in the Counting Ourselves 2022 survey with the hope that this thesis will reach people within the TNB community, education spaces, and the MHC system who can continue to add to the forward momentum of TNB people's access to positive MHC experiences in Aotearoa.

MHC Access for TNB people

MHC is defined by the American Psychological Association (APA) as "a category of healthcare service and delivery provided by several fields involved in psychological assessment and intervention (psychology, psychiatry, neurology, social work, etc)" (APA, n.d., para.1). To discuss current MHC access for TNB individuals, it is first necessary to acknowledge the history of MHC and psychology for the TNB community. MHC access,

psychiatry and psychology have a complex and contentious history with the TNB community (Tosh, 2016), with TNB people's experience with MHCPs commonly involving pathologisation of their gender and gatekeeping of gender affirming care (Kattari, 2021; Withey-Rila, 2021). The Diagnostic Statistical Manual of Mental Disorders (DSM) tracks the history of the pathologisation by MHCPs by how the clinical and societal understanding of gender has changed over time (Tosh, 2016). Tosh (2016) discussed the DSM as a glimpse into the societal context of periods of history, showing how behaviours and identities were classified as mental illnesses (e.g., homosexuality) and then declassified at a different time due to what was seen as 'normal' in society.

The current version of the DSM, the DSM-5, has updated the diagnosis previously known as gender identity disorder to gender dysphoria (American Psychiatric Association, 2013), reflecting a very recent shift in society's understanding and conceptualisation of gender diversity beyond a disorder diagnosis. Unlike the previous diagnosis, the criteria for gender dysphoria state that significant distress must be experienced for diagnosis, specifying that having a gender that differs from the sex assigned at birth is not, in and of itself, a disorder or mental health diagnosis (Kattari, 2021).

Schulz (2018) offered an alternative to the diagnosis of gender dysphoria, termed the Informed Consent Model of Transgender Care. This model critiqued the gender dysphoria diagnosis, highlighting a potential undervaluation in the DSM that the experience of distress is likely linked to society's response to gender diversity rather than an underlying psychological impairment. The informed consent model proposes TNB people's access to gender affirming health care, such as hormones and surgery, without requiring a referral and assessment from a MHCP. Within this model, referrals to MHCPs are an option but not a requirement and instead TNB people will be able to decide whether they are ready for gender

affirming health care treatment after being fully informed about the risks, side effects, benefits and possible consequences of gender affirming treatments, with the access to services being based primarily on the ability to consent to care rather than meeting criteria for the diagnosis of gender dysphoria. (Schulz, 2018).

Minority stress theory (Meyer, 1995, 2003), particularly gender minority stress theory (Hendricks & Testa, 2012; Testa et al., 2015), explains the presence of distress existing for TNB people due to society's responses to gender diversity. Minority stress theory posits that marginalised minority groups experience an increase in mental and physical health issues as well as the development of unique resilience and coping skills due to the regular experiences of stigma and prejudice. Gender minority stress theory, discussed in the context of TNB mental health, suggests that gender minority stress due to frequent experiences of stigma, discrimination, prejudice and violence is associated with depression, anxiety, non-suicidal self-injury and suicidality (Veale, 2023; Lefevor et al., 2019). This then offers an explanation for the mental health disparities between TNB people and their cisgendered peers, as an alternative to the historical pathologisation of transgender as a mental health disorder and cause of distress.

Despite the evidence that distress is likely a result of the frequent experiences mentioned above, the DSM diagnostic model roots internal personal distress as a core narrative of the experience of being transgender or non-binary. However, there is evidence suggesting that being transgender or non-binary is not necessarily a cause of distress itself, rather a valued life experience among TNB individuals who see being trans or non-binary as a way to live true to themselves, leading to life satisfaction and meaning (Schulz, 2018).

This is not to say that TNB people do not experience gender dysphoria or do not experience gender related distress, but more so to bring attention to the development in

understanding of TNB people's mental health that has happened in society and research within a very short period of time. A change that steps away from the pathologisation of TNB people's identities and brings forth different ways providers can work with TNB people. With hope of these changes continuing to move forward, there is a future of a system in Aotearoa where MHCP's and the MHC system can support TNB people with their mental health generally, as is their job, and when appropriate, support access to gender affirming care and the reduction of gender dysphoria when required.

Gatekeeping, as explained by Verbeek et al. (2022), is the process by which providers can delay or deny care to patients due to the strict application of readiness assessments and 'fitness' criteria for medical transition. Withey-Rila (2021) expands on this further, discussing that in Aotearoa, gatekeeping within the health care system is associated with a lack of shared decision making between patients and providers, with the providers having the capacity to make decisions for TNB patients, allowing the choice to decide to gatekeep and deny access to services. Currently, TNB people are still required to be diagnosed with gender dysphoria to be referred for gender affirming surgery in Aotearoa, under the public health gender affirming genital surgery service (GAgSS) (Te Whatu Ora, 2025). Working within the informed consent model would remove MHCPs from the role of gatekeepers and prioritise their role as collaborative partners in the decision-making process, using their professional expertise and knowledge to inform TNB individuals and equip them with the support and tools to make the best possible decision.

The pathologisation and gatekeeping that have been the norm of MHC for TNB people has led to negative experiences of distrust, discrimination, confrontation and feeling unsafe/being unsafe with MHCP's and the MHC system. Norris and Borneskog (2022), a Swedish integrative review, discuss the way in which negative experiences with health care

providers can predispose TNB people to feelings of fear, anxiety, and worry towards further interactions with health care providers, which can in turn affect the health-seeking behaviours of TNB people or cease health-seeking behaviours altogether. This fear can permeate TNB community spaces and create a sense of fear throughout the community, further reducing health-seeking behaviours. Flipping this idea, positive experiences can also flow into community spaces through individuals, leading to a positive impact on health-seeking behaviours and associated feelings about accessing care.

Current Standards of Care

The World Professional Association for Transgender Health (WPATH) has rejected a pathologising model of care (Kattari, 2021), and the 8th version of the standards of care (SOC), presents guidelines for MHCPs who provide MHC to TNB individuals (Coleman et al., 2022). The MHC chapter begins by importantly positioning the redirection from pathologisation, stating that transgender identity is not a mental illness, and that the higher prevalence of depression, anxiety and suicidality is linked to complex trauma, societal stigma, violence and discrimination. The chapter goes on to discuss that psychiatric symptoms can be lessened by access to gender affirming medical and surgical care, as well as with interventions that lessen experiences of discrimination and minority stress. The chapter highlights the need for mental health treatments to be delivered in ways that respect patient autonomy and recognise gender diversity. The recommendations are for MHCPs to use active listening to encourage exploration among individuals who are uncertain about their gender identity and to assist clients in determining their own paths. See Coleman et al. (2022) for further detailed information on the recommendations for MHC. It is important to note that the WPATH SOC are not a treatment requirement but is a recommendation for best practice for MHCPs working with TNB clients (Schulz, 2018).

Oliphant et al. (2018) provide a set of culturally contextual guidelines for gender-affirming health care, in addition to the WPATH SOC, in Aotearoa, grounded in Sir Mason Durie's *Te Whare Tapa Whā* model of health and well-being and the guiding principles of *Te Pae Māhutonga* (the Southern Cross). These guidelines provide culturally appropriate approaches to the provision of MHC for TNB people in Aotearoa. Te Whare Tapa Whā focuses on the equal importance and interconnectedness of taha whānau (family), taha hinengaro (mental health), taha wairua (spiritual health) and taha tinana (physical health) in a person's overall health and wellbeing. Chosen as the health framework for the guidelines with the intention to reposition mental health as an equally integral component for the balance of wellbeing and provision of holistic care (Durie, 1985).

The two guiding principles of Te Pae Māhutonga are: Te Mana Whakahaere, autonomy and Ngā Manukura, community leadership (Durie, 1999). Autonomy in the context of MHC means TNB individuals making informed choices about their care, free from barriers or pathologisation. Providers then practise the informed consent model as a vehicle for information, using their expertise to inform their patients and support them in decision-making. Community leadership in the context of MHC for the TNB community means that, for health promotion and the development of guidelines and MHC services to be effective, they must be led by trans community leadership. For MHCPs, this means collaborating with TNB community advisors and leaders, as well as following guidelines developed by the trans community to guide effective care.

Alongside the guidelines, it is essential to recognise and uphold the commitment and obligation to Te Tiriti o Waitangi (The Treaty of Waitangi) throughout health care services. Which for MHCPs looks like ensuring partnership, participation and protection with/of Māori

and Te Ao Māori, ensuring that health care services are available, accessible, acceptable and of quality to Māori.

There is a growing shift in recommendations for standards of care and guidelines for MHCPs to support in providing trans-affirmative, supportive MHC, as noted by Oliphant et al. (2018). However, although the shift in guidelines, TNB people are still reporting negative experiences with MHCPs and in MHC spaces (Ross et al., 2016), and Aotearoa research has found that many TNB people report feeling pressure to conform to a dominant narrative of what is expected from providers in fear of being denied adequate MHC if they are not 'trans' enough or are not experiencing 'enough' distress (Fraser et al., 2021).

Kattari (2021) and Oliphant et al. (2018) outline the key characteristics of provider and client interaction that have been identified as contributing to positive experiences, including welcoming environments, provider competency, trans-cultural awareness, therapeutic alliance, provider advocacy, and the use of correct pronouns and names. These key themes are noted throughout the literature, highlighting the importance of providers being competent to discuss TNB identities and topics whilst not reinforcing stigma, prejudice and discrimination that TNB people may experience in their day-to-day lives. Ross et al. (2016) found that when participants were asked to define a positive healthcare experience, they predominantly reported characteristics of providers. Specifically, a provider's knowledge of trans health and current happenings within the trans community, as well as respect shown by providers throughout the encounter. Similarly, Withey-Rila et al. (2024), in the context of primary healthcare in Aotearoa, found that participants defined a positive experience as including provider trans competency, providers as advocates for their patients, interfacing with other areas of healthcare, and basic professionalism (inclusive of kindness and compassion). For many TNB people, a MHCP may be the first person that they share

their gender identity to, making it imperative that the MHCP be equipped with appropriate sensitivity and knowledge enabling them to demonstrate and facilitate a positive example of disclosure for the client that they may then refer back to when disclosing their gender to people in their lives (Boroughs et al., 2015).

Barriers to MHC access

As this thesis will explore the strategies TNB people enact in response to barriers to accessing MHC, understanding these barriers is necessary. First, access, as defined by Romanelli and Hudson (2017), can be seen as a series of opportunities to identify healthcare needs, seek healthcare services, access healthcare resources, use healthcare services, and receive services appropriate to the presenting concern. Barriers, then, are anything that prevents, impedes, or complicates access.

Modern research suggests that many TNB people encounter significant barriers to MHC, existing and persisting due to the history of transphobic and pathologising beliefs held within systems able to influence access to MHC, such as legislators, lawmakers, politicians, scientists and educators. González Gutierrez (2024) found from the Counting Ourselves 2022 survey that the barriers to MHC access significantly experienced by TNB people in Aotearoa included the fear of providers: lack of knowledge, pathologisation, offensive attitudes and misgendering. Snow et al. (2019) conducted a systematic literature review of 8 international studies to identify obstacles and barriers faced by TNB people within MHC. Similarly, they found three major barriers: concerns about being stereotyped or pathologised; incompetent and unknowledgeable MHCPs; and cost and affordability. Echoed by others (Kattari et al., 2019; Kattari, 2021), these barriers either uniquely affect or are significantly amplified for the TNB community (Coventry et al., 2025). Kattari (2021) goes on to further elaborate that when TNB individuals have experiences with MHCPs that feel humiliating, stigma is

reinforced, and the effects of marginalisation can deepen, often resulting in disengagement with clinical services.

These barriers continue to make MHC a space that is inequitable for TNB people. Equitable access is further discussed by Henry (2025), who conceptualised the Tranz Liberation Framework in response to discourse in Aotearoa during the Posie Parker visit in 2023, noting that although there was overwhelming support for the trans community, this did not translate into improved conditions for the community. They offer three pillars: protection, access, and recognition to discuss the areas of material need for the TNB community to guide transformative action, and to clarify that TNB people will not experience equitable conditions (throughout systems and access) by acceptance and people protesting for trans rights alone. Although these pillars do not address MHC alone, they succinctly outline the collective goal when working in spaces that directly affect TNB people and where efforts should be focused.

The first pillar: protection, outlines that beyond the protection of the law as it currently stands in Aotearoa, there needs to be diversification and a reshaping of the current system, as laws alone have not ensured equal material conditions for TNB people. This means provisions and wider policies to facilitate equal access to housing, employment, social/health services and public spaces for TNB people. The second pillar, access, is focused on timely, safe, and affordable access to services and resources that enable TNB people to affirm their gender. Including: culturally safe, gender-affirming healthcare within the informed consent model, gender-affirming garments (such as binders and gaffs), and safe access to bathrooms. Henry (2025) supports that the informed consent model should be the norm throughout Aotearoa, and psychological assessments should not be required for access to gender affirming care, positioning patients as the experts of their care. Lastly, the pillar of recognition discusses both interpersonal and system-level recognition, in which TNB people

should be gendered correctly by others using their correct name and pronouns (including in forms and medical notes) without requiring the person to legally change their name or gender. The Tranz Liberation framework can be applied directly to the MHC system and offers a guide for the work that needs to be done in the MHC space, focused on these three pillars.

Research in Aotearoa

Currently, research specifically focusing on TNB people's access to, and experiences of MHC in Aotearoa is minimal. To date, Counting Ourselves has been the main study to research and collate data on this topic. Withey-Rila (2021) conducted research on contextualising positive experiences within primary care specifically and identified how TNB people create opportunities for autonomy within healthcare interactions. Although this research focused solely on primary healthcare, it also examined the strength and resilience of the TNB population and discussed strategies similar to those outlined in this thesis. González Guitierrez (2024) used the Counting Ourselves data to further conceptualise MHC access indicators for TNB people, focusing specifically on general MHC to close the literature gap identified by the prevalence of research on gender-affirming MHC. Although the framework guiding this research and the overall direction differed from this thesis, there was a focus on access to MHC and on the interaction between TNB people and MHCPs, highlighting the barriers in Aotearoa that align with this thesis.

Rationale for this thesis and research questions

There is a large amount of literature that documents the mental health disparities and disproportionate levels of discrimination that TNB people face compared to cisgender people, and a strong research space identifying the barriers TNB people face when accessing MHC.

A gap in the literature was evident, as there has been little focus on the ways TNB people navigate MHC through action and strategies. By exploring this further and understanding the strategies TNB people use in response to barriers, we can outline areas where efforts need to be prioritised when working towards an equitable, accessible and successful MHC system for TNB people.

I expect to identify useful strategies to address the barriers of the MHC system functioning as a form of resistance to the status quo. Based on the findings of international research such as Mousavi et al. (2025) and the national research of Withey-Rila et al. (2024) and Withey-Rila (2021) I expect to find a theme identifying the use of a strategy related to disclosure of gender details to MHCPs from participants, as well as, potentially a strategy relating to a high number of participants accessing private providers, due to the barriers of the public health system (González Guitierrez, 2024). It is also likely that participants will discuss the lack of provider competency, as this has been identified as a barrier in both international and national research.

In response to identified gaps in the current literature, the aim of this thesis was to answer the question, *What strategies are TNB people using when accessing MHC?* And by doing so, also provide examples of what a positive experience in MHC looks like and how to increase these positive experiences.

Method

Sample

For this thesis, I used data from the Counting Ourselves 2022 Aotearoa New Zealand Trans & Non-Binary Health Survey, Aotearoa's only comprehensive national survey of health and wellbeing for trans and non-binary people. This survey is repeated every four

years and has the eligibility criteria for people to take part who are trans or non-binary, aged 14 years or older and currently living in Aotearoa.

The 2022 survey included findings from TNB participants (N = 2,631) from all regions of Aotearoa, aged 14 to 86. The largest number of participants were aged 14-24 (53%), followed by 25-54 (43%) and 55-86 (4%). Compared to Aotearoa's general population, there was a higher proportion of Pākehā/ NZ European (77%), a similar proportion of Māori (14%) and a lower proportion of Asian (7%) and Pasifika (2%) participants. Counting Ourselves participants were asked what terms they use to best describe their gender, and were then asked to choose which would best describe their gender from the limited options of trans man, trans woman, or non-binary. Over half of the Counting Ourselves participants selected non-binary (56%), with an equal mix of participants selecting trans man and trans woman (both 22%) (Yee et al., 2025).

Participants for Counting Ourselves were recruited predominantly through posts made to social media, including Facebook, Instagram and YouTube (64%), followed by recruitment via word of mouth (31%), emails sent by organisations (9%), being told about the survey in person (8%), something else (7%), organisation website (6%) by flyer or print advertisement (5%) or lastly by being told by a health professional (2%). Trans, rainbow, takataapui, and MVPFAFF+ community organisations collaborated to promote the survey and help reach communities that might otherwise not have had access to survey recruitment. For example, older TNB people, people who lived rurally, people who had transitioned a long time ago, who were disabled or who were neurodivergent. The Counting Ourselves team monitored demographics throughout the data collection stage, prioritising outreach to under-represented groups.

Procedure

I selected open-text box questions from the Counting Ourselves survey that were likely to contain MHC access-related data, including open-text box answers from the gender-affirming care, care competency, general healthcare, and mental health sections. See the table below detailing the selected questions. Within these sections, questions were selected only if they directly inquired about MHC or followed from specific closed-choice questions that would prompt participants to respond about MHC access. For example, in section three, due to the focus of the section being gender affirming care, the open-text box questions predominantly ask about access to gender affirming health care treatment, such as hormones, surgery, fertility, voice therapy, and hair removal, yet there were also closed-choice questions that asked about access to counselling or psychological support. Because of this, I determined that the open-text boxes that followed these questions could prompt conversation about navigating MHC. The same process was followed when selecting the other questions.

Table 1

Details of Selected Questions

Survey Section	Question Description
Gender Affirming Care	You stated in the previous question that there were reasons why you haven't accessed health services that you would like. What are these other reasons?
Gender Affirming Care	You stated in the previous question that there were reasons why you haven't accessed the surgery that you would like. What are these other reasons?
Gender Affirming Care	Is there anything else you want to share about the Gender Affirming (Genital) Surgery Service or High Cost Treatment Pool?
Gender Affirming Care	* Is there anything else that you would like to share about your experiences of accessing gender affirming healthcare through the Aotearoa New Zealand public health system?
Care Competency	* Is there anything else you want to share about the level of support or respect you have received, as a trans or non-binary person accessing healthcare?

General Healthcare	* Is there anything else about your experiences accessing mental healthcare services that you would like to share with us?
Mental Health	Is there anything you would like to share about how your experiences as a trans or non-binary person are related to your mental health?

* Questions with data used in analysis

From here, I reviewed the selected questions and separated data related to MHC and my research question by identifying explicitly mentioned actions or strategies participants used when accessing MHC. Some instances involved participants talking about all their providers (e.g., GP, specialist, psychologist and endocrinologist) or using the term ‘providers’ in general, which I determined was still relevant to include. Of the seven questions I accessed, only three had relevant strategy data available.

Once responses that included strategies were filtered from the data, I spent time familiarising myself with the participants’ responses and noting the repetitive ideas and experiences discussed; these were mostly explicitly discussed by the participants, with little interpretation needed to infer implicit meaning. This familiarisation process included a lot of time for reflexivity for me, as the researcher, whilst reading the participants' experiences. Acknowledging the taonga (treasure) of participants’ words, figuring out a way to discuss what was shared without leaving out the participants' emotions, and creating a way to share findings that can be a part of the movement of change were priorities for me. After much discussion, a reflexive thematic analysis felt appropriate not only for me, as someone new to qualitative research, but also for the data's content. I developed my research design based on Braun and Clarke’s (2022) reflexive thematic analysis. Positioning me as a “subjective storyteller” with a focus on the experiential framework of thematic analysis, sharing the rich meaning amongst the perspectives and experiences of participants.

Next, multiple re-reads of participants' responses occurred beyond the familiarisation process into the coding stage. Since I was already familiar and immersed in the data, this stage was to continue reading slowly and repeatedly and to start actively pulling out the groups of ideas noted during familiarisation. I then sectioned them into my own groups, assigned code labels, and began forming and reforming themes.

During this time, I kept a reflexive journal, as recommended by Braun and Clarke (2022), as a tool for reflecting on my own identity, positions of privilege, and potential bias whilst engaging with participants' responses and writing this thesis. This meant that while I was reading the participants' responses, I would reflect on how they made me feel and any questions that came up for me, and I could then return to why I chose to do this thesis and why I was passionate about this research topic. Positioning my identity was important for the focus on subjectivity in qualitative research and for the belief that research cannot be value-neutral or disconnected from the researcher's identity. As a cisgender woman and Pākehā/NZ European, understanding and reflecting on the privileges of these identity groups, whilst also acknowledging my own connection to experiences of marginalisation and oppression as a woman and as a part of the queer community, was a constant process.

Guiding Framework

I was guided in my analysis by the transformative framework, chosen for its attention to inequities and power relationships, and its commitment to social justice and the transformation of systems of oppression. As Hurtado (2023) describes, the transformative paradigm, inspired by social movements, centres on the desire to create more equitable outcomes for marginalised communities. It is a research approach that critiques power relationships and aims to transform oppressive systems to emancipate individuals, enabling the researcher to challenge inequality and engage in social change. Researchers within this

paradigm respect the experiences of the community their research engages with and recognise the resilience, resistance and the forms of agency shown by the research participants. There is a focus on the intent to prioritise listening to voices that are often not prioritised and recognising that there are multiple lived realities and multiple truths to be captured. Researcher reflexivity within this paradigm is important, which felt well aligned with the reflexivity prioritised in the thematic analysis design of this research. Hurtado (2023) outlines that the method of data collection when working within the transformative paradigm should aim to capture the complexity of intersectionality as it emerges from participants, acknowledging the individual lived realities within marginalisation, privilege, and systems of oppression.

Consistent with the transformative paradigm, I approached this research with the intention of contributing to the social change needed to make MHC a safe, accessible, and inclusive space for all gender-diverse communities. The transformative framework's epistemology values participant knowledge, and in this thesis, I focused on the voices of the participants, positioning them as the experts of their gender over the more common "provider as expert" position within mental health research. To further align the transformative framework with the method of analysis, I stayed close to the data, with the analysis leaning more toward inductive and semantic approaches, driven by the content of the data and the explicit meanings of the words participants shared, without 'interrogating' underlying meanings that might be present. This was appropriate because the data were sampled from an already complete data set. I did not complete face-to-face interviews with the participants, so I did not get to explore their meaning further or go back to check that any interpretation was correct.

Findings

Three main themes emerged from the data, representing collections of meanings and strategies used by TNB people when interfacing with the MHC system. Before delving in, I would like to reiterate that the actions taken and strategies used by TNB people are necessary due to the barriers within Aotearoa's MHC system. I am exploring this from a strength-focused perspective, as there is already research in Aotearoa identifying and discussing the barriers to MHC (González Gutierrez, 2024). The experiences shared by participants in this section are clear examples of how the MHC system is failing and how TNB people are using reactive self-determination to create opportunities for autonomy in response to it. The way that I discuss strength, resilience and reactive self-determination is not to take away from the often disappointing, scary, and exhausting reality of accessing MHC.

Control of Disclosure

Control of Disclosure is the first theme and explores the decisions made by participants around disclosure of mental health or gender identity details in MHC spaces. The decision not to disclose is determined by a multitude of factors, often discomfort felt by the TNB person themselves, discomfort reflected by the provider, fear of potential discrimination or confrontation with the provider, or the worry that future access to care will be negatively affected. These anxieties and apprehensions do not come from nowhere; TNB people often share experiences and details of provider interactions with their friends and the wider community to warn of unsafe, discriminatory providers and affirming competent providers. This often equips TNB people with awareness and preparedness for the range of situations that may happen in MHC spaces. Non-disclosure, then, is used as a tool to control what a provider is privy to and, therefore, what may be witnessed in the provider's response to gender or mental health details.

I have split this theme into two subthemes, as I identified two distinct functions of non-disclosure described by participants. The first being prioritisation, a form of non-disclosure due to other mental health needs having to come first.

Prioritisation

TNB people, in some situations, are having to decide which part of their identity they show up to appointments with or without, based on what they are currently needing support with. By doing so, they are sacrificing discussing other parts of their identity, such as culture, race, sexuality, gender or mental health issues, out of the perceived or real threat that this may impact the care they are receiving.

> I don't want to disclose my gender to them (providers) as I fear it will get in the way of my other health concerns.
>
> I try not to let my psychologist into my trans health stuff because I don't think she would understand, and I feel some shame around it. And I already have other mental health things I need to prioritise because I can't afford to do more.

The above participants share that they have made the decision not to disclose that they are trans because they are aware, whether it be due to previous experiences, shared experiences from friends or the TNB community, or from signs given by the provider during interactions, that there is a chance that their access to care could change if they were to disclose their gender identity. In the second quote, the psychologist had not initiated any identity conversation from the beginning of the sessions and had not facilitated a space where this person felt able to explore their gender or their feelings of shame. By doing so, the psychologist left the responsibility for determining when/if to broach the topic of gender, as well as whether it is safe to do so, on the TNB client. In this example, it was determined that disclosure was not worth the risk for the participant, given the prioritisation of their other needs.

The use of the term ‘get in the way’ by the first participant creates a sense that they feel that by disclosing gender, the provider then may respond as if they have been blocked from discussing anything other than gender, removing the client’s ability to discuss non-gender-related topics. Due to the risk of this, and gender not being the presenting concern for this participant, they opt not to disclose gender to protect their ability to speak about their mental health concerns.

Omission

The second subtheme identified was omission, a form of non-disclosure that participants enacted to control the environment that they were in with MHCPs. Compared to the prioritisation subtheme, the reasons for the action of non-disclosure had a different purpose or intended outcome, centred on self-preservation, safety, simplicity, and avoidance of potential discrimination, rather than concerns that had to be prioritised.

> I never tell healthcare providers I am non-binary as I feel they would respect me less.
>
> I generally pretend I am not trans to make the whole thing (interacting with providers) easier.
>
> I tend to pretend to be a binary trans person when accessing healthcare for simplicity.
>
> I usually don’t disclose I’m trans with a doctor or therapist, it’s better to go in knowing how I’ll be treated than open up and have them mess it up or upset me.
>
> A lot of the time I don’t bother talking about my non-binary identity with health professionals, because although there are supportive practitioners out there it’s still a risk to bring it up. The risk I feel is less in outright hostility (although I am aware that happens) and more in that I’d have to educate them, which would be deeply tedious and a waste of my time.
>
> I do not disclose that I am non-binary to any healthcare professional because I am afraid of being mistreated, misgendered or refused care.
>
> It would be so good if medical places had things (posters, statements etc) that specifically made it clear that they were accepting of these things. I don't want to even bring it up in case the response is negative and impacts future healthcare in any way.

The word ‘pretend’ used by participants elicits a sense of concealment: participants arrive at an appointment and must conceal themselves, with the aim that this will lead to a simpler experience with a provider. Without this concealment or act of being someone other, the experience with the provider will likely be difficult, as discussed by the participant above: by not disclosing their gender, they know how a provider will treat them, while disclosure creates the risk of the unknown. Depending on the provider’s response, if negative, the experience will be “messed up”, or they will be upset by the provider’s response. This experience echoes throughout different minority communities. To watch a professional who is meant to provide care react negatively or awkwardly to details you are sharing is an extremely uncomfortable and scary position. The actual and potential experience of this contributes to why people opt to avoid accessing MHC, or, as I will discuss later in this section, opt to locate specifically trained providers to decrease the likelihood of this experience.

One participant noted that their decision to remain non-disclosing is primarily due to the risk of having to educate their provider and dedicate their own time during an appointment they have likely waited for and paid for, teaching the professional what their identity means and how to provide the correct care. If an appointment is then taken up by educating the provider, the presenting concern is unlikely to be explored, leaving the TNB person responsible for booking and funding further appointments, even though they could have accessed the care they needed in the initial appointment. The respect for resources or lack thereof is evident here, with responsibility for educating being that of the TNB person, rather than of the MHCP. This feels as though it speaks to the idea that a MHCP's time is more valuable as a resource than TNB persons’. Setting a precedent that TNB individuals are expected to educate the professional during the time they have waited for and funded, rather

than the professional spending their own time developing an understanding of gender and the standard of care for TNB clients. As the participant discussed, this is deeply tedious and a waste of their own time. Repeatedly defining who you are and what your care needs to look like is an exhausting process that in any other space would reflect negatively on the professional as being behind in their expertise and job expectations; however, for TNB people, this is too often the norm.

Provider Selectivity

The second theme, Provider Selectivity, explores the actions TNB people take before and during MHCP access to ensure they can obtain providers who can provide competent, adequate, and appropriate care. Actions identified within this theme predominantly require participants to access private MHC, enabling them to access care faster and make choices about their care, which would not be possible in public MHC. It is clear that this is not the goal of TNB people when needing MHC; private MHC is an expensive route to take, which is an inaccessible option for many people. This theme continues the discussion of the lack of trans competent providers, also highlighting how TNB people are navigating a public health system that is currently failing.

> I went the private route for a psychiatrist. It was expensive but I'd still be waiting for an appointment if I went through the public system.
>
> Timeframes to see psychiatrist after being referred by GP was so excessive I was forced to go private at high cost.
>
> Seeing a therapist (privately) is worth it, but so expensive.
>
> Having to go private sucks because it's expensive, but the alternative of waiting forever? not good.
>
> I have since gone private to get immediate help as the wait times in the public system is too long. Going private has been a lot better.

> As I am able to afford it, I am able to access ‘better’ care. A sad and unfair reality that money makes your access considerably better.
>
> Wish that it was available through the public service, as it took me years to afford it and find a good private provider with specialties and availability.
>
> I have to pay privately as I have never been able to get appropriate public health funded mental health care.

It is clear from the participants above that the inaccessibility of care through the public MHC system has been the determining factor in their decision to access care through the private system. Importantly, the way that this is described by the participants above expresses similar views towards this choice; this is not simply because they want private MHC, but rather that the wait times for public MHC are unpredictable and lengthy, and if able to get access at all, the care can then be inappropriate to the person's presenting concerns. The notion that private is the route to ‘better care’ is often heard across sectors of health care and is reflected here as a strategy TNB people use, when financially able, to access MHC.

> It was difficult to find a therapist with any experience with gender dysphoria and gender mental health issues, I had to change therapists and hunt around for a specialist.
>
> I researched, found and funded a visit to a specialist myself, and didn't involve anyone else. Partially shame, partially confusion, partially wanting to be sure I was referred to someone who wasn't transphobic and knew at least as much as I did about gender.
>
> I have been lucky enough to have the energy to look for people who would treat me well, and had good luck with a few public system referrals.
>
> Its been pretty good for the most part, mainly because I went out of my way to track down providers that would be supportive.
>
> I transitioned later in life and with a decent income that allows me to be selective about the healthcare providers I engage with.

> I specifically sought out a therapist who is LGBTQ and specializes in therapy for LGBTQ people.
>
> I specifically sought out a therapist who is a member of the rainbow community due to not wanting to have to educate a therapist about trans issues. Previous experiences with therapy had been very bad.
>
> I managed to find a Queer-friendly therapist, but it was a surprisingly difficult to find her and I had a two month wait until she was available because she was so busy. When searching for a therapist, I only found a few who clearly stated that they were LGBTQ+ friendly (and the others were not taking patients). That said, my therapist was fantastic and made me feel really comfortable.
>
> It's expensive - I pay for private therapy for a therapist that I know is polyamory and queer friendly.
>
> When searching for my private service provider, she specified that she was queer and ADHD friendly. This helped choose a provider
>
> I am careful with how I select my mental HCP's. I feel I have an advantage over others who need mental health care as I have been receiving some service on and off for 15 years and have a masters in psychology, which makes it easier to understand a provider's profile. I sometimes advise friends on how to select a provider that works for them.
>
> I paid to go privately. It took me 18 months to find someone who had the skills I needed and who could work with me. She was amazing but it was very expensive.
>
> I had to try multiple counsellors before I found the right ones for me and not everyone can afford this. The first counsellor I got through a rainbow community service provider was not trauma informed so I ended up stopping those sessions. Eventually I settled for two counsellors, a private trauma informed counsellor for PTSD and a different counsellor for gender affirmation from that same rainbow community service provider.

The participants above discuss other reasons for opting for private MHC, with a focus on the ability to select a provider. This selection process involves the provider's training, specialty skill areas and their publicly identified queer friendliness. This selectivity is not an option in the public health system, so when participants needed to prioritise this strategy to

access MHC, it often meant accessing expensive private MHC. Providers publicly listing their speciality areas of training, their experience and whether they are queer-friendly were identified as important indicators for TNB people when searching for MHCPs.

Queer friendliness is discussed by participants as the provider being a part of the LGBTQIA+ community themselves or having worked with the LGBTQIA+ community, and this is information that TNB people are explicitly seeking when searching for providers. As most people will use a search engine such as Google, it is necessary for the provider's experience and queer friendliness to be stated on the professional websites where the provider is listed. As discussed by a participant above, they only found a few providers with this information stated, and of those few, only one was taking on new patients. Being able to identify whether a provider is queer-friendly offers assurance that the TNB person will not have to educate the provider on their identity and will be safe to discuss gender topics with the provider, knowing competent care will be provided in response.

As discussed by the participants, being selective about providers uses personal resources, including time, money and mental effort. Therefore, people without these resources available will not be able to strategically search for and select a MHCP. As a strategy that involves resource availability, people without these resources must rely on public MHC referrals or emergency MHC, where provider choice is not an option.

The above participants also discuss discontinuing MHC and the choices made to stop MHC with a provider when the care provided is not adequate, or something happens during the appointment to demonstrate a lack of understanding about gender. This part of the strategy of being selective with providers is specifically about making the decision to continue or discontinue care, dependent on the level of care and the comfort factors present during the appointment with the provider. Identifying discrimination, lack of knowledge,

discomfort or bias and then choosing not see that provider again is a way of protecting wellbeing and staying safe. Although MHC may be important at that time, MHC from the wrong provider is not going to be beneficial, so the choice is made to discontinue and to search for someone else.

For the Future

The final theme, For the Future, includes the strategies TNB people use to navigate the MHC system, with the aim of creating a better future for TNB people. The motivation behind the strategies discussed in this theme are almost sacrificial in the sense that TNB people will put up with the aforementioned educating of providers, misgendering, worries of disclosing gender details, lack of provider competency and discomfort in an appointment due to a sense of duty to make an impact that will hopefully create change in MHC spaces for the next TNB people to come. This is discussed by participants in a way that positions these, albeit negative, experiences as having reasons, and these reasons as making the emotional toll of accessing MHC still just as uncomfortable and hard, but also purposeful.

> I am a very out, very proud trans person. I am very used to people demanding or needing explanations, and in terms of my own sense of self, I find it often irritating but also simply part of being trans at this moment in history, informing people is contributing to a movement bigger than myself, making it easier for everyone who comes afterwards, just as it has already been made easier for me. However, I ticked "uncomfortable" because in health settings, it angers me that I have to do it, it feels draining and unfair.

> Sometimes feel I have to let things slide and be the person to educate them so that the next trans person coming in there doesn't have to.

> I know that it's not because the clinicians or medical professionals I went to were very well versed in Queer health- it was purely because I am also a medical professional and I feel that I was able to use my knowledge and understanding of how to navigate

> the system to enable me to access what I could. I feel very privileged in that sense, and am working hard at making sure changes keep happening in all health spectrum to make all care for non-binary/trans people accessible, safe and affordable.

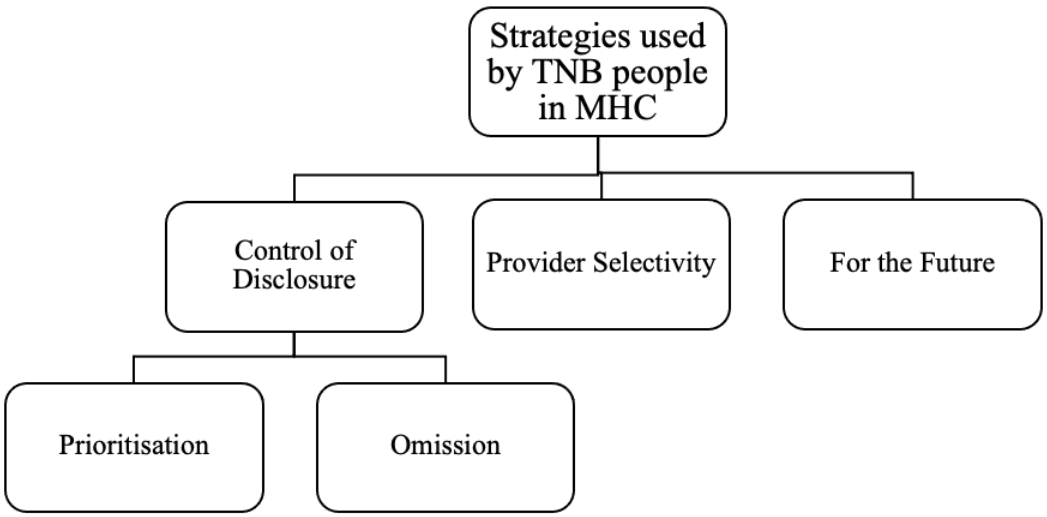
These participants' experiences demonstrate the work and active resistance being put in by the TNB community to challenge the status quo and push for a health care system that is accessible and works for TNB people. "Simply part of being trans at this moment in history", stated by the participant after explaining the irritating truth of people demanding or needing explanations of their gender identity, creates a reflection of the current political climate in western societies, and a reminder that the increase in right-wing, anti-trans discourse is now seeking to rewrite the recent progress of trans and queer communities. This statement, however, elicits hope that this is just where we, as a society, are in this moment of history, with the potential for the hard work to pay off and for the next moment in history to be easier, better, and safer for TNB people.

The wording chosen by the above participants: draining, unfair, irritating, let things slide and working hard, clearly positions that this strategy, and the truth of what advocating for your identity, quality of care and the future is not easy nor enjoyable. It means being headfirst in the discomfort of having to explain everything to professionals, to potentially expose yourself to discrimination, negative reactions and unsafe situations for those that come next. In the last quote, the participant discusses their education and knowledge as tools they can use to obtain what they need when accessing health care. They acknowledge the privilege that this is and that they are using this privilege of knowledge to make changes within the health care systems. We all take the tools in our personal toolboxes into the world with us, and, as this participant discusses, they are working hard with the tools of their knowledge whilst interacting with the MHC system to effect change for the future.

Whilst this theme was developed from a smaller pattern of meaning within the participant quotes, it felt important to include. Amongst our society's very recent history, there have been powerful community-led movements advocating for rights, whether queer, indigenous, black, or feminist. These fights for change historically involve risk and discomfort before change occurs. This strategy used by these participants is an example of discomfort for future change, of the small yet mighty decisions made within uncomfortable contexts to explain gender, educate providers and provide corrections when pronouns or gender terms are used incorrectly, all with the future in mind as motivation.

Figure 1

Chart Showing Themes and Subthemes



Discussion

This research builds on existing knowledge while also providing a new angle of inquiry into MHC for TNB people in Aotearoa with a focus on the self-determination, resistance, action and strategy used by TNB people when navigating mental health care, a system with pervasive barriers that unequally affect TNB people. There is a budding space in

research that focuses on TNB people's voices and shared experiences, aiming to understand what creates positive experiences in MHC. This thesis addressed a gap in Aotearoa literature, examining the interactions TNB people have with the MHC system and, in response, the choices and strategies they use to empower themselves, adapt, and self-protect whilst navigating MHC. The findings of this thesis offer insight into the changes needed in MHC, including offering guidance on how interactions and the provision of care would need to look and feel to create positive experiences for TNB clients. Importantly, this thesis clearly shows what MHC should not look like, as directly reflected in TNB people's sharing of their experiences. This discussion section will contextualise the findings regarding control of disclosure, provider selectivity and for the future within current research literature, identifying the limitations and strengths of this study, as well as future directions for research.

Interpreting Findings

Control of Disclosure

Withey-Rila (2021) conducted research examining the experiences of TNB people interacting with primary healthcare in Aotearoa and what contributes to a reported positive experience with General Practitioners (GPs). In their research findings, a theme labelled the sphere of control was identified, describing the ways in which TNB people take control of their primary healthcare where they can, to empower themselves. Participants discussed that one way they take control is to choose a specific, carefully planned moment to disclose their gender identity details to their GP, with the goal of improving interactions and increasing the likelihood of positive outcomes.

This thesis then offers insight into the 'sphere of control' within MHC spaces in Aotearoa, named control of disclosure. This theme followed a similar discourse to the research above. The choice made around disclosure or non-disclosure of gender identity

details empowers TNB people to control interactions with MHC providers. Due to the multiple potential outcomes during interactions with MHCPs, being able to control the information that the provider is privy to acts to both avoid discrimination and discomfort (Kcomt et al., 2020; Kattari et al., 2019) as well as the probability of having to educate providers about gender and the care that is appropriate and required. Disclosure of gender identity details has been explored in international research, predominantly discussed in general healthcare settings or with health care providers grouped as a whole without specifications (McKay & Watson, 2020; Sequeria et al., 2020), with less research able to be located specifically discussing disclosure in the contexts of MHC with MHCPs. Findings such as that of Sequeira et al. (2020) support control of disclosure as a finding, identifying TNB youth aged 12-26 reporting that they have intentionally avoided disclosure with health care providers even when they have determined this as an important topic that they wish to discuss.

Control of disclosure was split into two subcategories for this research, as the functions were clear. Non-disclosure was used as a strategy by TNB people either to protect their emotional well-being or to prioritise other presenting concerns, with non-disclosure of gender used to ensure access to care without the added worry of a provider gatekeeping care pathways.

Disclosing identity details in MHC spaces is understood to increase the potential for effective therapy outcomes by enabling a holistic approach (Fraser et al., 2025), acknowledging how the intersectional aspects of identity converge and inform our understandings and experiences in the world, including our mental health. Although this is identified in best practice guidelines, the disappointing reality of discrimination, assumptions of cisnormativity, use of heteronormative and cisnormative language, and the lack of

initiation of conversations being the overwhelming norm from providers has created a current space where TNB people are reporting intentional omission of gender identity or mental health details. Providers' responsibility to initiate conversation came up often in other research (Semp, 2011; Fraser et al., 2025; Sequeira et al., 2020; Rossman et al., 2017), as this seemingly small misstep of failing to initiate conversation regarding identity, risks having a larger impact on the therapeutic relationship. By being silent, whether it be intentional or due to discomfort and lack of knowledge, providers are reinforcing a cisheteronormative society, and assuming cisgender as the default normal until told otherwise by their client, having to 'come out' to them (Fraser et al., 2025).

The way for providers to initiate conversation is well outlined within guidelines of care, and can involve simple routines, such as asking pronouns and preferred name when meeting clients and then continuing to use these correctly (du Preez et al., 2022; Fraser et al., 2025; Kattari et al., 2020; Oliphant et al., 2018). There are other comfort factors involved in whether this action itself would be enough to enable TNB people to feel able to disclose identity details, yet it is a small, simple-to-implement action that can disrupt the current normal.

The other factors that can facilitate or prevent TNB people's choice to disclose their gender within mental health spaces include the perception of comfort, safety, provider competence, potential for discrimination, the actual experiences of discrimination, relevance of their gender to their presenting concern, and the initiation of conversation being led by the provider. Fraser et al. (2022) researched mental health support experiences of rainbow rangatahi, young people, in Aotearoa and found that, regarding comfort and disclosure, rangatahi were more comfortable discussing gender than they were to disclose gender. The difference in terminology is important here; discussion of gender would be expected to

follow the disclosure of gender, supporting the view that disclosure is the 'hard part' as the MHCP's response has not yet been displayed. If the TNB person reaches the discussion stage of gender with the MHCP, it would be assumed that disclosure has occurred and that the provider's response was adequate and appropriate, facilitating further open conversation. The findings of this thesis align with the discussion of disclosure being the challenging step of interaction with MHCPs, with no participants in this research specifically mentioning the comfort levels of discussing gender with their MHCP beyond disclosure, assuming the same point, that if the provider's response to disclosure or gender is supportive and knowledgeable, discussion would then occur with some ease or added comfort.

The finding of non-disclosure of gender due to the prioritisation of other health concerns acts to ensure access to the required MHC and gender affirming healthcare without the added risks of providers deciding not to provide this care or gatekeeping different forms of support. The reality of having to choose between things about yourself and between things that you may be struggling with, based on which is more in need of attention on the day of your appointment, is a problematic way of MHC being provided and assumes that someone's concerns are able to be separated off into a hierarchy of importance. From the understandings of the sociological concept of intersectionality, these parts of oneself cannot and should not be expected to be separated or discussed as completely independent from each other. I question how, with this happening, adequate, appropriate MHC has been achieved if a client is having to appear as someone they are not or split parts of themselves off to prioritise an appointment to make the provider more comfortable or make the conversation 'easier'.

Intersectionality, rooted in black feminist activism (Parmenter et al., 2026), explained by Roy (2023), is an analytical framework that explores the understanding that one person can be a member of multiple identity groups, all with different exposure to privilege, power,

marginalisation, discrimination and minority stress. Gender, sexuality, ethnicity, race, class, and dis/ability are the identity groups most often described when speaking about intersectionality. How you identify within these groups exposes you to levels of privilege versus marginalisation within society. For an intersectional therapy approach, these identities cannot be discussed separately, as this fails to incorporate the potential converging effects of an individual's identities and the notion of interlocking oppressions (Cuádraz & Uttal, 1999), which increase someone's risk of exposure to negative experiences and marginalisation. Creating a space where TNB people are unable to disclose gender identity excludes the individual from being able to discuss their full selves and the experiences they have had relating to their gender, whether that be euphoric and positive, or negative and relevant to their presenting concerns with the MHCP.

Overall, the risk is most present for TNB people when first disclosing gender details, due to being unable to predict the provider's reaction and opinions that will be displayed in response. This thesis contributes to understanding how TNB people experience the risk involved in disclosure of gender details and how they make decisions about disclosure, self-determining whether to disclose gender details and by doing so, claiming autonomy and control in situations. Previous research, such as Withey-Rila (2022) and Kattari et al. (2020), indicates that comfortable environments influence TNB people's decision to disclose their gender.

Mousavi et al. (2025) explore the multiple stages of disclosure, adding further depth to the understanding of disclosure as a complex social process that has profound effects on the well-being of TNB people. These stages of disclosure are the decision-making process, the disclosure event, mediating processes, and outcomes. The decision-making process includes approach goals (reasons to disclose) and avoidant goals (reasons not to disclose).

Approach goals, for example, could be goals of achieving understanding, social support and connection, and avoidant goals could be goals to avoid discrimination, rejection and conflict. Discussion from participants in this thesis demonstrated the use of the decision-making process by showing how people weigh the pros and cons of their approach goals and avoidant goals to determine whether disclosure is necessary and safe at that specific time. Mousavi et al. (2025) found that during their review of literature, most discussions of disclosure focused on the avoidant goals, or reasons not to disclose. This thesis also predominantly explores avoidant goals, as participants' experiences focus more on what was a barrier to disclosure and what led them to choose not to disclose, rather than on what they sought by disclosing or the positive approach goals behind disclosure. This could be explained by the format of the Counting Ourselves survey questions, from which the data for this research were obtained, which focused on barriers to MHC access rather than directly on positive MHC experiences. Or due to evidence suggesting that we, as humans, have superior recall of undesirable or negative memories for adaptive purposes (Baumeister et al., 2001). Or maybe because of previous experiences with MHC, the participants experienced *avoidant* related concerns more saliently than motivations for *approach* or disclosure.

Provider Selectivity

The findings from the theme provider selectivity show that TNB people strategically search for providers who are queer-friendly and have experience with trans MHC, likely increasing the probability of a positive experience and appropriate MHC. This is echoed by Withey-Rila et al. (2024), who found that TNB individuals will exert control over their healthcare experience by choosing to move to a different provider if appropriate care is not provided. This strategy serves as a form of control, with the goal of accessing a knowledgeable provider, avoiding negative experiences, and discontinuing care with a

MHCP as soon as the TNB person feels uncomfortable or dissatisfied with the interaction. These findings and this form of control elicit a strong sense of resistance, a way of saying "no, I will not even give you access to me to cause harm". By TNB people doing research for providers who publicly label themselves as trans affirming or specialising in working with TNB and queer identities, they are actively working to protect themselves from the chance of negative experiences. That is not to say these providers are perfect or to say that MHCPs who do not say they are LGBTQIA+ friendly will always cause harm. But more of a highlight of the active work TNB people are doing within this strategy to access MHC only from a provider they feel will demonstrate appropriate MHC provision and understanding.

With TNB people confirming that they will look for trans-friendly providers by their listed specialities and the hope that they will publicly list that they are trans-friendly, it is important for providers to list their specific training, specialties, and experiences. Gender Minorities Aotearoa, for example, has a website with a healthcare services database, to date listing 98 individuals or organisations deemed gender affirming for both transition-related MHC and general MHC. Thirty of the listed providers are in Tāmaki Makaurau, Auckland, and thirty-four in Pōneke, Wellington, leaving the additional thirty-four providers spread throughout the country. To be listed on this database, Gender Minorities requires providers to complete a form confirming whether they have completed training with Gender Minorities Aotearoa, clinical training for trans patients, or trans sensitivity training. This information is listed on their websites, which I think is important as it provides insight for TNB people into the criteria a provider or organisation must meet to be listed as gender-affirming and trans-friendly.

As shown in the findings, this strategy of provider selectivity involves privileges of resource availability; it takes time, money, and emotional resources to seek out and access the

small number of trans-friendly MHCPs in Aotearoa. González Gutierrez (2024) found that private providers were the most frequently accessed providers among participants in the 2022 Counting Ourselves survey, proposing that access to private MHCPs could be due to limited access, long waitlists, and the inability to select providers within the public MHC system, and the higher satisfaction with private providers reported by TNB participants. The findings of this research support the conclusion that increased access to private providers for TNB individuals is due to all the above, particularly the need for faster access to MHC without the waitlists of the public health system and the ability to choose a MHCP who will be knowledgeable and supportive.

In Aotearoa, publicly funded MHC is usually accessed through a GP referral. Due to funding constraints and limited availability of MHCPs, there is little selectivity, leaving the TNB person unable to control where they are referred to. The number of participant responses relevant to the provider selectivity theme indicates that selecting a MHCP is a strategy often used by TNB people.

Regarding unmet need for MHC, the participants of Counting Ourselves reported that in the year prior to completing the survey 59.6% had experienced instances of not accessing MHC when requiring this support (González Gutierrez, 2024), whereas unmet need for the general Aotearoa population for 2021/2022 was only 8.8% (Ministry of Health, 2022) identifying a significant disparity in the ability for TNB people to access MHC when it is needed. González Gutierrez (2024) goes on to posit that the disparate difficulty in accessing MHC for TNB people may be due to higher rates of general and trans-specific barriers.

Notably, the Counting Ourselves 2022 survey found that 59% of participants were *comfortable* or *very comfortable* discussing their gender identity with a MHCP (Yee et al., 2025). As discussed earlier, it was found that private MHCP's were the most accessed

provider by participants. This reported comfort may then be due to TNB people having researched and located a MHCP intentionally, with whom they would be comfortable discussing gender.

To contextualise these findings within international literature, the core ideas discussed within this theme that have led to opting for private MHC have been found within critiques of public MHC systems, such as that of Ellis et al. (2014) finding lack of provider competency, pathologisation and gatekeeping as issues experienced by TNB participants when accessing public MHC in UK. And such as Shipherd et al. (2010) finding that in the US although a majority of the participants were insured, cost was still a significant reported barrier, leading to theorising that TNB people are seeking MHCPs that are not within their insurance coverage, such as potentially private, specified trans affirming MHCPs. However, as also noted by González Gutierrez (2024), I was unable to find any studies that explore the utilisation of private MHCPs specifically.

This thesis supports that by enacting strategies when navigating MHC, TNB people are attempting to decrease barriers to care; however, an issue remains, due to the small number of trans competent providers this strategy does not necessarily decrease the difficulties of accessing MHC, but is likely to prevent further barriers, such as a lack of provider trans competency and gatekeeping. This strategy is likely not a priority as often for cisgender individuals as the worry of a MHCP being able to provide adequate care is lessened, however, we can assume that individuals from other communities who are marginalised and who also experience minority stress and disparate access to MHC may seek providers that are a member of their community or are specialised in MHC for their community.

The lack of queer-affirmative and trans competent providers is repeated throughout this research as both a barrier to care and an issue identified by participants having informed their use of the strategies; control of disclosure, provider selectivity and for the future. Tan et al. (2025) discuss gaps in the training provided in psychology programmes, leaving psychologists entering the workforce underinformed about how to care for queer communities. By surveying 15 of the total 17 directors of psychology training programmes in Aotearoa, it was found that regarding queer content being covered within the programme curriculum, over half (57.1%) of the programmes adopted an 'add-on' approach by use of teaching such as guest lectures, rather than meaningful inclusion of queer content throughout the curriculum. This lack of prioritisation creates an implication that queer content is non-essential and more of a tick-box exercise, rather than essential learning that equips psychologists with the tools necessary to provide appropriate care for queer people.

Hayward and Treharne (2022) interviewed 8 clinical psychology students in Aotearoa, asking what they had previously learnt about providing care to trans people, how they would feel about trans community members having a teaching role in their program, and which teaching modes would suit this role. All 8 participants identified significant gaps in their knowledge of providing care for trans people, as well as a desire to develop their knowledge to avoid placing an educational burden on their future clients, expecting the client to teach them about trans MHC. The participants discussed that there was little to no teaching in their clinical psychology programme that had taught about the provision of care to trans people. It was agreed that learning from transgender community members would be valuable within the programme, although how this can be achieved without burdening the TNB community is yet to be determined. Further research is necessary to develop a culturally safe platform for delivering queer-affirmative content (Tan et al., 2025).

For the Future

The theme, for the future, found that TNB people are handling negative experiences with MHCPs and within the MHC system strategically, aiming to change these spaces for the next TNB person. The findings of this theme follow the acts of resistance seen throughout history in movements of activism by various minority groups, challenging the status quo and working for changes in society's systems and legislation, and fighting for equal rights and access to education, healthcare, politics, and workplaces.

Within Psychology, we can use the women's liberation movement of the 1960's-1990's as one example of this form of resistance and as a demonstration of how change can be made in the psychology discipline. This example shows cisgender women's fight to change their access to care and experiences of pathologisation, while simultaneously challenging society's gendered views on what a woman's role in society was/is. The guiding statement of the National Women and Mental Health Campaign positioned that:

> Mental health legislation and treatment are powerful weapons of social control which affect all people but women are a priority target. Behaviours that challenge the patriarchy are diagnosed as crazy and the treatment for this aims at social readjustment and conformity to white, middle-class male standards of mental health. (Crook, 2018, p. 1160)

At the time in our recent history of this movement occurring, women were pathologised based on their biological sex and what society expected of their gender, with a heterosexual expectancy, being subordinate to men, and expected to care for the home, the children and the husband with a polite, subservient eagerness. Psychology was accused by American feminists as being a link in the chain of women's oppression, due to the disproportionate targeting of women with psychopharmaceuticals (medications used for

mental health disorders such as antidepressants) and reinforcement of gender norms from MHCP's. In 1977, at the first women's mental health conference in London, a new definition of mental health was formed: mental health as self-determination, being able to choose to fit in or not fit in, to change or not. This definition asserted women's autonomy in the understanding and treatment of mental health, whilst also focusing on the social constructs of what it means to fit in or seek change.

When activism is thought of, large displays of protest come to mind. This movement began, as many others have, with community members sitting down together to talk about their experiences of emotions, discrimination, and oppression, a practice termed 'consciousness-raising' during the feminist movements. Thoughts and feelings that had once been considered private suffering were identified as shared experiences. This then developed into social critique and political action, with the emergence of feminist therapy as complementary to feminist political activism and as a space where women transformed their sadness and once-private emotional struggles into anger and political action. Women accumulated the skills and experiences necessary to instigate social change, demonstrating their commitment to supporting one another and taking action to improve the quality of life for women (Crook, 2018).

When identities themselves are deemed as political, living as yourself is resistance and activism (Siqueria & Lopez, 2026). The current political climate in Aotearoa is seeing a rise in far-right political ideologies of transphobia and homophobia influenced by international politics (Galbraith & Lamusse, 2025; Wintemute et al., 2025), which seek to undo the gains of the past 40 years that saw decriminalisation of queer and trans people in Aotearoa, and in the past 12 years saw marriage equality. Solidarity among Rainbow communities and allies is essential now, more than ever, demanding attention from scholars

and activists to the liberatory aspirations, resistance and experiences of LGBTQIA+ people (Galbraith & Lamusse, 2025).

Forms of activism, such as those identified in this theme, are examples of infrapolitics. Defined by Malatino (2021) as acts of support and solidarity that are not immediately identifiable as political action, yet are essential for the eventual occurrence of political mobilisation. Actions such as the informal building of community, the provision of care to others, and daily expressions of pride and defiance, often associated with political activism and movements, are deeply powerful behaviours (Hansen, 2024). Research completed in Brazil by Siqueria and Lopez (2026) sought to explore how resilience and resistance manifested for TNB people who engage in activism. The theme 'purpose' was identified, which demonstrated the meaning-making that participants formed through their engagement in activism, with 'serving future generations' discussed by participants as an aspect of their purpose. The participants discussed their desire to contribute to a better world for youth and the next generations to come, as well as recognising the TNB people who came before them. This research did not discuss MHC, however, relevant to the theme 'for the future', it did discuss TNB people's resistance within oppressive systems, and the long-term commitment TNB people make to reshaping these systems. The participants discussed their acknowledgment of being a 'part of something bigger', similarly highlighting the sense of sacrifice discussed earlier in the findings of this thesis. Findings from Hagler et al. (2025) also found that TNB youth in the US expressed a motivation for their engagement in activism to achieve social change to benefit future generations.

The findings of 'for the future' show how TNB people are resisting and rebelling in their experiences of MHC through infrapolitical actions. By essentially 'putting up' with behaviours that often cause people to avoid MHC, to push toward a future of better care. By

educating providers, challenging misgendering, discrimination and the gatekeeping of care, MHC spaces are slowly being moulded into spaces that see TNB MHC as a priority and moving towards a system that can provide adequate and appropriate care for the next TNB people to come.

Likely, TNB people are not always walking into MHC spaces planning on engaging in activism in this way or examining their actions when they leave their appointments to this extent. However, the participants of this research discussed this strategy in a way that is just simply fact to them; they are making choices, although they feel frustration and exhaustion in the face of it, because they feel a duty both to the TNB person who came before them, as well as to the TNB person who will come after them.

Whilst discussing resilience, resistance and activism, reflecting on potential romanticisation of these terms is important. To reposition, the need for resistance and activism is due to systems that oppress and discriminate against TNB people. For some people, fighting back against oppression and engaging in activism creates meaning and purpose in their lives, but this cannot be an expectation of all TNB people. Protecting oneself from burnout, exhaustion, or negative consequences that can come from activism and removing oneself from negative experiences can also be an act of resilience and resistance (Puckett et al., 2025).

An extensive search of international literature was completed to contextualise the findings of the theme ‘for the future’. The databases APA PsycNet, PubMed, Google Scholar and the Waikato University Library were searched using the terms: Trans self-advocacy in mental health care, self-advocacy in mental health care, trans peoples resistance in mental health care, gender diverse peoples self-advocacy in mental health care, gender queer peoples self-advocacy, creating autonomy in mental health care, trans people actions when accessing

mental health care, strategies used by trans people in mental health care, strategies used by non-binary people in mental health care, trans strategies, and trans peoples response to barriers in mental health care. From the results of this search, I was unable to locate international research with findings discussing the self-advocacy of TNB people when accessing mental healthcare or with discussions from TNB people seeing the future as a motivator for resistance and activism when accessing mental health care. This points to the findings of this theme potentially being a first in MHC research for TNB people.

Within the psychology discipline, developments such as the change in the DSM-5 of diagnosis to gender dysphoria, as well as the increased implementation of the informed consent model within MHC, represent a small change in the right direction. However, as discussed throughout this thesis, there is work to be done before we see MHC being a space for TNB people, where access is equitable, safe and where the provision of care is appropriate and knowledgeable.

Strengths, Limitations, and Implications

This study involved limitations due to the technique of sampling data from an already existing data set. Because the Counting Ourselves survey was not designed to identify the strategies I sought to uncover in this research, this thesis relied on questions eliciting participants' discussion of these strategies. And due to this, there is a potential that the depth of understanding that may have come from interviewing (individual interviews or focus groups) TNB individuals with questions directly enquiring about strategies, was not achieved (Lambert & Loiselle, 2007; Ryan et al., 2009).

Another limitation may be present due to strategy use and demographics not being compared within this research, missing further understanding that may arise from comparisons of the differences in the use of strategies between age, gender and ethnicity.

The large number of participants of the Counting Ourselves survey and the multiple techniques used by the Counting Ourselves team to access TNB people that may otherwise not be able to access the survey (such as older TNB people and people who live rurally) meant that there is greater diversity in age, culture, ethnicity, gender identity, and dis/ability represented in this data, strengthened this thesis by offering a much larger and widespread group of TNB peoples, opinions and experiences then I would have been able to achieve if completing interviews. .

Practical recommendations from the findings of this research include the responsibility for providers to safely initiate conversations with TNB regarding gender identity at the beginning of an interaction. As TNB people have shared, they often enter the MHC environment looking for safety signals and a confirmation of whether they can discuss gender details. Providers beginning this conversation comfortably and confidently, without it feeling investigatory or inappropriate, signal that they are likely knowledgeable and able to provide appropriate responses and care practices. MHCPs should also consider the importance of having public information available about their training, professional experience and ability to provide MHC to TNB people, as well as explicitly listing if they are a safe space for TNB people.

Future directions

Future research using interviews would be beneficial for further exploring the motivations behind the use of strategies, as well as how TNB people view the strategies they use and how they feel when using them. Interviews would also allow for collaboration with participants throughout the writing stage, to ensure any interpretation of meaning is correct, as well as creating a space where participants can ensure the thesis direction aligns with their goals for themselves and the trans community. As noted in the limitations, specifically

comparing strategy use and demographics would also provide further understanding of strategy use between groups.

For the theme, control of disclosure, exploring further the motivations or 'approach goals' of disclosing gender beyond when this is the presenting concern with MHCPs would be beneficial, as this has been discussed mostly in terms of the avoidant goals or reasons not to disclose. The subtheme 'prioritisation' would also benefit from further questioning in interviews, as understanding appointment time constraints, un/affordability of appointments and concerns of gatekeeping will likely provide information to guide further change within provider education and MHC appointment structure. This information will also likely provide direction on how space can appropriately be given to discussing identity and prioritising people's intersectionality in appointments. Both to ensure that TNB people are not having to omit these details, and to ensure it does not end up as the only topic they are able to discuss in an appointment, because of consequently having to educate underinformed providers.

I would also like to see further qualitative research regarding the 'for the future' strategy, discussing with TNB people further how self-advocacy, activism, reactive self-determination, and infrapolitics may be enacted in daily life and in experiences of MHC.

I think, possibly most importantly, as noted by other scholars (Tan et al., 2025; Hayward & Treharne, 2022), is the need to explore an educational intervention to facilitate the implementation of queer content within psychology programmes in Aotearoa. Both this thesis and the cited literature discuss the importance of this in reducing the repeated issues of provider incompetency, which, in time, would then relieve the need for the use of the strategies discussed in this thesis. However, a working model has yet to be developed. Based on the recommendations from Tan et al. (2025), Hayward and Treharne (2022) and Du Preez et al. (2022) any development of an educational intervention needs to be created in

collaboration with trans community members, with mindful care taken to ensure that the TNB community is not burdened by having to educate students, with compensation and credit being provided for their contributions. Community organisations such as Gender Dynamix Aotearoa currently provide training to professionals and organisations regarding LGBTQIA+ identities, inclusion and provision of care. Future research could aim to collaborate with community organisations to develop a University model of teaching queer content, with the involvement of programme directors, looking at how this can then be meaningfully woven into the curriculum. Directors of programmes would also have to commit to providing staff upskilling to ensure that staff feel confident and equipped to teach culturally safe, queer content.

The clinical psychology students interviewed by Hayward and Treharne (2022), discussed that they think they would learn best from trans community members being involved in teaching activities, sharing their experiences. However, as discussed by Hayward and Treharne, important consideration is needed about asking a small group of trans people to represent all trans people and whether this is realistic or appropriate.

I feel queer content needs to be integrated from the Undergraduate level to allow for the development of learning for students across their university careers. Developing an education model through collaboration and mixed-method studies, focused on implementation throughout university degree levels, would greatly benefit both psychology students and their future TNB clients.

Conclusion

This thesis sought to explore how TNB people are navigating the MHC system, using a qualitative thematic analysis of data from the only nationwide Aotearoa survey of TNB health and wellbeing. The findings revealed that in response to the documented systemic

barriers to accessing MHC in Aotearoa, TNB people are enacting strategies to improve their access and experiences. The strategies identified involve control of disclosure of gender identity details, the selectivity of MHCP's and the handling of negative experiences for the betterment of the future for TNB people. The findings of this research highlight aspects of MHC access and interactions that lead to TNB people having positive experiences. By understanding what leads to positive experiences, we are then able to further understand negative experiences and the areas within the system of MHC where efforts are needed to create change. Beyond the system, the participants in this research told us, through the experiences they shared, how to work as MHCPs to facilitate positive experiences and provide appropriate, safe care. This thesis has shown that TNB people will not put up with the status quo; they have been, and will continue to make, decisions for themselves and for the TNB community to access quality care when they require it. Overall, this thesis provides evidence that there is a need for the development of educational interventions within the psychology programmes at the universities of Aotearoa to teach queer content, as well as changes within our healthcare system to prioritise MHC as a service, working to decrease the lengthy wait times that are amplified by the small number of TNB appropriate MHCPs available. The findings of this thesis support that any change implemented needs to be led by trans leaders and carried out in collaboration with the trans community and that at its core, MHC needs to be provided with TNB people as the experts of their gender and care goals, with providers as the vehicles of knowledge, acknowledging self-determination and supporting TNB clients to make informed decisions about MHC.

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