# Improving Healthcare for Trans and Gender Diverse People: Exploring the Feasibility of Social Prescribing Pathways

**by**

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For every trans and gender diverse young person
who has been told they do not belong.

May you *always* know your worth and place in this
world.

# Abstract

Trans and gender diverse people experience significantly poorer health outcomes in comparison to their cisgender counterparts, with trans and gender diverse young people (TGDYP) at increased risk due to their vulnerable developmental stage. Social determinants (e.g., loneliness, hostile social and political climates, minority stress) contribute to these disparities, and are compounded by the clinical focus of, and challenges accessing, gender-affirming care (GAC). Responsively, the National Healthcare Service (NHS) in England has publicised calls for holistic approaches to GAC that address the social determinants of health. Social support has been identified as a key protective factor, with Social Prescribing (SP) offering a formalised route to such support. Thus, this thesis explored the acceptability and feasibility of embedding SP within gender-identity clinics (GICs) to improve health outcomes for TGDYP. Given the existing evidence for SP is inconsistent and theoretically underdeveloped, the Social Identity Approach to Health (SIAH) was applied to theoretically ground SP and its adaptations for TGDYP.

Three studies were conducted in this thesis. Study One systematically reviewed SP literature through a SIAH lens, finding SP most effective when it fosters meaningful social connections anchored in shared group identity, with link workers playing a critical role. Study Two, a two-part qualitative investigation, identified meaningful group memberships for TGDYP and practical SP implementation strategies. Developing and utilising our novel Qualitative Triangulation Framework to integrate multi-stakeholder perspectives, the study revealed that TGDYP-specific social support is vital for wellbeing and participants articulated enthusiasm at GIC-integrated SP. However, preferences varied by transition stage: early-stage TGDYP preferred support-focused groups, while later-stage individuals favoured activity-based spaces. Concerns were raised about GICs' capacity to deliver SP that provisions these varied spaces and whether GIC-facilitated support would be perceived as genuine or conditional, especially amid the Cass Review's staged care model. Responsively, Study Three evaluated a gender clinic integrating social support into their care pathways. Findings indicated that integrated social support was symbolically affirming of diverse TGDYP needs, especially when support was delivered by those with lived experience, fostering trust and perceived authenticity. However, implementation was limited by late offering and systemic barriers.

Collectively, the findings presented in this thesis suggest that SP has significant potential to enhance TGDYP health, but only if it is well resourced, sensitive to transition-stage identity needs, and delivered by identity-aligned link workers. Thus, we propose a model that involves outsourcing SP delivery to established SP providers with the infrastructure for access, while retaining care coordination within identity-relevant roles such as trained link workers or care navigators with lived experience. Future research should build on our qualitative, cross-sectional insights by quantitatively validating the proposed SP model through longitudinal designs that capture how social support and identity needs evolve over time. Implementation studies are also needed to explore how SP can be delivered in partnership with trusted providers to effectively support TGDYP.

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# Publications and Conference Proceedings

**Peer-Reviewed Publications:**

**Staras, C.O.,** Wakefield, J.R.H., McDermott, D.T., & Jones, B.A. (2024). An evaluation of the role of social identity processes for enhancing health outcomes within UK-based social prescribing initiatives designed to increase social connection and reduce loneliness: A systematic review. *Journal of Community and Applied Social Psychology, 34*(5), e2878. https://doi.org/10.1002/casp.2878

**Staras, C.O,** Wakefield, J., McDermott, D., & Jones, B. (2025). The Development and Application of the Qualitative Triangulation Framework (QTF) for Exploring Tension Within and Across Qualitative Data Sets: Case Studies of Trans and Gender Diverse Youth's Healthcare Experiences. *The International Journal of Qualitative Methods, 24.* https://doi.org/10.1177/16094069251371463

**Conference Proceedings and Presentations:**

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, September). *Exploring the Feasibility of Social Prescribing for Trans and Gender Diverse People.* European Professional Association of Transgender Health (EPATH) Sixth Conference. Hamburg, Germany. *Oral Presentation.*

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, July). *Improving Healthcare for Trans and Gender Diverse People: Exploring the Utility of Social Prescribing Pathways.* An invited presentation for Nottingham Young People's Gender Service CPD training session.

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, May). *Improving Healthcare for Trans and Gender Diverse people: Exploring the Feasibility of Social Prescribing Pathways.* An invited presentation for the University of Exeter. Oral Presentation.

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, May). "*I believe Social Prescribing would be the base of the trans-healthcare pyramid": Exploring the Feasibility of a PsychoSocialBio Model of Trans and Gender Diverse Healthcare.* INQYR: Advancing LGBTQ+ Health, Well-being & Resilience. Birmingham, UK. *Oral Presentation.*

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2024, November). *Improving Healthcare for Trans and Gender Diverse People: Adapting and Testing the Effectiveness of Social Prescribing Initiatives.* An invited presentation for the British Association of Gender Identity Specialists, Nottingham, UK. *Oral Presentation.*

**Staras, C.O.** Wakefield, J., McDermott, D., & Jones, B. (2024, October). *Being queer is many things, but one of the things we need is community": A Social Identity Approach to Health-Informed Thematic Analysis of Community Engagement Among Trans and Gender Diverse People in England*. An invited presentation for the National Autonomous University of Mexico. *Oral Presentation.*

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2024, June). *Effectiveness of UK-Based Social Prescribing Initiatives Designed to Increase Social Connection, Reduce Loneliness, and Benefit Wellbeing: A Systematic Review*. 6th International Conference on Social Identity and Health, Limerick, Ireland. Oral Presentation.

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2023, August). *Effectiveness of UK-Based Social Prescribing Initiatives Designed to Increase Social Connection, Reduce Loneliness, and Benefit Wellbeing: A Systematic Review.* British Psychological Psychology Social Psychology Section Conference, Edinburgh, UK. *Poster.*

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2023, August 22nd). *Improving Healthcare for Trans and Gender Diverse People: Adapting and Testing the Effectiveness of Social Prescribing Initiatives*. An invited presentation for the University of Toronto, ON. Oral Presentation.

# Glossary of Key Terms

**Cisgender:** A person whose gender identity aligns with their sex assigned at birth.

**Gender-affirming care (GAC):** A range of medical, psychological, and social interventions that support an individual in aligning their gender identity and expression with their lived experience. GAC may include hormone therapy, surgeries, voice training, and mental health support, as well as non-clinical forms of affirmation like social support and identity validation.

**Gender-Affirming Surgery:** A range of surgical procedures that help align an individual's physical characteristics with their gender identity. These surgeries may include chest/top surgery (e.g., mastectomy or breast augmentation), lower surgery (e.g., phalloplasty, vaginoplasty), facial feminisation or masculinisation, and other related interventions.

**Gender Identity:** One's internal sense of their gender, which may or may not align with their sex assigned at birth. Gender identity can include identities such as male, female, non-binary, or other self-defined terms, and may evolve over time.

**Gender Identity Clinics (GICs):** Specialist healthcare services in the UK that provide assessment, support, and gender-affirming interventions for individuals experiencing gender incongruence.

**Gender Incongruence:** A marked mismatch between an individual's experience or expressed gender and their sex assigned at birth.

**Gender Minority Stress Theory (GMST):** A theoretical framework that explains how stigma, discrimination, and societal marginalisation contribute to negative mental and physical health outcomes for gender minority individuals (e.g., TGD people). GMST highlights both external stressors (e.g., violence, misgendering) and internal stressors (e.g., internalised transphobia, identity concealment) as contributors to chronic stress.

**Gender Transition (sometimes referred to as *transition*):** The process by which a person changes aspects of their life to better align with their gender identity. This may include social (e.g., name and pronouns), medical (e.g., hormone therapy, gender-affirming surgery), and/or legal (e.g., documentation) changes.

**Hormone Therapy:** A form of gender-affirming medical care that involves the administration of sex hormones (e.g., Oestrogen or Testosterone) to induce physical changes that align an individual's body with their gender identity. Effects may include changes in voice, fat distribution, muscle mass, hair growth, and secondary sexual characteristics.

**Identity Salience:** The degree to which a particular aspect of one's identity (e.g., gender identity) is prominent and influential in shaping one's self-concept and behaviour in a given context.

**Link workers:** Specialist non-clinical professionals who support individuals referred through social prescribing by helping them navigate and access appropriate community-based services.

**Minority Stress:** Chronic stress faced by individuals from stigmatised social groups due to ongoing experiences of discrimination, prejudice, and systemic inequality. For TGD individuals, this includes misgendering, exclusion, and societal invalidation.

**Social Identity Approach to Health (SIAH):** A theoretical framework that explains how group memberships and shared social identities impact health and wellbeing.

**Social Prescribing (SP):** A healthcare practice that enables clinicians to refer service users to non-clinical community services, such as peer support groups, arts activities, or exercise programs, to increase social connectedness. Link workers typically support individuals in accessing and engaging with these services.

**Trans and gender diverse (TGD):** An umbrella term referring to individuals whose gender identity differs from the sex they were assigned at birth.

**Trans and gender diverse young people (TGDYP):** TGD individuals who are in adolescence or young adulthood.

# Chapter 1

## General Introduction

### 1.1. Introduction

The journey through the healthcare system for trans and gender diverse (TGD) people in England is often marked by waiting, uncertainty, and mistrust. Access to gender-affirming care (GAC) is shaped not only by clinical gatekeeping, but by broader conditions of social exclusion: from discriminatory education environments and precarious housing to isolation from peers and communities. These challenges are especially acute for TGD young people (TGDYP), whose distress is too often pathologised while the structural conditions that generate distress remain unaddressed. As debates around the future of GAC intensify, particularly in the wake of the Cass Review, there is an urgent need to ask: what does meaningful care look like, and how might it move beyond the clinic?

Against this backdrop, this chapter introduces the background and rationale for this programme of research. It begins by outlining the English context for GAC and the limitations of current service models. It then considers the key role of social support for improving health outcomes of TGD populations, considering how this would address present GAC limitations. The potential of Social Prescribing (SP) to provision formalised social support is then discussed, before considering the specific utility of SP for TGDYP who experience intensified challenges in comparison to other TGD populations. This chapter concludes with the overarching research aims and questions that guide this thesis, and a road map of how each chapter achieves this.

### 1.2. Gender-Affirming Care

#### *1.2.1. What is Gender-Affirming Care?*

Gender-affirming care (GAC) describes the practices, medical interventions, and support that is offered to TGD individuals (i.e., people whose gender identity does not align with their sex assigned at birth; Crowley et al., 2021) to alleviate gender incongruence (i.e., discomfort with one's gender both mentally and physically; Muller et al., 2023). GAC allows TGD people to live as their authentic selves and improves overall health outcomes (e.g., Muller et al., 2023; Puckett et al., 2017). GAC *typically* entails hormone therapy (e.g., Testosterone and Oestrogen), surgeries (e.g., vagino/phalloplasty and top surgery), and psycho-social support (e.g., talking therapies and support groups; Carlile et al., 2021; Muller et al., 2023). While surgeries are usually one off (e.g., top-surgery, unless revisions are required) or take place over a series of discrete surgical stages (e.g., phalloplasty), hormone therapy is typically lifelong[1]. However, the types of GAC available, and ease of access, differs by region and country dependent on laws and policies relating to the rights of TGD people (Goldenberg et al., 2020; Jessani et al., 2024). Additionally, the structure and funding of healthcare services can compound access further (Kiely et al., 2024; Surendran et al., 2025).

### *1.2.2. Accessing and Navigating Gender-Affirming Care in England*

Within England, GAC is delivered through Gender Identity Clinics (GICs). Access to GICs, and the types of care that are available through them, depend on the age of the individual accessing GICs, and whether these are public or private providers.

#### 1.2.2.1. Public Providers: Children and Young People

For children and young people (CYP), defined as those under the age of 17 in the context of GAC[2], support is currently limited to psycho-social interventions (NHS England, 2024). CYP presenting to general practitioners (GPs) with distress related to gender are referred to secondary care services (i.e., mental health or paediatric services) for assessment. If concerns about gender are not primarily attributable to other significant challenges (e.g., adverse home environments), secondary services may refer them to Children and Young People's Gender Incongruence Services (CYPGIS; NHS, 2024). This service specification is newly introduced and currently operational in three regions: 1) North West (Liverpool and Manchester), at the Alder Hey Children's Foundation Trust, and the Royal Manchester Children's Hospital; 2) London, at the Evelina London Children's Hospital, Great Ormond Street, and South London and Maudsley NHS Foundation Trust; and 3) South West, through the Bristol Royal Hospital for Children (NHS, 2025). Wait times for a first appointment at CYPGIS is currently 3 years (NHS England, 2025).

This regional model of care was developed in response to the Cass Review (2024a); an independent review commissioned by NHS England in 2020 to evaluate the adequacy and safety of existing gender identity services for CYP, namely, the Gender Identity Development

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[1] Some individuals may choose to stop hormone therapy due to medical or personal reasons, which can reverse some, but not all, effects of hormones (MacKinnon et al., 2022).

[2] Individuals aged 17 and over are referred to adult gender services for pragmatic and developmental reasons: 1) extended wait times can mean these individuals risk aging out of CYPGIS; and 2) their developmental stage can make clinicians more confident about diagnoses and treatment plans (NHS, 2020; NHS England, 2025).

Service (GIDS) at the Tavistock and Portman NHS Foundation Trust. The review delivered a critical assessment of GIDS, citing serious concerns including a lack of consistent clinical approach, insufficient evidence base for medical interventions, and inadequate management of coexisting mental health or neurodevelopmental conditions (Cass, 2024a). In light of these findings, GIDS was brought to a managed close on 31 March 2024, and the new CYPGIS centres in London and the North West began operation in April 2024, with the South West service following in November 2024 (NHS England, 2024). This reformed model emphasizes holistic, multidisciplinary assessments, prioritizing psychological support and developmental understanding before considering any medical interventions. These services are part of NHS England's *Early Adopter* model, intended to provide more localised, timely, and integrated care (NHS England, 2024).

While the Cass Review has been widely cited as a turning point in shaping the current model of care (Cass, 2024a), the evidentiary basis for its conclusions has not been without controversy. Critics have pointed out that the review prioritises certain forms of clinical evidence, such as long-term randomised control trials, while discounting other sources of knowledge, including lived experience, observational studies, and international clinical consensus (e.g., WPATH guidelines; Horton, 2024; Noone et al., 2025). As such, the review's call for greater caution has been interpreted variously: by some as a necessary response to uncertainty and risk in care of a vulnerable population (Cass, 2024a; 2024b), and by others as a manifestation of epistemic injustice that sidelines the voices and needs of TGDYP (Horton, 2024; Noone et al., 2025). The new clinical commissioning policies have therefore become a flashpoint in wider debates over evidence, ethics, and the role of ideology in healthcare decision-making (Horton, 2024). These tensions underscore that the current reforms, while framed in terms of clinical safety and governance, are situated within a politicised field. Against this backdrop, the support now offered within CYPGIS reflects a significant reconfiguration of priorities and practice.

Support offered within CYPGIS includes family therapy, individual counselling, and support navigating gender identity, with a focus on exploring feelings around gender rather than transitioning (NHS England, 2024). As such, a set number of appointments have not been specified given the end goal within CYPGIS is not a treatment plan in contrast to previous CYP gender identity services (e.g., GIDS). Coordination with schools and families to support the child's wellbeing, alongside evaluations for neurodivergence and mental health issues are also recommended (Cass, 2024a). Unlike in previous CYP gender identity services (i.e., GIDS), where puberty blockers (i.e., GnRH analogues) were routinely offered alongside psycho-social support, the provision of puberty blockers within CYPGIS is now highly restricted. Although often used to delay puberty and provide time for CYP to explore their gender identity without the added distress of physical changes, puberty blockers are no longer available outside of an NIHR-commissioned clinical trial. This is in line with new clinical commissioning policies following safety concerns raised in the Cass review (Department of Health and Social Care, 2024). In a select number of cases, CYP aged 16 and over may be prescribed gender-affirming hormones (e.g., Testosterone and Oestrogen). However, this is rare, with no clear criteria, and subject to review by a national multidisciplinary team (NHS England, 2025).

#### 1.2.2.2. Public Providers: Adults

For adults, defined as those aged 18 years and over[3], GAC is multidisciplinary (NHS England, 2022; 2023). Adults presenting to general practitioners with distress related to their gender can be referred directly into adult Gender Identity Clinics (GICs). At the time of writing, there are seven established national NHS GICs in operation across England[4]. In addition to these, regional pilot services are currently commissioned in Manchester (The Indigo Gender Service; launched December 2020), Sussex (Sussex Gender Service; launched April 2022), Cambridge (The East of England Gender Service; launched June 2021), and Cheshire/Merseyside (Cheshire and Merseyside Adult Gender Identity Collaborative; launched February 2021; GIRES, 2024).

All clinics (both established and pilots) follow NHS service specifications for surgical (NHS England, 2023) and non-surgical (NHS England, 2022) adult GAC, ensuring consistent provision across clinics. GICs offer multiple services, including formal diagnosis of Gender Incongruence, psychological support (e.g., referral to adult mental health services), endocrinology (i.e., covering the provision and monitoring of gender-affirming hormones), surgery referrals, hair removal, and speech and language therapy (NHS England 2022; 2023). However, access to these services is dependent on local service provision (Silver et al., 2025). Adults presenting to GICs typically attend a minimum of two appointments prior to diagnosis and subsequent access to GAC (NHS England, 2022). Recent empirical data collected in 2023

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[3] 17-year-olds may be referred into adult GICs, but with the intention that long wait lists will mean they do not receive care until after their 18th birthday.

[4] Adult GICs operational in England include: 1) The Laurels Gender Identity Clinic (Exeter); 2) The Nottingham Centre for Transgender Health (Nottingham); 3) The Northern Region Gender Dysphoria Service (Newcastle upon Tyne); 4) The Leeds Gender Identity Service (Leeds); 5) Porterbrook Clinic Gender Identity Service (Sheffield); 6) The Tavistock Centre (London); and 7) Northampton Gender Identity Clinic (Northamptonshire).

suggests that wait times for accessing first appointments at GICs within England vary between 23 and 87 months, with the wait for a second appointment averaging around 1-year following the first appointment (Squires et al., 2024). This reflects an 117% increase in wait times for first appointments compared to 2019 (Squires et al., 2024), and this continues to trend upwards. Collated data from national GIC websites as of June 2025 substantiates this, with an average approximate wait time increase of 18.3% for first appointments from 2023 to 2025. Resultant wait times span 24 to 96 months (see Table 1.1 [5]).

**Table 1.1.**

*NHS National GIC Wait Times for First Appointments.*

| NHS Gender Clinic | First Appointment: 2019 | First Appointment: 2023 | First Appointment: 2025 |
|---|---|---|---|
| The Laurels Gender Identity Clinic | N/A | 87 Months | 96 Months |
| The Nottingham Centre for Transgender Health | 30 Months | 23 Months | 24 Months |
| The Northern Region Gender Dysphoria Service | 26 Months | N/A | 77 Months |
| The Leeds Gender Identity Service | 30 Months | 57 Months | 72 Months |
| Porterbrook Clinic Gender Identity Service | 19 Months | 62 Months | 71 Months |
| The Tavistock Centre | N/A | 60 Months | 72 Months |
| Northampton Gender Identity Clinic | N/A | 53 Months | 60 Months |

***Note.*** Wait time data presented in this table were collated in May 2025 for the purposes of this thesis. Figures draw on earlier analysis conducted by Squires and colleagues (2024) and have been supplemented with publicly available information from NHS gender identity service providers (NHS Cumbria, Tyne and Wear, 2025; NHS Leeds and York Partnership, 2025; NHS Sheffield Health and Social Care, 2025; NHS Bridge View Medical, 2025). N/A denotes instances where data could not be obtained in the review by Squires et al. (2024), primarily due to high service demand that precluded reliable estimation by clinics at the time.

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[5] Note that wait time data is not provided in this table for pilot clinics given these are predominantly transfer services and therefore there are no direct referrals from which actual wait times for this specific service can be established.

#### 1.2.2.3. Private Providers

In response to extensive NHS wait times, a growing number of individuals seek GAC through private healthcare routes (Holti et al., 2024). Private providers, such as GenderGP, GenderCare, and London Transgender Clinic, offer services including hormone therapy, psychological assessment, and referrals for surgery (GenderCare, 2024; GenderGP, 2025; London Transgender Clinic, 2025). While these services can expedite access, they are not universally accepted by NHS providers for continuation of care, and cost presents a barrier for many (Holti et al., 2024). Additionally, the Cass Review (Cass, 2024a) has raised concerns about the consistency and regulation of private gender services, especially for CYP.

For those who begin hormone therapy privately while awaiting NHS care, the issue of continuity is further complicated by the discretionary nature of *bridging prescriptions*: interim hormone prescriptions provided by GPs to reduce harm in cases where a patient is already self-medicating or has a private prescription. NHS guidance permits such prescriptions in specific circumstances, but emphasises clinical judgement and individual comfort with prescribing (British Medical Association, 2024). In practice, this results in significant regional and interpersonal variability, with some GPs facilitating shared care while others decline all involvement (Silver et al., 2025). This variability often leaves individuals in precarious positions, especially those who cannot afford long-term private care or who experience delays in NHS referral pathways (Silver et al., 2025). Overall, the absence of a formalised protocol for integrating private and NHS-initiated care contributes to unequal access and delays in continuity of treatment. Together, these pathways form a complex and often fragmented system that TGD individuals must navigate, with significant implications for their access to timely and effective care.

### *1.2.3. Clinically-Centred Services and their Neglect of Social Determinants of Health*

While CYP and adult pathways differ in their emphasis, CYP services prioritising psychological exploration and adult services offering more direct access to medical interventions, both remain firmly situated within clinical frameworks. CYP services are now more developmentally informed and psychologically focused, following the Cass Review (although note priorly highlighted controversy on this decision). In contrast, adult services maintain a medical model focused on diagnosis and treatment. Yet despite these differences, a common shortcoming persists: neither pathway adequately addresses the broader social determinants of health that impact TGD people's wellbeing. In both cases, distress is largely understood and treated at the individual level, either through psychotherapy or medical transition, rather than situated within the social environments that often generate or exacerbate that distress. Although the expansion of services (i.e., through regional clinics) signals some recognition of the needs of TGD populations, in practice these systems remain fragmented, overly medicalised, and disconnected from the broader social realities that shape health and wellbeing (Hail-Jares et al., 2021; White et al., 2023). These social conditions, including discrimination, socio-economic marginalisation, and loneliness, constitute forms of *minority stress*, a term used to describe the chronic stress faced by members of stigmatised minority groups as a result of systemic inequality (Hendricks & Testa, 2012; Meyer, 2003). These stressors are not peripheral to care, but central determinants of health outcomes for TGD people (White et al., 2023).

These social determinants affect health through multiple pathways. Directly, persistent exposure to minority stress contributes to worsened mental health (Scheim et al., 2024) and chronic physiological dysregulation (e.g., HPA-axis overactivation; Ahmed et al., 2023). Indirectly, systemic discrimination limits access to stable housing, employment, education, and affirming environments; all which serve as protective buffers against distress (Hajek et al., 2023; Scheim et al., 2024). In the absence of these supports, TGD individuals experience reduced help-seeking, delayed care, and loneliness (Miller et al., 2023; Scheim et al., 2024). Thus, while access to GAC is important, its capacity to improve health outcomes is limited when the services themselves fail to engage with these broader social determinants (White et al., 2023).

Despite widespread recognition that holistic care is necessary (Coyne et al. 2023; Marshall et al. 2019), and responsive calls by NHS England for holistic approaches to care that address psycho-social determinants of health (i.e., minority stress and loneliness; NHS, 2019), service delivery remains anchored in clinical individualism. Adult GICs and CYPGIS alike offer psychological interventions such as counselling and therapy, supports that are undoubtedly valuable, but which often conceptualise distress as internal and treatable at the individual level (NHS England, 2025). These psychological interventions therefore fail to address the hostile or invalidating environments that contribute to distress in the first instance. Thus, even when existing GIC services work well, they cannot compensate for unmet social needs like safe housing, gender-affirming schools, or community connection (White et al., 2023). Although provisioning psychological support marks a shift away from purely medicalised responses, these models still fall short in addressing the wider social and relational contexts that shape wellbeing for TGD individuals. Particularly for individuals who may not wish to medically transition, but for whom social affirmation of their identity is vital for their wellbeing, providing care pathways that recognise and support these experiences is critical (Vandermorris & Metzger, 2023).

Compounding this limitation are structural barriers in service access itself (Holland et al., 2024; White et al., 2023). Long waitlists (Thibeault et al., 2025), inconsistent service delivery (Boyd et al. 2022; Witney et al., 2025), and fragmented care pathways (Thibeault et al., 2025; Taylor et al., 2024) not only delay access to essential medical interventions, but also prolong exposure to the very social conditions that undermine health, including gender incongruence, loneliness, and minority stress (Thomas et al., 2024; Restar et al., 2021). In this way, service inefficiencies do not exist in isolation; they deepen the consequences of already unmet social needs (Hajek et al., 2023).

Taken together, these challenges illustrate how current service models, while essential in principle, fall short in practice. The absence of a coordinated response to the social determinants that shape TGD peoples' lives result in care that is insufficient, misaligned, and in many cases inaccessible. This disconnect between what TGD individuals need to thrive and what current services provide, highlights a critical gap. What is needed, then, is an approach to GAC that recognises social connection, affirmation, and identity safety not as secondary to clinical treatment, but as central to TGD health. Addressing this shortcoming may offer a pathway to mitigating multiple barriers simultaneously, underscoring the need for service innovations that extend beyond clinical care and attend meaningfully to the social dimensions of health (e.g., loneliness and minority stress).

## 1.3. The Role of Social Support in Mitigating Psycho-Social Challenges

A growing body of research has identified social support as a key protective factor that directly addresses these unmet psychosocial needs, particularly by buffering the negative effects of minority stress among TGD individuals (e.g., Puckett et al., 2023; Wilson & Liss, 2022). This is explained by Gender Minority Stress Theory (GMST; Meyer et al., 2015), which posits that social support can reduce the perceived impact of minority stress, enhance identity affirmation, and promote resilience (Hajek et al., 2023; Elmer et al., 2023; Puckett et al., 2023). These GMST processes are suggested to improve health through reducing both mental and physiological responses (e.g., HPA-axis overactivation) to minority stress events (e.g., discriminatory encounters; challenges accessing healthcare; Ahmed et al., 2023; Meyer, 2003).

This suggests that integrating social support pathways within GAC would offer an evidence-based strategy to buffer the psychosocial consequences of the aforementioned systemic challenges.

### *1.3.1. From Minority Stress to the Social Identity Approach to Health*

While GMST has been instrumental in identifying social support as a buffer against minority stress, its explanatory power is limited. Specifically, it offers little insight into the psychological processes that mediate the protective effects of support (Austin & Goodman, 2018; Rimmer et al., 2022), nor does it account for the fact that not all forms of social support are equally beneficial (Rimmer et al., 2022). Some group affiliations may fail to mitigate, or may even exacerbate, stress, depending on factors such as group quality, cohesion, and inclusivity (Chi, 2023; Puckett et al., 2019; Rimmer et al., 2022). Moreover, even when controlling for comparable levels of social support, TGD people report greater loneliness than their cisgender (i.e., individuals whose gender identity aligns with their sex assigned at birth) LGBQ[6] peers (Puckett et al., 2023), pointing to more complex identity-specific dynamics, such as those linked to transitioning identity stress (DuBois et al., 2017). Finally, GMST tends to conceptualise support primarily in terms of stress reduction, a deficit-focused approach, whereas emerging research highlights its broader role in promoting wellbeing and quality of life (Carnes et al., 2017; Lewis et al., 2023). These limitations of GMST highlight the need for a more nuanced understanding of *how* and *why* social support functions in order to formalise social support into an effective healthcare pathway. The Social Identity Approach to Health (SIAH; Haslam et al., 2008a; 2024) offers such a perspective, providing a richer account of the psycho-social mechanisms through which social support and group belonging enhances health and resilience.

### *1.3.1. A Social Identity Approach to Health (SIAH)*

The SIAH (Haslam et al., 2008a; 2024) posits that meaningful group memberships, defined as identifying with groups with which an individual has a shared identity, improves health outcomes. This is because meaningful social identities provide access to social support, sense of belonging, control, self-efficacy, and purpose (Haslam et al., 2018). Collectively, these psychological processes enhance one's ability to manage stress (Jetten et al., 2017), improving

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[6] Lesbian, Gay, Bisexual and Queer.

both mental (e.g., Cruwys et al., 2014) and physical (e.g., Steffens et al., 2016a) wellbeing (see Chapter 2 for a more comprehensive overview of the SIAH).

For TGD populations, the SIAH directly builds on GMST research by detailing *how* social support (or its absence) translates into both psychological and physiological health outcomes (e.g., Haslam et al., 2018). Thus, the SIAH not only elucidates *why* TGD individuals face health disparities, but also explains *how* to design interventions that draw on social support: by facilitating the creation of meaningful, affirming group identities. In practice, identity-building interventions grounded in SIAH principles have already yielded measurable improvements in mental health, immune functioning, and cardiovascular markers across other minoritised groups (e.g., older men; Gleibs et al., 2011; those with social anxiety; Haslam et al., 2019; older adults in residential care; Knight et al., 2010; individuals in retirement; Steffens et al., 2016a).

By extension, researchers can hypothesise that a similar approach, one that helps TGD individuals form or join supportive, identity-affirming groups, would produce parallel benefits. This raises an important question: which existing intervention models in England are best suited to deliver this kind of identity-based support at scale? One emerging approach is Social Prescribing (SP; Haslam et al., 2024). Although SP has not yet been applied to TGD groups, its core mechanism, linking individuals to community-based groups, maps precisely onto SIAH's identity-building processes (Haslam et al., 2024). The next section, therefore, turns to SP as a promising pathway for improving health outcomes among TGD people through providing standardised access to meaningful social support.

## 1.4. The Promise of Social Prescribing

Social Prescribing (SP) is a non-clinical healthcare initiative that involves healthcare professionals connecting service users to community programmes (e.g., horticulture workshops, crafting groups) to reduce loneliness, improve social connection and health (Haslam et al., 2024; Hayes et al., 2023; see Chapter 3 for a more extensive overview of SP). Although often presented as a practical solution to loneliness, recent evidence suggests SP may function through deeper psychological mechanisms. Specifically, studies indicate that SP improves health outcomes by facilitating social identification and belonging; the very mechanisms outlined in the SIAH (Haslam et al., 2024; Kellezi et al., 2019; Stevenson et al., 2019; Wakefield et al., 2022). From this perspective, SP can be understood as a natural delivery system for identity-based interventions.

In this way, SP aligns closely with SIAH-based intervention models, which aim to improve health by fostering membership in meaningful, affirming social groups. Empirical studies of SP report a range of positive outcomes comparable with SIAH-based interventions, including reduced loneliness, enhanced social connectedness, and improved quality of life, particularly among minoritised populations (e.g., socially isolated individuals; Carnes et al., 2017; older men; Gleibs et al., 2011; those with poor mental health; Morton et al., 2015). Thus, SP provides a way to leverage the benefits of SIAH-based interventions within existing healthcare pathways in England.

### *1.4.1. Challenges for Social Prescribing Implementation with TGD Populations*

Given the value of SP for facilitating access to social support, a factor repeatedly identified as vital for TGD wellbeing (Hajek et al., 2023; Elmer et al., 2023; Puckett et al., 2023), alongside emerging evidence that its benefits can be explained through the SIAH, SP presents a promising and scalable tool for improving TGD health outcomes. Despite its promise, several outstanding questions remain for the effective design and implementation of SP for TGD populations. These challenges are both methodological, limiting the robustness of the evidence base, and practical, especially with regard to its novel application to TGD groups. Addressing both issues is critical for understanding how SP might be beneficial to TGD populations, and how it can be feasibly implemented.

#### 1.4.1.1. Methodological Limitations

While the SIAH offers a compelling theoretical explanation for how SP may improve health, these outcomes have not always been interpreted through the lens of social identity processes, leading to gaps in both theory and evaluation. Most SP evaluations prioritise descriptive or service-level outcomes (e.g., referral rates, programme uptake), rather than measuring the psychological processes thought to underpin its effectiveness (Bickerdike et al., 2017; Evers et al., 2024). As a result, even when SP produces positive outcomes, it remains unclear *why* these benefits occur or how they might be replicated across different populations and contexts (Dayson et al., 2017; Husk et al., 2019). This has contributed to SP's inconsistent evidence base (Bickerdike et al., 2017; Dayson et al., 2017; Evers et al., 2024; Husk et al., 2019).

This limitation reflects a broader issue of SP being treated as a 'black box' intervention. In essence, it is not always clear *how* or *why* SP works, even when benefits are observed (Bickerdike et al., 2017). While recent theoretical work has begun to address this (e.g., through the SIAH; Wakefield et al., 2022), few studies have systematically explored the empirical evidence for this relationship. Without robust, theory-driven evaluation, efforts to adapt SP to new populations risk being inconsistent or misaligned with the processes that actually promote wellbeing (See Chapter 3 for a more in-depth exploration of these challenges).

Thus, in order to develop a SP programme for TGD populations that is meaningful, there is a need to 1) systematically review existing SP literature through an appropriate theoretical lens (i.e., the SIAH) to establish a more complete picture of *how* and *why* SP works and 2) apply these theoretical understandings to the group for whom SP is being designed for (i.e., TGD individuals) to establish potential population-specific mechanisms that may shape engagement with, and outcomes of, SP (e.g., transitioning identity stress and changing social identities over the course of TGD individuals' transition; Dubois et al., 2017).

#### 1.4.1.2. Limited Application to Trans and Gender Diverse Populations

Beyond methodological concerns, SP's application to TGD populations remains unexplored. Given the potential of SP in other minoritised groups (e.g., socially isolated individuals; Carnes et al., 2019; older men; Gleibs et al., 2011; and those in residential care; Knight we al., 2010), its lack of application to TGD communities is a notable omission, particularly given heightened loneliness, discrimination, and mental health challenges among TGD communities compared to their cisgender counterparts (McNeil et al., 2012; Toomey et al., 2018). Given these challenges, TGD groups represent a population for whom interventions that facilitate access to affirming social support may be especially valuable.

Although emerging evidence suggests SP may support health through the development of meaningful social identities (Haslam et al., 2024), it is unclear whether, and how, this approach aligns with the preferences, expectations, and lived experiences of TGD groups. While extant literature has explored the value of social support for TGD individuals (e.g., Puckett et al., 2023; Wilson & Liss, 2022), translating this support into effective health interventions is a notable absence from the literature. There is currently no research evaluating the *want* for or *perceived value* of SP among this population, nor has there been an effort to adapt SP pathways to meet their specific needs. This presents both a knowledge gap and a missed opportunity to extend the benefits of SP to a marginalised group for whom social connectedness may be particularly protective.

Crucially, any steps to adapt SP for TGD populations must account for issues of trust, safety, and community relevance. Many TGD individuals report strained or negative experiences with healthcare providers, contributing to widespread mistrust of the NHS (e.g., Herlitz et al., 2024; Wright et al., 2021). If poorly implemented or not well communicated, SP may be perceived as a prerequisite for GAC; another systemic barrier to living as their authentic self. Poorly tailored implementation of SP may also create the impression of "friends on prescription": that is, a superficial or tokenistic attempt to address loneliness through externally imposed relationships, rather than a genuine, community-led opportunity for social connection. As such, careful consideration is needed regarding how, when, and where SP is introduced to this group.

Additionally, practical questions remain about delivery. For instance, whether TGD individuals would prefer TGD-specific groups valuing safety, or prefer integration into broader community initiatives to foster inclusion and visibility. These questions speak not only to individual preference but also to systemic factors, such as the availability of trained facilitators, the geographic distribution of services, and the social climate of local communities.

In sum, while SP shows considerable promise as a vehicle for supporting TGD wellbeing, its translation into this context requires targeted exploration. Understanding both the *need* for and *acceptability* of SP among TGD groups is essential for ensuring that future interventions are both effective and affirming.

### *1.4.2. Trans and Gender Diverse Young People as a Critical Priority for Social Prescribing*

While SP has potential across all age groups, adolescence and early adulthood represent a particularly critical window for intervention due to heightened exposure to social stressors and ongoing identity development (Kirkbride et al., 2024; Muhl et al., 2025). Particularly for TGD populations, evidence suggests that their experiences will differ across the lifespan (Breder & Bockting, 2023; Li et al., 2021), with TGD young people (TGDYP) experiencing heightened psycho-social vulnerability in comparison to their older counterparts (Goulding et al., 2023). Thus, TGDYP represent a compelling group with whom to begin exploring SP.

While the aforementioned limitations of GAC affect TGD people broadly, their impact is especially acute for young people. TGDYP often face long delays and restrictive eligibility in CYP gender identity services, only to encounter further barriers when transitioning to adult care (Goulding et al., 2023). Particularly given the recent changes to the function, format, and delivery of CYP gender identity services (i.e., the move from GIDS to CYPGIS), TGDYP experience inconsistent and uncertain service provision (Cass, 2024b). Particularly for TGDYP aged 16-17, they may find themselves in a precarious position, whereby they have 'aged-out' of CYPGIS, but are too young to access adult GICs. This transition gap can further delay access to GAC for TGDYP, compounding psychological distress and social exclusion (Stepney et al., 2025).

At the same time, TGDYP must navigate additional life-stage challenges, including education, housing, independence and identity formation (Corlett et al., 2023). In response to these challenges, TGDYP often report feeling *left behind* as their developmental trajectory becomes impeded by their inability to live as their authentic selves (Grant et al., 2025; Restar et al., 2021). These intersecting factors place TGDYP at heightened risk for poor health outcomes and unmet needs compared to older TGD adults who may have more stable access to care or community (Breder & Bockting, 2023).

Together, these factors position TGDYP as a high-need population and make a strong case for targeted SP. With youth being particularly vulnerable to these social determinants of health, supporting identity development and social connection during early adulthood may not only buffer the effects of minority stress, but also prevent downstream manifestations of health disparities observed in older TGD populations (Muhl et al., 2025; Scheim et al., 2024). For these reasons, the present research seeks to explore the acceptability, feasibility, and design considerations of identity-based SP interventions for TGDYP: a population for whom timely, affirming support may be especially consequential.

### 1.5. Rationale and Research Aims

In light of the limitations of existing GAC pathways in England, particularly clinical, individualised approaches and a failure to address the broader social determinants of health, there is a pressing need to develop holistic interventions that enhance TGD wellbeing. As demonstrated, social support is a central protective factor for TGD people, and SP offers a promising mechanism for formalising access to such support. This thesis applies the SIAH to understand whether SP might improve health outcomes for TGDYP, *how* and *why* it might work, and under what conditions it can be effectively and affirmingly delivered.

Importantly, this research centres TGDYP as an especially vulnerable subpopulation. TGDYP face unique developmental and structural challenges, including service transition gaps, identity formation stress, and limited autonomy, that intensify the consequences of unmet psychosocial needs. Adolescence and young adulthood are also recognised as critical periods for identity development and wellbeing intervention (Kirkbride, 2024). Thus, understanding how SP can be tailored to meet the needs of this group not only addresses a gap in practice, but offers a unique opportunity for early, identity-affirming intervention. Thus, this thesis makes a dual contribution. It advances theoretical understanding of SP through a SIAH lens, and it provides the first empirical exploration of SP's applicability to TGDYP: a population for whom psychosocial support is both critically needed and structurally neglected. To achieve this, the main research questions explored in this thesis are:

1. How can the SIAH inform the effective implementation of Social Prescribing as a healthcare intervention?
2. How can the SIAH inform our understanding of the psychological processes through which social support enhances wellbeing for TGDYP?
3. In what ways can a SIAH-informed model of Social Prescribing be designed and implemented to improve health outcomes for TGDYP?

### 1.6. Thesis Structure

The three research questions explored in this thesis were addressed by conducting a systematic review and 2 empirical qualitative studies (see Figure 1.1 for an overview of how these were addressed in each study). The organisation of chapters to address these research questions are summarised below.

**Chapter 2: Theoretical Framework:** Chapter 2 presents the SIAH as the conceptual foundation of the research. The chapter explores how group memberships and social connectedness influence health outcomes, and why this approach may be particularly relevant for TGD populations.

**Chapter 3: Systematic Review:** This chapter tests the explanatory power of the SIAH in the context of SP by synthesising existing literature. Positioned prior to the methodology chapter, the review serves as a theory-testing and scoping exercise. Its early placement reflects its foundational role in refining the focus of the empirical work. By identifying key psychological mechanisms that underpin SP, the review directly shaped the research questions, design, and analytic strategies that follow. In this way, the methodology chapter (Chapter 4) is informed by and responsive to the outcomes of the systematic review.

**Chapter 4: Methodology:** Chapter 4 outlines the ontological, epistemological, and methodological foundations of the empirical work. It justifies the use of a pragmatic, exploratory sequential qualitative design and describes the rationale for methodological pluralism, participatory approaches, and ethical considerations. The chapter explains how the review's findings (Chapter 3) shaped decisions around data collection, analysis, and stakeholder engagement across the empirical studies.

**Chapter 5: Development of the Qualitative Triangulation Framework (QTF):** This chapter introduces the QTF, a novel analytic tool developed as part of this thesis to support the analysis of multi-perspective qualitative data. Designed to address tensions between stakeholder views and centre TGDYP's perspectives, the QTF provides a transparent, structured framework for identifying convergence and divergence in the data. Its placement before the empirical chapters reflect its application in both Study 2, Part 1 (Chapter 6) and Part 2 (Chapter 7), where it enabled the development of nuanced, reflexive themes grounded in stakeholder experience.

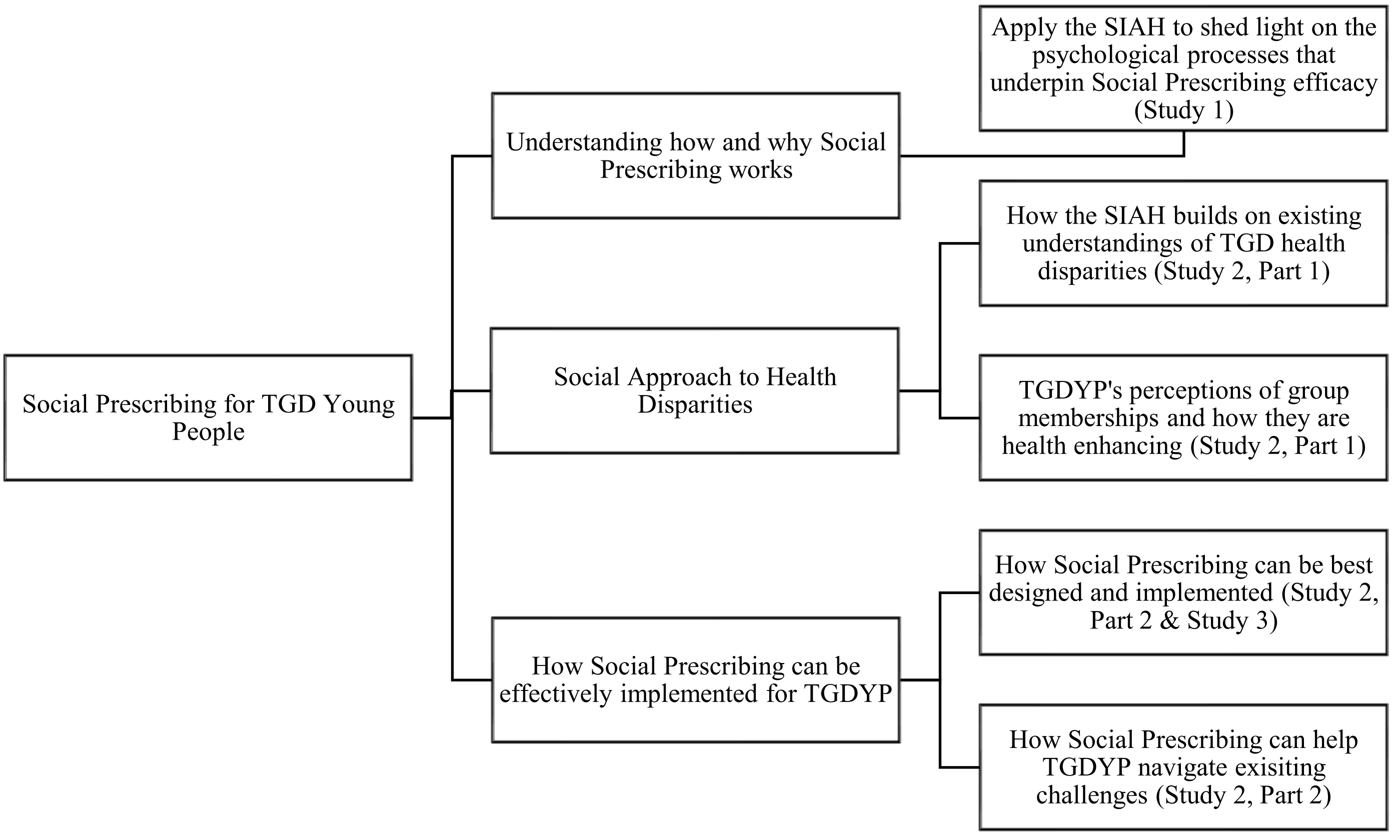
**Chapter 6: Study 2, Part 1 – Exploring Meaningful Social Connections:** This chapter presents the first empirical study, which explores how TGDYP experience meaningful social connections and the psychological value of these connections in their daily lives. The QTF is used to support theme development, ensuring findings are rooted in participants' lived realities while remaining analytically rigorous. The study deepens understanding of the mechanisms identified in the systematic review and provides a foundation for designing TGD-inclusive SP pathways.

**Chapter 7: Study 2, Part 2 – Designing a TGD-Inclusive Social Prescribing Pathway:** Building on the previous chapter, this study focuses on how TGDYP and healthcare professionals envision SP in practice. The QTF is again used to identify points of convergence and divergence between groups, informing the design of an SP pathway that is both theoretically grounded and practically viable.

**Chapter 8: Study 3 – Service Evaluation of a GIC Social Support Model:** This final empirical chapter evaluates an existing gender clinic that integrates social support into its care model. The study examines whether a service model similar to SP is acceptable and beneficial to TGDYP. Positioned last, this study tests the real-world relevance of the research findings and offers insight into how theory-informed interventions play out in practice.

**Chapter 9: General Discussion and Conclusion:** The final chapter synthesises findings across all studies, revisits the original research questions, and reflects on the contributions of the thesis. It discusses practical implications, theoretical advancements and proposes directions for future research, emphasising real-world impact and relevance.

**Figure 1.1.**
*Main research areas to be explored and corresponding studies within this thesis.*



# Chapter 2

## The Social Identity Approach to Health

### 2.1. Introduction

This thesis is grounded in the Social Identity Approach to Health (SIAH; Haslam et al., 2008a; 2024). The SIAH posits that groups influence their members' health, and that this influence can be positive (Social Cure) or negative (Social Curse). This diverges from traditional approaches to health outcomes where determinants of health are posited to be largely individualistic (Lehman et al., 2017). Instead, the SIAH presents a *socio-psycho-bio* model of health, which places group processes at the forefront (Haslam et al., 2024). This chapter explores the origins of the SIAH, including the Social Identity Approach (SIA; Tajfel & Turner, 1979) within Social Psychology, applications of the SIA to stress management, and how this provided insight into the psychological mechanisms which underpin positive health and wellbeing outcomes as a result of group identification. It then critically evaluates the applicability of the SIAH for better understanding health disparities documented by TGDYP (e.g., Hajek et al., 2023; Scheim et al., 2024). This chapter concludes with a review of how the SIAH has been applied to health interventions, and thus how a SIAH-informed perspective could offer novel insights into how best to develop and tailor SP for TGDYP. By critically evaluating both theoretical and empirical gaps, this chapter lays the groundwork for later discussions on designing identity-based interventions for improving TGDYP's health.

### 2.2. Social Identity Approach (SIA)

The SIA is an umbrella term used to refer to Self-Categorisation Theory (SCT; Turner, 1991) and Social Identity Theory (SIT; Tajfel & Turner, 1979). Collectively, these theories explore the dynamics between groups and individuals (Tajfel & Turner, 1979; Verkuyten, 2021). SIT was developed first, and focuses on the relationship between our personal and social identities. It posits that our group memberships are an important source of self-esteem, so we are motivated to ensure that our group is perceived positively by outgroups (Tajfel & Turner, 1979). SCT developed from SIT, and focuses more on the cognitive and psychological aspects of group memberships (Turner, 1987). Since SIT and SCT make similar predictions, this section centres on the broader SIA framework rather than distinguishing between the two.

The SIA argues that as well as having a personal identity, we each have multiple social identities, each of which pertain to different group memberships, and integrate to form one's complex social identity. Thus, our social identity is comprised of our group memberships. While some group memberships may be formed based on arbitrary demographic characteristics (e.g., people aged 16 – 25) or proximal groupings (e.g., people who go to one's educational institution), other group memberships create more meaningful social identities (Haslam et al., 2024; Tajfel & Turner, 1979). These latter groups are rooted in shared experiences, creating a *shared social identity* (Neville et al., 2021). These shared social identities are the basis for productive social interaction, giving way to trust, organisation, and respect (Ellemers et al., 2004; Neville & Reicher, 2011). This shifts individuals from being psychologically separate beings to members of a mutual social group with whom they share emotional intimacy (Neville et al., 2021).

At any one time, one of these groups can become *salient* (or cognitively conspicuous) to us, leading us to perceive ourselves as a member of that group, and perceiving people who share that membership/social identity as *ingroup members* (Tajfel & Turner, 1979). The salience of a social identity can vary depending on the context and individual readiness to activate that identity, a process influenced by perceiver readiness (Haslam et al., 2023). Moreover, we think and behave in ways that are consistent with the norms of that group, aligning with its normative fit, which reinforces identity salience and ingroup identification (known as "*The Norm Enactment Hypothesis"*: Jetten et al., 2017; Neville et al., 2021). When our group membership also serves to differentiate us from others, enhancing comparative fit, the boundaries between us and the outgroup become clearer, further strengthening our identification with the ingroup. Thus, individuals define themselves in relation to these meaningful and salient group memberships, influenced by both the context and the social structures that frame them (Tajfel & Turner, 1979).

Thus, while identity salience is key to perceiving oneself as a member of a group, identity salience is a dynamic process (Jetten et al., 2017). For example, we perceive ourselves as members of different groups in different contexts, and will also perceive the same person as an ingroup or outgroup member depending on the current context (e.g., an American psychologist is considered an ingroup when our psychologist identity is salient, but an outgroup member when British national identity is more prominent).

Further, individuals are likely to hold different feelings towards each group of which they are members, feeling a stronger sense of belonging to some more than others. This sense of belonging is known as *group identification* (Haslam et al., 2024). It is strongly-identifying group members who are particularly likely to think and behave in norm-consistent ways when a group becomes salient to them (Haslam et al., 2024; Jetten et al., 2017). It is this concept of group identification that is at the heart of the SIAH, and the role that these group memberships play in shaping health outcomes (Haslam et al., 2024).

## 2.3. Social Identity Approach To Health (SIAH)

The SIAH developed through application of the SIA to the topic of stress and how people perceive and appraise it. Lazarus and Folkman's (1984) Classic Transactional Model of Stress Appraisal posits that an individual must first decide if a stimulus is stressful (primary appraisal). If deemed stressful, they must then decide whether they can cope with it (secondary appraisal). Whilst SIA was originally developed as a theory of intergroup conflict (Haslam et al., 2011; Lazarus & Folkman, 1984), applying the SIA to the Classic Transactional Model of Stress Appraisal demonstrated that meaningful group memberships affect both primary and secondary appraisal. For instance, Levine and Reicher (1996) demonstrated how the degree to which a situation is perceived as threatening (primary appraisal) depends on which social identity is salient. If the threat directly impacts that salient social identity, it increases the likelihood of the threat being perceived as more severe compared to someone for whom that identity is not prominent. For example, a minor injury may feel highly threatening to someone who strongly identifies as an athlete because it jeopardises their ability to perform, whereas the same injury may be less identity-threatening for someone who's identity is not tied to their physical performance. This is because the injury is not just a physical symptom but is also associated with the potential loss of one's group membership (i.e., with other athletes). Thus, one's salient group membership at the time of the threat plays a crucial role in determining the intensity of the perceived threat.

Regarding secondary appraisal, research explains how, once acknowledging that a stimulus is a threat, the degree to which individuals feel they can cope with it, and thus experience it as stressful, is mediated by group identification (Haslam et al.., 2011; McKimmie et al., 2019). This is because group identification (i.e., meaningful as opposed to arbitrary group memberships) increases perceived access to social support to help manage the threat (Haslam et al., 2011). Thus, one's important group memberships influence the way stressful events are perceived and appraised.

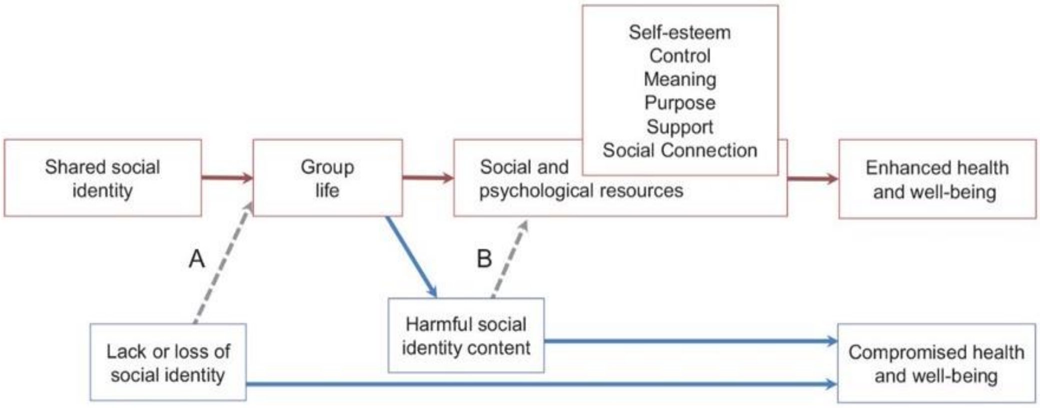
Although primary and secondary appraisals are often viewed as linear processes, their relationship is reciprocal; an increase in perceived coping resources (secondary appraisal) can reduce the likelihood of future stimuli being perceived as stressful (primary appraisal; Haslam et al., 2011). These observations led to a new perspective on stress appraisal: rather than “Do I find this stressful?” and “Can I handle it?”, the focus became “Do *we* find this stressful?” and “Can *we* handle it?” (Haslam et al., 2018).

### *2.3.1. Social Cure Processes*

These observations regarding the importance of group identification for stress appraisal led to more general explorations of the relationship between group identification and health/wellbeing (Haslam et al., 2008a; Jetten et al., 2012; Marmot, 2015). Introduced by Jetten and colleagues (2009), their work provided a theoretical foundation for understanding how social connections promote wellbeing. Their approach, termed the *Social Cure*, illustrated how meaningful social identities are central to good health through buffering against the negative health consequences of stress (known as “*The Social Identity Hypothesis”*; Branscombe et al., 1999; Jetten et al., 2017). This is because meaningful social identities, developed through identifying with groups with which an individual has a shared social identity, provides access to social support, a sense of belonging, control, self-efficacy, and purpose: Psychological processes that are fundamental for leading healthy and meaningful lives (known as “*The Identification Hypothesis”*; Haslam et al., 2018; Jetten et al., 2017 also see Figure 2.1).

**Figure 2.1.**

*Social identity as a basis for group life, social and psychological resources, and health. Taken from Haslam and colleagues (2024).*



*Note*. Adapted from Haslam and colleagues (2018). The red lines delineate a social cure pathway in which shared social identity is a basis for productive participation in group life that gives people access to key resources and thereby supports their mental health. The blue lines delineate a social curse pathway in which (A) lack of social identity denies people access to group life or (B) membership in problematic groups denies people access to these resources (as indicated by the dotted lines), and hence is harmful to their mental health.

#### 2.3.1.1. Outcome Variables

Based on these hypotheses, Social Cure researchers have evidenced positive health outcomes in mental, physical, and behavioural health domains. For example, strong group identification has been associated with increased self-esteem in individuals with autism (Cooper et al., 2017), children, older adults, and former residents of a homeless shelter (Jetten et al., 2015). Reduced depression has been observed in Norwegian surgery patients (Haslam et al., 2005), Australian school students (Bizumic et al., 2009), global majorities (Branscombe et al., 1999), university students (Branscombe & Wann, 1991; Cameron, 1999; Iyer et al., 2009), and people with Multiple Sclerosis (Wakefield et al., 2013). Greater happiness is reported among immigrants (Bobowik et al., 2017), and more general wellbeing and quality of life improvements are seen in a variety of populations (Cruwys et al., 2014), including children and older adults (Jetten et al., 2015; Steffens et al., 2016a).

While much SIAH research has focused on these psychological wellbeing outcomes (Steffens et al., 2016a), emerging research on physical health outcomes is also promising. For example, Steffens et al. (2016a) demonstrated that maintenance of social relationships post-retirement reduced mortality risk among those in retirement, even when accounting for pre-existing physical health; an effect size comparable to that observed for physical activity on mortality risk (also see Putnam, 2000). Similar improvements on subjective measures of physical health (i.e., through the physical health subscale of the WHOQOL-BREF; WHO, 1996) were also observed by Celebi and colleagues (2017) among Syrian refugees.

However, research on physical health outcomes is largely self-report, lacking objective measures of physiological functioning (Steffens et al., 2016a). Addressing this concern, a handful of researchers have begun exploring physiological outcomes. For instance, Griffin et al. (2024) documented higher post-awakening cortisol responses associated with social identity gain, indicating better stress coping responses. Similarly, research suggests that social group memberships positively influence biomarkers associated with stress responses (e.g., oxytocin and opioids; Inagaki et al., 2020; Pearce et al., 2017). Group identification can also influence health behaviours (Jetten et al., 2017). For instance, groups that promote positive health practices (e.g., eating healthy and regular exercise) can encourage this behaviour in individuals who identify with that group (known as "*The Norm Enactment Hypothesis*" where individuals adopt behaviour normative of the group; Jetten et al., 2017 Hopkins & Reicher, 2016).

Collectively, this body of work illustrates positive health outcomes associated with group identification at both clinical and subclinical levels.

#### 2.3.1.2. Mediating Variables

Emanating from these findings, SIAH researchers considered variables that may mediate the relationship between group identification and health outcomes observed (i.e., the psychological processes through which group identification predicts health-related outcomes; Jetten et al., 2017). Reflecting on previous research informed by the SIAH, four key psychological resources are suggested to stem from group identification. The first, *social connection*, defines one's sense of social intimacy with other ingroup members (known as "*The Connection Hypothesis"*; Jetten et al., 2017). This allows individuals to experience shared social identity, increasing the likelihood of perceiving oneself as similar to others. This imparts a sense of trust between oneself and other group members, and improves one's self-worth (Cooper et al., 2017). This shared social identity provides the second psychological resource: a sense of *common direction, meaning, and purpose* (known as "*The Meaning Hypothesis"*; Cruwys et al., 2014; Jetten et al., 2017). This enables group members to channel their energy towards a collective purpose, imbuing a sense of meaning in their lives (Hopkins et al., 2016). Thirdly, this shared social identity also shapes the provision and receipt of *social support* (known as "*The Social Support Hypothesis"*; Jetten et al., 2017). This is because individuals are more likely to offer support to other ingroup members compared to outgroup members (Levine et al., 2005). Correspondingly, shared social identity also increases the likelihood of positive receipt and beneficial utilisation of social support (Haslam et al., 2011). Finally, when people feel they have the first three psychological resources, they may feel more in control of their behaviour (Greenaway et al., 2015), granting psychological resource four; *a sense of collective efficacy, agency, and power* (known as "*The Agency Hypothesis"*; Avanzi et al., 2015; Jetten et al., 2017). This efficacy increases one's ability to manage demanding life events (e.g., discrimination, changes to one's social environment; Celebi et al., 2017). These psychological processes were subsequently included in later SIAH models (e.g., Wakefield et al., 2020) to establish an evidence base for the psychological processes that underpin health improvements in response to group identification.

While the aforementioned psychological mechanisms underpin both mental and physical health outcomes, recent work also explores physiological mediators of the relationship between group identification and positive health outcomes. For instance, Inagaki et al. (2020) explored neurochemical mechanisms, specifically the role of opioids in social bonding. By administering the opioid antagonist Naltrexone, they compared responses to images of close others and strangers under both Naltrexone and placebo conditions. Their results demonstrated that opioid inhibition due to Naltrexone negatively affected social bonding with close others (i.e., meaningful social connections), but had no effect on strangers. This suggests that neurochemical mechanisms responsible for social bonding (e.g., opioid receptor binding) operate specifically within meaningful social relationships rather than all social interactions. Given the role of endogenous opioids in regulating various physiological functions (e.g., pain, euphoria, stress resilience; Shenoy & Lui, 2023), these findings suggest that neurochemical mechanisms present in meaningful social relationships also contribute to downstream physiological benefits. Building on this, Griffin et al. (2024) demonstrate that meaningful relationships increase one's perceived ability to manage stress, reflected in stress biomarkers such as enhanced Cortisol Awakening Responses (CAR). Increased CAR subsequently protects physical health through reducing stress dysregulation responses such as HPA-axis overactivation. Although preliminary, physiological evidence, when combined with psychological processes (e.g., social support, sense of meaning in life etc.), presents a compelling argument for the impact of meaningful group identification on health.

#### 2.3.1.3. Multiple Group Identifications

Although identifying with one group has demonstrated beneficial health outcomes, SIAH researchers have also shown that there are added benefits to identifying with multiple groups simultaneously (Charles et al., 2023; Haslam et al., 2018; Sonderlund et al., 2017). Multiple group memberships have been associated with improvements in wellbeing (Binning et al., 2009; Jetten et al., 2015), resilience and coping (Haslam et al., 2008a; Jones & Jetten, 2010), quality of life (Haslam et al., 2008a) and stress (Iyer et al., 2009). This is because multiple group memberships enhance access to psychological resources (e.g., sense of meaning in life, social support; Jetten et al., 2017).

However, contrary to widely held assumptions, the value of multiple group memberships is not an additive process (i.e., it does not merely increase an individual's psychological resources in a linear fashion; Sonderlund et al., 2017). Instead, holding multiple group memberships enables individuals to provision support from their multiple social identities, where different groups provide different types of support. This becomes increasingly important in a context of rising social mobility, which has contributed to the growing diversity and complexity of people's social environments (Sonderlund et al., 2017). Resultantly, the different social identities that become salient within different parts of individuals' lives need to be reflected in the social groups to which they belong. Thus, multiple group memberships allow people to experience good quality social connections within all the social identities that they adopt.

Expanding on this, Charles and colleagues (2023) observe that it is the diversity in these multiple group memberships that is key to increased health benefits. This is because diverse social relationships not only provision meaningful support from individuals' multiple social identities, but also leads to increases in creative self-efficacy. Creative self-efficacy refers to one's perceived ability to creatively perform a task; a skill associated with increased cognitive flexibility (Steffens et al., 2016b). Charles et al. (2023) propose that it is this cognitive flexibility that allows people to reappraise challenging social environments (e.g., those characterised by discrimination and loneliness), overcoming cognitive biases that attend to negative social stimuli (e.g., social rejection; also see Cacioppo & Hawkley, 2009). As such, multiple group memberships enhance the likelihood of one making positive appraisals of their social environments, including their perceptions of social groups of which they are a member, increasing perceived access to health-enhancing psychological resources (also see Jetten et al., 2015).

Having said that, while multiple and diverse group memberships demonstrate health-enhancing benefits (e.g., Charles et al., 2023; Sonderlund et al., 2017), these benefits only hold when these multiple identities are compatible with each other (Iyer et al., 2009; Sonderlund et al., 2017). This is because compatibility between group identities allows a person to see their various group identities as complementary. This is because these multiple groups have similar norms and values, making it easy to be part of these groups simultaneously. This in turn increases perceived simultaneous access to multiple psychological resources that these different groups provide (Sonderlund et al., 2017). However, if these groups are incompatible with each other (e.g., being LGBTQ+ in a religious community that does not accept LGBTQ+ identities), it creates tension, where an individual feels torn between their different social identities. As a result, incompatibility can lead to group disidentification or support withdrawal due to perceived anti-normative behaviour (Kellezi & Reicher, 2012; also see 2.3.2.2. Violating Ingroup Norms), reducing access to health-enhancing resources and subsequent health benefits (Matschke & Fehr, 2017). Group (in)compatibility is particularly poignant for TGDYP given widespread discrimination limiting access to multiple accepting social spaces (Scheim et al., 2024; also see 2.4. Application of the SIAH to TGD Populations for further discussion).

#### *2.3.1.3.1 Social Identity Model of Identity Change*

Group compatibility is particularly important in times of change/transition in one's life, such as those identity transitions experienced by TGDYP (see 2.4. Application of the SIAH to TGD Populations for further discussion). As posited by the Social Identity Model of Identity Change (SIMIC; Jetten et al., 2014), this is because life transitions (e.g., moving home, starting a new job) can disrupt one's access to existing social groups and associated support (e.g., connections with their local community or former work colleagues). The stress caused by losing these valued social identities can negatively impact health (Haslam et al., 2024; Jetten et al., 2014). Nonetheless, during life transitions, wellbeing can be maintained through 1) maintaining group memberships from before the transition and 2) by acquiring new group memberships during/after the transition (Jetten et al., 2014; see Figure 2.2). Compatibility between former and new group memberships helps facilitate integration of one's former and current social identity, providing one with a sense of identity continuity and stability (Jetten et al., 2014; Haslam et al., 2024). Thus, having multiple compatible groups reduces one's sense of identity loss during transitional points in their life, increasing perceived access to health-enhancing group resources.

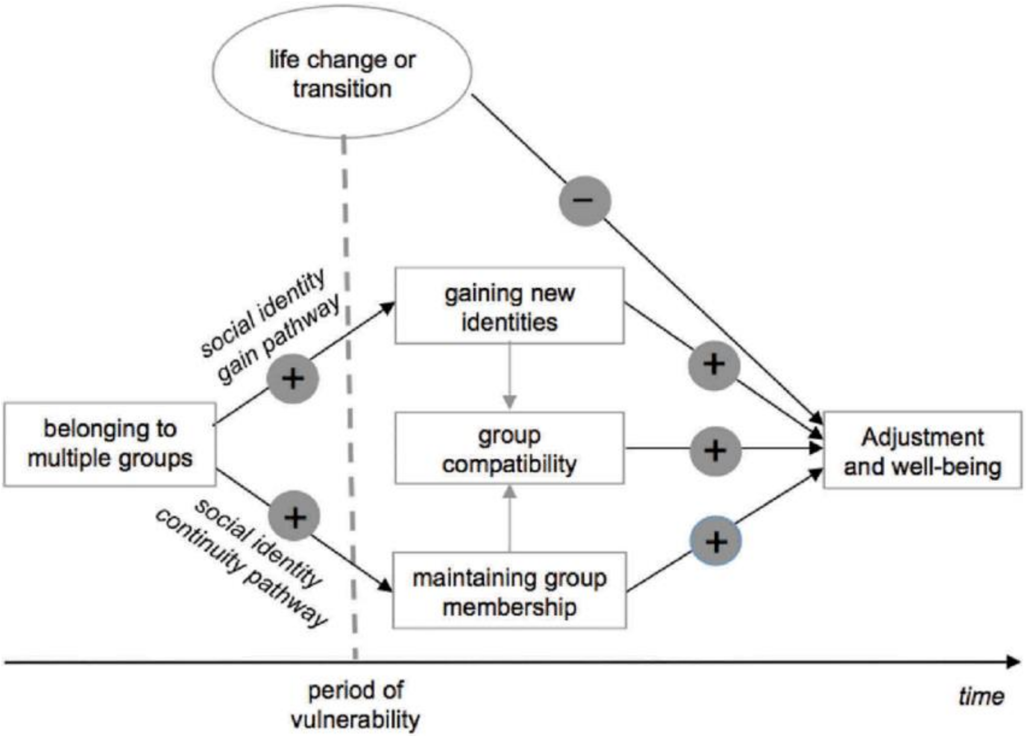


**Figure 2.2.**

*The SIMIC, taken from Jetten and colleagues (2014).*

Empirical work has demonstrated the value of multiple compatible group memberships for refugees, retirees, older migrants, former veterans and international students (Ballentyne et al., 2021; Haslam et al., 2018; Jetten et al., 2018; Ng et al., 2018; Wakefield et al., 2024). These studies demonstrate that successful adjustment and wellbeing during major life changes are enhanced when individuals maintain valued pre-existing social identities and/or acquire new, meaningful ones. SIMIC principles have also informed interventions such as "Groups 4 Health" which aims to foster social group ties to protect health. This evidence highlights SIMICs value as both an explanatory framework and a foundation for targeted, real-world interventions supporting wellbeing during life transitions.

Overall, the literature demonstrates how meaningful group memberships improve health through both psychological and physiological mechanisms. Multiple group memberships further enhance health, but only if identities are compatible. These multiple compatible group memberships are particularly important in transitional periods of one's life where their social identities and associated group support can be threatened. Recognizing the impact of social identities on health underscores the importance of fostering inclusive, supportive communities that help individuals maintain and integrate their meaningful group memberships.

### *2.3.2. Social Curse Processes*

Although a great deal of work has been done within the SIAH literature to explore Social Cure processes, researchers have also examined the darker side of group memberships: when groups can harm health and wellbeing. First discussed by Kellezi and Reicher (2012), Social Curse processes involve group memberships harming their members, usually via one of three mechanisms: 1) unhealthy group norms; 2) ingroup support being withheld due to a member violating ingroup norms; and 3) intergroup stigma (e.g., low ingroup status compared to outgroups). Altogether, these processes can diminish the health/wellbeing-related value of meaningful group memberships (see Figure 2.1).

#### **2.3.2.1. Unhealthy Group Norms**

Groups are held together by their sense of shared identity which, in part, is based on in-group norms (Haslam et al., 2024; Kellezi & Reicher, 2012). Whilst these shared normative values can provide a sense of belonging and meaningful identity, when norms within the group become detrimental, they can harm group members instead of benefitting them (Kellezi &

Reicher, 2012). Unhealthy norms may encourage destructive behaviours such as excessive risk taking, substance misuse, or hostility towards outsiders (Dingle et al., 2014; Griffiths, 2023; Kellezi & Reicher, 2012; McNamara & Parsons, 2016). In extreme cases, these norms can pressure individuals to conform even when it is against their personal will. The Kosovo conflict (February 28th, 1998 – June 11th, 1999), for example, illustrates how war-torn communities might normalise violence, creating environments in which aggression and mistrust are reinforced rather than discouraged (Kellezi & Reicher, 2012). This is because group members normalise and internalise these behaviours in order to remain a member of that group, where loss of one's group membership is deemed more detrimental than participating in destructive behaviour (Haslam et al., 2024; Kellezi & Reicher, 2012).

#### 2.3.2.2. Violating Ingroup Norms

While conformity to unhealthy ingroup norms can appear counterintuitive, group memberships often come with expectations (i.e., that one should think and behave in certain ways; Smith & Louis, 2010). Failure to meet these expectations is often met with rejection and ostracization, seizing one's access to health-enhancing psychological resources that these groups provide (Kellezi & Reicher, 2012). This is demonstrated by Crane and Platow (2010) who observed that highly identifying group members expressed dissatisfaction at group members who violated group norms, even when a large majority of the group take on that behaviour (also see Kellezi & Reicher, 2012 for similar observations). These ingroup 'deviants' are judged more harshly than members of the outgroup who exhibit similar behaviour (termed the *Black Sheep Effect*; Marques & Paez, 1988). This is because individuals define themselves by their group memberships (Tajfel & Turner, 1979). Thus, it becomes important to one's self-concept and identity stability that the norms of groups by which they define themselves are consistently reinforced (Neville et al., 2021; Tajfel & Turner, 1979).

#### 2.3.2.3. Intergroup Stigma and Low Status

In addition to maintaining a stable individual and group identity, reinforcing group norms is also important to make the ingroup appear legitimate to outgroups (e.g., Bettencourt et al., 2001; Sasse et al., 2022). This is because strong group norms increase perceived group legitimacy (Haslam et al., 2008a). Groups labelled as legitimate are more likely to be respected by outgroups and viewed as high status, reducing intergroup discrimination, and increasing the health of ingroup members (Bezouw et al., 2020; Haslam et al., 2008a). Conversely, illegitimate groups, for example groups that do not have strong normative values, are more likely to experience stigma and discrimination from outgroups due to being deemed low status, negatively affecting health outcomes (Bezouw et al., 2020; Kellezi & Reicher, 2012). This is because belonging to visibly devalued groups can compromise wellbeing through exposure to minority stress (Sonderlund et al., 2017). This can create a vicious cycle where low status reinforces marginalisation, leading to further negative psychological and social outcomes. Members of devalued (or marginalised) groups may also struggle with internalised discrimination (e.g., transnegativity within TGD communities; Anderson et al., 2020), reduced self-esteem, and fewer opportunities for upward mobility (Tajfel & Turner, 1979).

#### *2.3.2.3.1. Navigating Low Status Group Identity*

Although low status often co-occurs with perceptions of illegitimacy, the two are not synonymous. Some marginalised groups, such as LGBTQ+ communities, may hold strong, cohesive norms that confer legitimacy, yet still experience discrimination because of broader societal stigma. Further, belonging to a low-status group does not automatically lead to reduced self-worth or negative well-being outcomes. Instead, individuals may adopt various strategies to reshape their self- or group-evaluations, or even alter their group's status (see The Identity Restoration Hypothesis; Jetten et al., 2017). These strategies include *individual mobility, social creativity, and social change,* with the chosen approach depending on structural factors such as the permeability of group boundaries, as well as the legitimacy and stability of the ingroup's position relative to others (Ellemers et al., 1993; Tajfel & Turner, 1979; also see the *Integrated Social Identity Model of Stress* for similar explanations; Haslam & Reicher, 2006).

For instance, if an individual perceives group boundaries as permeable, meaning they can move in and out of the group, they are likely to adopt *individual mobility* strategies. This involves dissociating from the low-status group to minimize negative psychological consequences, such as discrimination (Known as "The Social Mobility Hypothesis"; Jetten et al., 2017). However, when group boundaries are impermeable, leaving the group is not an option. For instance, when groups are involuntary ascribed such as ethnicity, gender and family membership, individuals may wish to disidentify with the group, but society may continue to categorise them as part of that group. This impermeability makes the perceived legitimacy and stability of the group particularly important.

If the group's low status is viewed as legitimate (fair) and stable (unlikely to change in the future), members may adopt *social creativity* strategies (see The Social Creativity Hypothesis; Jetten et al., 2017). This involves reframing societal perceptions of the group by emphasizing positive stereotypes rather than internalising its subordinate status. For example, a sports team that consistently loses against higher ranking teams may choose to accept their low-status, and instead reframe the team's position by emphasising team spirit and community engagement rather than focusing on wins. Conversely, if the group's low status is seen as illegitimate (unfair), unstable (likely to change in the future), and lacking social recognition, members are more likely to pursue *social change* strategies. In these cases, individuals strengthen their ingroup identification and work collectively to improve their group's status, often through political activism or social movements (Known as "The Social Competition Hypothesis"; Jetten et al., 2017; Branscombe et al., 1999).

The chosen status-management strategy significantly impacts an individual's social identity, as group membership and personal identity are interconnected (Haslam et al., 2008a; Tajfel & Turner, 1979). When individuals belong to groups that promote psychological well-being and positive norms, the centrality of these memberships to their identity means that losing them, whether due to life transitions (e.g., moving, changing jobs) or through individual mobility, can have negative consequences for well-being (Iyer et al., 2008). Therefore, when selecting a strategy, individuals must weigh the potential loss of group membership (and the resultant loss of psychological resources such as social support) against the costs of remaining in a low-status group. The caveat here is that not all strategies will be open to the person in all cases, particularly where groups have impermeable boundaries. Group members' actions could also enhance the status of the group (e.g., via *social change* strategies), and in some cases low-status can promote wellbeing. For instance, when individuals experience group-based discrimination, they may strengthen their identification with the group, which can buffer the negative effects of discrimination on wellbeing (known as "The *Rejection-Identification Hypothesis"*; Jetten et al., 2017). Thus, while the SIAH provides a valuable framework for understanding when groups can harm health, personal and contextual factors can impact how individuals experience, and navigate, harmful group identities.

### *2.3.3. Groups as Inherently Good or Bad?*

While much SIAH literature has emphasised either the benefits (social cure) or costs (social curse) of group memberships, emerging research suggests that groups can be both helpful and harmful simultaneously (Jones et al., 2024; Wakefield et al., 2019). For TGDYP specifically, this duality may be particularly relevant. Participation in TGD communities can provide crucial support, validation, and identity affirmation, but these same communities may also impose pressures or judgements on members who are perceived as *not trans enough* (Doyle, 2022), potentially leading to exclusions or internalised stress. Recognising that groups can simultaneously provide resources and impose costs highlights the complexity of social identity processes and suggests that interventions should aim to maximise supportive aspects while mitigating harmful dynamics.

### *2.3.3. SIAH Summary*

The SIAH provides a comprehensive framework for understanding the interplay between social identities and health outcomes. Through the Social Cure, group identification has been shown to enhance psychological well-being, physical health, and resilience by fostering social support, a sense of meaning, and collective efficacy (Jetten et al., 2017). The evidence supporting these benefits spans both psychological (e.g., Steffens et al., 2016a; 2016b) and physiological mechanisms (e.g., Inagaki et al., 2020), highlighting the profound impact of meaningful social connections on health. Moreover, multiple group memberships further strengthen these health benefits, particularly when identities are compatible and provide individuals with diverse psychological resources (Charles et al., 2023; Iyer et al., 2009).

However, the SIAH also acknowledges the darker side of group identification through Social Curse processes, where unhealthy group norms, rigid ingroup expectations, and intergroup stigma can negatively impact well-being (e.g., Kellezi & Reicher, 2012). While strong social identities can serve as a buffer against stress and discrimination, belonging to low-status or marginalised groups can introduce additional challenges (Jetten et al., 2017). The strategies individuals adopt, ranging from individual mobility to collective action, illustrate the dynamic nature of social identity and its influence on health.

Ultimately, the SIAH underscores the importance of fostering inclusive and supportive communities that enable individuals to maintain meaningful group memberships while mitigating the risks associated with unhealthy or stigmatised identities. By recognising the centrality of social identities in shaping health, interventions and policies can better support the health of diverse communities, particularly those facing systemic discrimination, such as TGD individuals.

## 2.4. Application of the SIAH to TGD Populations

Given the central role played by social identity in affecting health, the SIAH provides a valuable, but underutilised, framework for understanding health disparities among TGD populations. As outlined in Chapter One of this thesis, TGD individuals consistently report significantly poorer health outcomes in comparison to their cisgender counterparts (Hajek, 2023; Scheim et al., 2024). This has been attributed, in part, to heightened discrimination experienced by TGD individuals (Vries & Hannema, 2023). Research to date has explained these health disparities using Gender Minority Stress Theory (GMST; i.e., that heighted discrimination increases stress and associated negative physiological responses; Hendricks & Testa, 2012; Puckett et al., 2023; also see Meyer, 2003 on stress-related health problems). However, recent research highlights the mediating role of social support between gender minority stress and health outcomes (e.g., Diamond & Alley, 2020; Wilson & Liss, 2022), which GMST is unable to fully capture. Beneficially then, the SIAH provides unique theoretical value.

Unlike GMST, which primarily focuses on stress and its negative consequences, the SIAH explains how social group memberships can serve as both risk and protective factors. By applying the SIAH to TGD populations, research can move beyond deficit models of minority stress and explore how social interventions could enhance resilience and health outcomes. This section explores how applying the SIAH can help research better understand the mediating role of social support, exploring how group memberships and discrimination shape health outcomes for TGD individuals.

### *2.4.1. TGD Group Identification: Social Cure or Social Curse?*

Beginning with explanations for poorer health outcomes, the SIAH sheds light on the health implications of intergroup discrimination and low-status group membership (Jetten et al., 2017; Sonderlund et al., 2017; Tajfel & Turner, 1979). Through *Social Curse* mechanisms, the SIAH explains how the stigmatised status of TGD identities in society can compromise wellbeing through increased exposure to minority stress (Aldridge et al., 2024; Sonderlund et al., 2017; also see Hendricks & Testa on GMST). This is because low-status group members are subject to increased discrimination from outgroups (Bezouw et al., 2020; Kellezi & Reicher, 2012). Given the intrinsic link between one's self- and group- identity, negative evaluations (e.g., being perceived as low status, stigmatised, illegitimate; Kellezi & Reicher, 2012; Sonderlund et al., 2017) of the groups one belongs to become internalised (Moyer et al., 2019; Rodriguez et al., 2017; also see Puckett et al., 2023 on internalised transnegativity). Internalised negative evaluations subsequently undermine self-esteem and perceived self-worth, thereby contributing to negative health outcomes (Moyer et al., 2019; Rodriguez et al., 2017).

In conjunction with negative group evaluations, TGD health outcomes may be further impacted by unhealthy group norms (Kellezi & Reicher, 2012). Whilst not explored specifically within TGD communities, research on wider LGBT populations highlights how excessive alcohol consumption and substance misuse can become normalised as part of group life. In these contexts, alcohol often functions as a shared coping mechanism for managing minority stress, with repeated use becoming embedded within social interactions and identity construction (Emslie et al., 2017; Jaspal, 2022). This normalisation of unhealthy coping practices can inadvertently reinforce harmful norms, increasing vulnerability to poor health outcomes. Given the overlaps between LGBT and TGD communities, a SIAH lens could shed further light on distinct unhealthy group norms that may be present within TGD communities. In a similar vein, research also observes intragroup discrimination among LGBT people, leading to feelings of identity illegitimacy among particular groups (e.g., bisexual individuals; Oswald et al., 2024). Comparable findings are also reported for TGD communities, whereby non-binary identities are often viewed as less valid in comparison to cisgender and binary trans people (McCarty & Burt, 2024). Social Curse processes explain this, since group membership is accompanied by expectations regarding how group members should think and behave (Kellezi & Reicher, 2012). These expectations form normative group values which, when perceived as having been violated, prompt exclusionary actions towards 'non-normative' group members. Thus, the SIAH is a valuable tool for understanding differential experiences of social support (e.g., Rimmer et al., 2022), and the conditions under which it both enhances and undermines health.

While Social Curse processes can reduce the perceived benefits of group memberships (i.e., because they increase the likelihood of minority stress exposure and associated negative health consequences; Moyer et al., 2019; Rodriguez et al., 2017), GMST research has also demonstrated the buffering role of social support (Barras & Jones, 2024; Diamond & Alley, 2020; Jones et al., 2023; Wilson & Liss, 2022). Elucidated by the SIAH, *Social Cure* mechanisms illustrate how social support may reduce the impact of minority stress on health outcomes. For instance, through the *Connection Hypothesis*, we can understand how a sense of shared experiences and identity among TGD communities can facilitate trust (Jetten et al., 2017). This is essential for allowing TGD people to feel safe in their identities (Kulesza et al., 2025; Poliwoda et al., 2024), particularly given significant mistrust they have in wider social settings (e.g., with cisgender individuals; Rothbaum et al., 2024). Building on this, the *Meaning Hypothesis* explains how this shared identity provides TGD people with a sense of purpose by encouraging them to work together to achieve collective goals (i.e., authenticity in their gender identity; Jetten et al., 2017; Poliwoda et al., 2024). Moreover, this shared social identity increases TGD people's receptiveness to ingroup support (i.e., other TGD people) when they encounter difficulties (e.g., barriers to healthcare access; Poliwoda et al., 2024); support they might feel unable to accept from outgroup members (e.g., cisgender people) due to perceived discrimination (Rothbaum et al., 2024). Altogether, these Social Cure processes empower TGD people with a sense of self-efficacy that helps them navigate the challenges associated with transition (e.g., pervasive discrimination, challenging healthcare encounters, etc.; Scheim et al.., 2024). Thus, *Social Cure* and *Social Curse* mechanisms provide a useful framework for understanding how social identities and the (lack of) support that may be derived from them help to facilitate or undermine good health outcomes for TGD groups.

Importantly, and as mentioned prior, group memberships are not inherently Social Cure or Social Curse. Recent research from Jones and colleagues (2024) captures this, illustrating that many TGDYP concealed their identity to maintain family support, while others who opted to live authentically experienced a sense of disconnection from their familial unit. In both cases, Social Cure and Social Curse processes co-exist, rather than present in isolation. Thus, it is important to view social group memberships not as absolutes, but as embodying a combination of social identity processes that can simultaneously influence health outcomes.

### *2.4.2. Navigating Minoritised Identity*

Building on predictions made by GMST, the SIAH also considers strategies that individuals may adopt to navigate their minoritised identity. For TGD communities, these strategies are particularly beneficial. This is because they allow individuals to negotiate their identity beyond its minoritised status, mitigating some of the negative health consequences associated with minority stress. These strategies include *social mobility* and adopting *multiple social identities.*

#### 2.4.2.1. Social Mobility among TGD Communities

Social mobility refers to one's ability to move up or down a social hierarchy (Xie et al., 2022). As mentioned previously, the SIAH notes several social mobility strategies, where social mobility acts as an umbrella term for individual mobility, social creativity, and social change. The strategy adopted is dependent on the permeability of group boundaries, and the stability and legitimacy of the group's status (Ellemers et al., 1993; Jetten et al., 2017; Tajfel & Turner, 1979).

For TGD individuals, individual mobility, defined as attempts to leave or psychologically dissociate from a stigmatised group in order to access the advantages of a higher-status group (Jetten et al., 2017), is not always feasible due to the relatively impermeable nature of TGD identity (Dias et al., 2021). Although some TGD people may seek to ‘pass’ as cisgender, passing aligns more closely with *managing visibility* than with true group exit. This mirrors long-standing discussions in the racial-passing literature, where appearing to belong to a higher-status group can reduce immediate exposure to discrimination, yet does not alter one’s underlying group membership nor fully protect individuals from internalised stigma (Albuja et al., 2018; Harper, 1998). Similarly, for TGD individuals, passing may temporarily reduce overt cisnormative scrutiny, but it does not constitute individual mobility in the classic social-identity sense because one’s TGD identity remains psychologically salient and socially consequential (Anderson et al., 2020; Moyer et al., 2019; Rodriguez et al., 2017). Moreover, passing is often fragile and context-dependent, particularly in healthcare settings where documentation, bodily markers, or personal history may reveal TGD status (Pfeffer, 2014; Stryker, 2008). Thus, while some may experience passing as a pragmatic strategy for navigating a cisnormative world, others experience it as reinforcing restrictive gender norms or distancing them from TGD communities, thereby reducing access to identity-affirming social support and potentially exacerbating loneliness or internalised transnegativity (Anderson et al., 2020; Iyer et al., 2008; Sycamore & Mattilda, 2006). Given these complexities, individual mobility is neither universally attainable nor reliably associated with long-term psychological benefit for TGD people (Brennan et al., 2021; Bränström & Pachankis, 2021; Moynihan, 2010).

Instead, alternative strategies such as *social creativity* and *social change* may be more beneficial for long-term wellbeing. The stability and legitimacy of TGD groups’ status play a crucial role in the adoption of these strategies. The *Social Creativity Hypothesis* (Jetten et al., 2017) suggests that when a groups status is perceived as stable and its boundaries as relatively fixed, individuals may seek to redefine their group identity in a way that enhances its value rather than attempting to leave the group. In this context, TGD individuals may challenge cisnormative narratives by embracing diverse gender expressions, rejecting binary gender expectations, and fostering community-based affirmations of identity (Cahill et al., 2025). This reinterpretation strengthens self-esteem and ingroup cohesion, reinforcing the legitimacy of TGD groups in broader society.

Additionally, the *Social Competition Hypothesis* (Jetten et al., 2017) highlights how collective action and advocacy efforts can challenge systemic discrimination, improving social conditions for wider TGD communities. However, the effectiveness of collective social change is tied to perceptions of group status stability and legitimacy. If TGD status is perceived as unstable and illegitimate within broader societal frameworks (i.e., it is constantly changing or perceived as unfair), mobilising for collective change is more likely to occur. While mobilising for systemic change can be challenging, particularly in a context of pathologisation and legal restrictions (Goldberg et al., 2020), the groups illegitimate status can encourage advocacy efforts, including legal recognition campaigns, community-building initiatives, and public education, improving perceptions of TGD group's status (e.g., like observed with the Stonewall riots which sparked the modern LGBT rights movement, leading to organised activism, pride marches, and long-term social and legal advances; Jenkins, 2019).

Thus, while individual mobility may provide short-term relief, social creativity and collective action offer more sustainable and empowering strategies for TGD individuals navigating discrimination. Ultimately, the choice of mobility strategy is shaped by the extent to which group boundaries are perceived as permeable, and how stable and legitimate TGD groups' status is within society. These decisions will also be influenced by individual beliefs, personal experiences, and the geographic context in which the individual lives, as access to supportive communities and the visibility of discrimination can vary across locations.

#### 2.4.2.2. Multiple Group Identifications among TGD Communities

Alongside social mobility strategies, TGD individuals may also draw on multiple social identities as an additional way of buffering against discrimination (Charles et al., 2023; Iyer et al., 2009). For example, a person may emphasise a professional or cultural identity in contexts where their TGD identity is devalued, while continuing to draw on TGD or activist communities for support (Sonderlund, 2017). This ability to shift between identities can reduce the psychological burden of discrimination targeted at a single identity (Sonderlund, 2017). The protective function of multiple social identities also extends beyond responding to threat to ensuring meaningful support is available at all stages of transition, particularly where identity salience may change. For example, when exploring one's gender identity and undergoing GAC, their TGD identity may be most salient and therefore connections with other TGD people may be most relevant. However, later in transition gender identity may be less salient and thus other aspects of social identity (e.g., sports club, hobbies, career) are more important and protective.

However, not all TGD individuals have access to alternative social identities, evidenced by pervasive loneliness among TGD people (e.g., Hajek et al., 2023; Spivey & Edwards-Leeper, 2019). Some may lack additional group memberships to draw upon, limiting their ability to disengage from the negative implications of belonging to a minoritised group (Sonderlund, 2017). Furthermore, the pervasive discrimination faced by TGD individuals can heighten the salience of their minoritised identity, making it a central aspect of their self-concept. This can complicate efforts to build connections with other social groups, restricting access to meaningful relationships beyond their minoritised identity (Goffman, 1969; Sonderlund et al., 2017). Thus, while multiple social identities can be protective, several factors impact TGD people's ability to gain and maintain these multiple relationships.

##### *2.4.2.2.1. Applying the SIMIC to TGD Communities*

Another challenge impacting TGD peoples' ability to maintain multiple social identities is the inevitable identity transition that occurs during gender transition (Haslam et al., 2008b; 2018). Distinct from more normative identity transitions (e.g., becoming a student or changing jobs), gender transition involves a broader set of psychological, social, and structural changes. For TGD individuals, transition can require navigating stigma and discrimination, renegotiating social categories and relationships, managing physical and bodily changes, and rebuilding networks in ways that directly affect continuity of the self. These combined demands make gender transition uniquely complex relative to other identity transitions (Chen et al., 2020). The SIMIC offers a useful framework for understanding how TGD individuals manage these transitions and access to social support during this time. Specifically, the SIMIC explains how gender transition can threaten one's existing social relationships (Jetten et al., 2018). This is because the changes that TGD people undergo throughout the course of their transition can disrupt their relationships with others (Doyle et al., 2023). This can include their relationships with those prior to their transition (i.e., because TGD people may feel they no longer identify with those groups, or the relationship quality may change; Hajek et al., 2023; Rood et al., 2017) and those they seek out during, or after, their transition (Doyle et al., 2023; Hajek et al., 2023). Moreover, change to TGD individuals' social identities as they transition (i.e., because they are seen to adopt a different social category, such as male instead of female) can mean that their multiple social identities become incompatible (i.e., identifying as male and being part of female-only sports clubs; Arnoldussen et al., 2022). Thus, whilst the SIMIC, and the SIAH framework more broadly, suggests that both maintaining and gaining group memberships can be protective for health, integrating multiple social identities can be increasingly challenging for TGD people in comparison to their cisgender counterparts (Arnoldussen et al., 2022).

### *2.4.3. Summary: Applying the SIAH to TGD Communities*

The Social Identity Approach to Health (SIAH; Haslam et al., 2008a; 2024) provides a valuable framework for understanding the health disparities experienced by TGD individuals, particularly in relation to discrimination, social support, and group membership. While Social Curse processes explain how low-status group membership can negatively impact wellbeing by increasing exposure to discrimination and internalised transnegativity, Social Cure mechanisms highlight the protective role of social support in buffering against minority stress (Jetten et al., 2017). However, the benefits of group membership are not universal, as intragroup discrimination and unhealthy group norms may also pose challenges for some TGD individuals (McCarty & Burt, 2024; Puckett et al., 2023).

To navigate their minoritised identity, TGD individuals may employ different strategies, including social mobility and multiple group identifications. Social mobility, which can take the form of individual mobility, social creativity, or social change, is shaped by the permeability of TGD group boundaries and perceived legitimacy and stability of intergroup relations (Jetten et al., 2017). While passing as cisgender (a potential individual mobility strategy) may offer short-term relief from discrimination, it often comes at the cost of loneliness and loss of ingroup support (Brennan et al., 2021; Branstrom & Pachankis, 2021). Instead, social creativity and collective action can serve as more sustainable strategies for challenging discrimination and improving long-term wellbeing (Jetten et al., 2017).

Additionally, maintaining multiple social identities can serve as a psychological buffer against discrimination by allowing individuals to draw upon different identities for support when one aspect of their identity is under threat (Iyer et al., 2009; Sonderlund et al., 2017). However, for TGD individuals who often have limited alternate group memberships, alongside the increased challenges gender transition poses for integrating their multiple social identities (Jetten et al., 2014; Sonderlund et al., 2017)), their minoritised status may dominate their social experience, reinforcing social exclusion and further complicating identity-based coping strategies (Arnoldussen et al., 2022; Hajek et al., 2023).

Overall, the SIAH provides a comprehensive framework for understanding both the risks and protective factors associated with TGD identity. While discrimination and exclusion can negatively impact health, strong ingroup identification, social support, social creativity, and collective action offer pathways to resilience, highlighting the importance of fostering inclusive and affirming social environments for TGD individuals. Existing SIAH-informed work with TGD people has illustrated how identity-affirming familial relationships can buffer minority stress, pointing to the value of identity-aligned support in everyday life (Jones et al., 2023; 2024). This thesis extends these insights by examining additional social identities and support contexts beyond the family, allowing for a fuller understanding of when social support facilitates and/or constrains positive health outcomes for TGD communities. Thus, the SIAH is a useful tool for understanding when social support facilitates and/or hampers positive health outcomes for TGD communities, as suggested (but not systematically interrogated) by GMST research. This highlights effective strategies for developing SIAH-inspired health-related interventions to enhance TGD health outcomes, aligning with NHS calls for holistic care (NHS, 2019; 2023).

## 2.5. Applying the SIAH to Health-Related Interventions with TGD communities

Having established the health-enhancing role of group identification, and how this may function specifically for TGD groups, the SIAH can be considered an appropriate framework for developing health interventions for TGD populations. Chapter 1 highlighted the potential utility of Social Prescribing (SP) interventions, given their group-based nature. However, outstanding questions remain: 1) How can SIAH mechanisms (i.e., ‘active ingredients’) that underpin group-based health benefits be translated into effective interventions? (Steffens et al., 2019); and 2) To what extent do SIAH mechanisms underpin the health benefits observed following SP participation? This section explores key health interventions grounded in the SIAH. These studies provide compelling evidence that the health benefits derived from such programs are fundamentally rooted in group-based processes. Given this, the SIAH offers a valuable lens through which to understand and refine SP interventions. This discussion concludes by highlighting the potential for applying the SIAH to SP, underscoring the need for further research to establish a robust evidence base for its effectiveness before SP can be tailored for TGD populations.

### *2.5.1. SIAH-Based Interventions*

#### 2.5.1.1. Groups 4 Health (G4H)

A primary example of an intervention developed explicitly from the SIAH is G4H (Haslam et al., 2016). G4H is a structured program designed to address social disconnection by equipping individuals with the skills to build and maintain meaningful group-based relationships. Recognising that loneliness is a major determinant of poor mental and physical health (Haslam et al., 2009; 2024), G4H seeks to enhance individuals' capacity to cultivate beneficial social identities (Haslam et al., 2016).

The G4H programme consists of five structured sessions, each targeting a different aspect of social connection: 1) *Schooling*, to raise awareness of the benefits of group memberships for health; 2) *Scoping*, to identify current group memberships; 3) *Sourcing,* to identify and strengthen existing, valued social identities and associated group memberships; 4) *Scaffolding,* for developing new social connections that align with one's personal values; and 5) *Sustaining*, to review progress one-month post-programme completion and develop long-term plans for maintaining social ties (Haslam et al., 2016).

Randomized controlled trials (RCTs) have provided robust evidence supporting G4H's effectiveness. Studies have shown that participation in G4H leads to significant reductions in depression, anxiety, and loneliness, while improving self-esteem, social connectedness, and life satisfaction among those presenting with social isolation, affective disturbance, social anxiety (Haslam et al., 2016; 2019) and young people exhibiting symptoms of depression and/or loneliness (Cruwys et al., 2019). Improvements in these areas, resulting from participation in G4H, have been shown to be more significant than those achieved in usual treatment conditions for social anxiety, particularly among individuals not receiving psychopharmacological treatments (Haslam et al., 2019). Similar observations have also been noted for comparisons between G4H and CBT for reducing loneliness (Cruwys et al., 2021a; 2019). Moreover, adaptations of G4H have demonstrated effectiveness across diverse populations, including clinical populations (Cruwys et al., 2021b), and older adults (Whitmore et al., 2025). Further adaptations for individuals undergoing specific life-transitions, including civilian retirees (La Rue et al., 2023), those leaving elite sport (Young et al., 2024), the military (Enable America, 2021), and those recovering from substance misuse (Young et al., 2024) have also been developed, underscoring G4H's broad applicability.

#### 2.5.1.2 Broader Social Identification-Building Interventions

Beyond G4H, a broader range of health interventions have been developed based on the principles of the SIAH (Steffens et al., 2019). Termed *social identification-building* interventions, these programmes are specifically designed to enhance an individuals' sense of belonging to meaningful social groups (Steffens et al., 2019). These interventions are split into four broad categories: 1) group decision making (e.g., Knight et al., 2010); 2) reminiscence groups (e.g., Haslam et al., 2014); 3) shared activities (e.g., Morris et al., 2012); and 4) group-based therapy (e.g., Meuret et al., 2016). Broadly speaking, interventions typically involve structured activities that foster group cohesion, shared identity, and mutual support, distinguishing them from interventions that merely encourage social interaction without a focus on identity formation (Steffens et al., 2019; e.g., Social Prescribing).

Research highlights the substantial health benefits of social identification-building interventions across mental and physical health domains (Steffens et al., 2019). For instance, increased group identification was consistently associated with reduced depression, anxiety, and stress among older men (Gleibs et al., 2011) and community, student, and clinical samples (e.g., Cruwys et al., 2014). Enhanced social identity was also linked to better immune function, cardiovascular health, and lower mortality risk among older men (Gleibs et al., 2011), those with social anxiety (Haslam et al., 2019), and older adults in residential care (Knight et al., 2010). Collectively, these benefits also enhance personal resilience, providing a psychological buffer against stress, strengthening coping mechanisms and overall well-being (e.g., Haslam et al., 2010; Morris et al., 2012). Crucially, Steffens and colleagues (2019) established that the health benefits of these interventions were directly attributable to group-based processes rather than general social interaction alone as suggested in previous theoretical models (e.g., MAGI; Borek et al., 2019). This supports the notion that identifying with a group, rather than simply participating in social activities, is the key ‘active ingredient’ in improving health outcomes (Steffens et al., 2019).

### *2.5.3. Implications and Need for Further Research*

Review of social identification-building interventions and studies on G4H demonstrate that health benefits are deeply rooted in group-based psychological processes. However, while these interventions demonstrate significant positive outcomes, further research is needed to refine our understanding of the specific mechanisms that drive these effects. Questions remain about which aspects of social identification contribute most to health improvements, how these interventions can be optimized for different populations (i.e., does group membership and identification building look different for different populations), and the long-term sustainability of their benefits (Steffens et al. 2019).

Nonetheless, extant research on SIAH-informed interventions suggests that SP initiatives could benefit from explicitly emphasising social identity principles (Haslam et al., 2024). As outlined in Chapter 1 of this thesis, SP is an emerging healthcare approach that connects individuals to community-based activities and social support networks to improve health outcomes. While SP initiatives inherently involve group-based processes, their effectiveness varies widely, and the role of social identity in driving these benefits has yet to be systematically examined (Stevenson et al., 2019; Wakefield et al., 2022). Given the evidence supporting the role of social identification in health, applying the SIAH framework to SP could help optimize its impact by identifying the conditions under which it is most effective and for whom, and increasing funding for these health-enhancing interventions (What Works Network, 2014).

## 2.6. Conclusion

This chapter has explored the SIAH, outlining its foundational theories and demonstrating how social group memberships influence health outcomes. The Social Cure framework highlights the protective role of strong social identities in promoting psychological and physiological well-being, while the Social Curse perspective acknowledges that certain group memberships can have detrimental effects, particularly when they reinforce unhealthy norms or expose members to discrimination. However, these processes do not exist in isolation. Instead, groups can be both a Social Cure and a Social Curse. Research on multiple group identities and identity transitions further illustrates the complex ways in which social group belonging shapes health, particularly in contexts of identity change and minority stress.

Applying the SIAH to TGD populations provides a novel lens to understand health disparities and protective factors. While minority stress and discrimination contribute to poorer health outcomes, strong ingroup identification and social support networks within TGD communities can serve as vital resources for resilience. However, challenges such as intragroup discrimination and difficulty maintaining multiple compatible identities complicate these benefits, making it crucial to identify strategies that optimize the health-enhancing potential of social identities. Nonetheless, it suggests that group-based interventions that encourage social identification may be a useful tool for improving TGD health outcomes. SP could be one such intervention, particularly given SP pathways already exist within the NHS in England and thus adaptation, rather than developing interventions from the ground up, would be more resource efficient.

Overall, given the potential health-enhancing role of group identification for TGD groups, the SIAH presents itself as an appropriate framework for developing health interventions for TGD populations. Researchers have translated SIAH principles into health interventions for cisgender populations (e.g., G4H), but this has not been explored with TGD populations nor specifically applied to SP. Nonetheless, G4H and broader social identification-building interventions have demonstrated significant success in improving mental and physical well-being by fostering meaningful social connections. These findings suggest that the benefits of SP may also be attributable to social identity processes, though further research is needed to establish the ‘active ingredients’ that drive its effectiveness. Given the promising results of SIAH-based interventions, there is strong potential to apply these insights to leverage SP, particularly for marginalized groups such as TGD individuals.

This discussion lays the groundwork for the next chapter (Chapter 3) in this thesis, which systematically reviews existing research on SP interventions through a SIAH lens. By critically evaluating this evidence and identifying the ‘active ingredients’, the subsequent chapters are shaped by these insights and will examine how social identity processes can be leveraged to design more effective and inclusive health interventions, with Chapters 6 through 8 focusing on their relevance and applicability to TGD populations.

# Chapter 3 (Study 1)

## An Evaluation of the Role of Social Identity Processes for Enhancing Health Outcomes Within UK-based Social Prescribing Initiatives Designed to Increase Social Connection and Reduce Loneliness: A Systematic Review.

This chapter has been published in *Journal of Community and Applied Social Psychology* as: **Staras, C.O**., Wakefield, J.R.H., McDermott, D.T., & Jones, B.A. (2024). An evaluation of the role of social identity processes for enhancing health outcomes within UK-based social prescribing initiatives designed to increase social connection and reduce loneliness: A systematic review. *Journal of Community and Applied Social Psychology, 34*(5), e2878. https://doi.org/10.1002/casp.2878

This chapter is largely the same as the journal publication. Small changes to style and formatting have been made to ensure the chapter is consistent with the rest of this thesis.

**Statement of Authorship:**

*Research conception and design:* CS, BJ, JW, DM.

*Data collection:* CS.

*Data synthesis and interpretation:* CS, BJ, JW, DM.

*Drafting of article:* CS.

*Article editing and revisions:* CS, BJ, JW, DM.

The findings from Chapter 3 (Study 1) have also been presented at the following academic conferences:

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, July). *Improving Healthcare for Trans and Gender Diverse People: Exploring the Utility of Social Prescribing Pathways.* An invited presentation for Nottingham Young People's Gender Service CPD training session.

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, May). Improving Healthcare for Trans and Gender Diverse people: Exploring the Feasibility of Social Prescribing Pathways. An invited presentation for the University of Exeter. Oral Presentation.

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2024, November). Improving Healthcare for Trans and Gender Diverse People: Adapting and Testing the Effectiveness of Social Prescribing Initiatives. An invited presentation for the British Association of Gender Identity Specialists, Nottingham, UK. Oral Presentation.

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2024, June). Effectiveness of UK-Based Social Prescribing Initiatives Designed to Increase Social Connection, Reduce Loneliness, and Benefit Wellbeing: A Systematic Review. 6th International Conference on Social Identity and Health, Limerick, Ireland. Oral Presentation.

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2023, August). Effectiveness of UK-Based Social Prescribing Initiatives Designed to Increase Social Connection, Reduce Loneliness, and Benefit Wellbeing: A Systematic Review. British Psychological Psychology Social Psychology Section Conference, Edinburgh, UK. Poster.

## 3.1. Abstract

**Background:** The UK's National Health Service has introduced Social Prescribing (SP) initiatives to tackle loneliness and ill-health, yet it lacks a theoretical foundation and evidence base for SP's effectiveness. Recent research applies the Social Identity Approach to Health (SIAH) to explain SP's health benefits, emphasising how social connection unlocks health-enhancing psychological mechanisms. This systematic review therefore aims to assess UK-based SP programs designed to boost social connection and alleviate loneliness, examining programme efficacy and the role of SIAH processes in health outcomes.

**Methods:** Following PRISMA guidelines, a narrative synthesis of articles published from May 5th, 2006 (when SP was first introduced in the NHS), to April 8th, 2024, was conducted, and their quality assessed using CONSORT-SPI (2018). Of these programmes, 10 employed a mixed-methods design, eight qualitative, and one quantitative service evaluation, totalling 3,298 participants.

**Results:** Results indicate that SP's psychological value lies in quality rather than quantity of social connections, with meaningful connections fostering shared identity, perceived support, and self-efficacy, the latter of which sustains social engagement post-programme. The SIAH was a useful tool for mapping mixed-methods findings onto a common theoretical framework to highlight these key proponents.

**Conclusion:** Overall, this review underscores the importance of SIAH-informed SP interventions in enhancing social connectedness, reducing loneliness, and promoting overall health.

**Key Words:** Social Prescribing; Social Identity Approach to Health; Loneliness; Interventions; Health

## 3.2. Introduction

Increasing demand for healthcare and a £30 billion funding gap led the UK's National Health Service (NHS) to set out their Five Year Forward View to address how the UK's health was going to be managed just under a decade ago (Ham, 2017; NHS, 2014; also see MacIntyre & Hewings, 2023, on government strategies for tackling loneliness). Within this, they emphasised the need for increased preventative approaches and self-supported care to tackle the rising number of health inequalities and long-term health conditions, the latter of which consumed 70% of the NHS's budget. To achieve this, the NHS proposed to adopt longer-term sustainable programmes that acknowledge how social and economic deprivation increase the incidence of ill-health. Preventable illnesses such as obesity and mental health conditions, where loneliness is a root cause, were felt to be a particular priority, and a call for evidence-based action and preventative services was recommended. However, 2014 was not the first time that the NHS highlighted the necessity of focussing on socio-economic predictors of ill-health. In 2006, the Department of Health advocated for the introduction of SP as an integral part of NHS care to help with the management of long-term illness (Department of Health, 2006). The SP model was developed to increase NHS sustainability, as well as the availability of holistic support for the UK population (NHS, 2019).

### *3.2.1. Social Prescribing*

SP is a non-clinical healthcare initiative where health professionals connect their patients to community groups and activities (e.g., arts programmes, health walks, horticulture groups, supported education) with the intention of improving their health and wellbeing by reducing loneliness and increasing illness self-management and social integration (Haslam et al., 2024; Hayes et al., 2023; NHS, 2019). Important to note is that early models of SP in the UK were largely seen as a way of providing holistic healthcare. However, in the advent of the loneliness epidemic (Ng, 2024), particularly following COVID-19, and the publication of early work demonstrating how loneliness reduction is a mediating process through which SP improves wellbeing, the utility of SP for specifically addressing loneliness is being increasingly recognised (e.g., Haslam et al., 2024).

Dependent on the clients established needs, the focus of SP and the subsequent nature of the intervention may differ. Haslam and colleagues (2024) identify three tiers of SP: 1) Community focus with community-level initiatives that are often incidental (e.g., a library or community garden); 2) Targeted populations (e.g., those with mental health conditions) with specific group programmes (e.g., a choir or community exercise programme); and 3) A focus on individual clients with person-centred interventions. These are often purposive where a link worker (who aims to holistically understand client needs) directs the client to most suitable social prescription and supports them through this process to facilitate their introduction to, and continued membership of, groups and activities (e.g., Sharman et al., 2022). All tiers of SP are useful and help researchers and practitioners to identify how best to support clients based on their presenting needs. Importantly, because SP strengthens connections between primary care and the voluntary and community sectors, it encourages the development of a more diverse range of local community activities and initiatives. This means that SP can be particularly beneficial for marginalised groups whose needs might not have been previously met within local communities, for example, due to access challenges or anxieties around finding and introducing oneself to new groups (e.g., Brandling & House, 2009; Kellezi et al., 2019). Further, this expanded provision of social spaces increases the likelihood of incidental SP, where good community connection and reduced loneliness is a natural feature of a well-functioning and connected society (Haslam et al., 2024): an integrated approach to care that maximises social, financial, and educational resources (NHS, 2014) which is beneficial for reducing unnecessary healthcare use and enhancing community health (Wakefield et al., 2019).

### *3.2.2. Social Prescribing Apprehensions*

Although SP initiatives have evidenced positive health outcomes (e.g., Carnes et al., 2017; Kellezi et al., 2019; Pescheny et al., 2019; Wakefield et al., 2020), many argue that enthusiasm is premature (Dayson et al., 2017; Husk et al., 2019). In part, this is reflective of the implementation challenges experienced by SP providers with several outstanding questions for service delivery. For example, what is the capacity needed by NHS services to run SP initiatives alongside current health provisions? (Westlake et al., 2023). This begins by understanding how SP is distinct from other existing healthcare services whilst also comprehending how it can fit within, and complement, current health systems (Westlake et al., 2023). Unfortunately, many primary care providers are still at the early stages of understanding how SP is distinct (Westlake et al., 2023), limiting their time to think about the formats and pathways through which they can deliver SP services that draw on existing resources and therefore reduce the capacity needed to run them. Having this understanding would be advantageous given funding and resource challenges within the NHS as well as a push for more sustainable programmes (NHS, 2019). However, the reality is that many SP services are delivered without thought to this, limiting beneficial outcomes as well as researchers' ability to conduct robust evaluations (Evers et al., 2024).

Another consideration relates to for whom, and in what context, SP is favourable over other health and social interventions. For instance, personality dispositions may impact one's engagement with, and the health benefits obtained from, SP participation (Husk et al., 2019). Whilst present research is lacking in this domain, there is research to suggest that one's enjoyment in social life is heighted if they are an extrovert in comparison to introverts (Newton et al., 2018). Consequently, the uptake and effectiveness of SP among introverts may be limited.

Another reason enthusiasm for SP is deemed premature relates to the inconsistent evidence base (Dayson et al., 2017; Husk et al., 2019). Consequently, there is a need for evidence at all stages of the intervention (e.g., the pathway level; Husk et al., 2019). Indeed, guidelines for developing new healthcare interventions highlight the importance of conducting systematic reviews to ensure that all current aspects of the intervention (and any future developments) are evidence-based (Kunisch et al., 2022). Within medicine and the social sciences, such approaches are integral where the impact of health interventions can be widespread (e.g., on public health and policy) and thus there is an impetus to minimise bias within treatment protocols (Kunisch et al., 2022). However, despite SP becoming increasingly more common in the UK (Bickerdike et al., 2017), research (including systematic reviews) has been unable to reliably establish the health-enhancing processes that underly SP and thus articulate gold standard SP protocols to achieve consistent benefits for improving health outcomes. The fact that the NHS 5-year Forward View (NHS, 2014), its subsequent review (NHS, 2017), and newly established 10-year Health Plan for England (NHS, 2025) highlighted the urgent need for evidence-based action within the social sphere makes this lack of evidence a concern.

### *3.2.3. Difficulties Establishing Social Prescribing Efficacy*

Difficulties in establishing SP efficacy, in part, stem from the limited coherent synthesis of SP findings; synthesis is necessary to understand what parts of SP are effective and what parts need further development. However, variation within SP programmes, both in terms of their definition and design, makes it difficult to compare outcomes in a meaningful way (i.e., identifying for whom, and under what circumstances SP is helpful, e.g., Bickerdike et al., 2017; Husk et al., 2019). For example, and as highlighted prior, Haslam and colleagues (2024) identify three tiers of SP, each with different purposes and subsequent interventions. To complicate matters further, Kimberlee (2015) outlines four different formats of referral into, and evaluation of, SP programmes: 1) signposting; 2) light; 3) medium; 4) holistic (Kimberlee, 2015; also see Husk et al., 2019; Moore et al., 2022 for more recent use of these groupings). Each of these have different levels of primary care involvement and evaluative processes. For example, *signposting* SP (comparable to Haslam et al., 2024's Tier 1) involves service users autonomously accessing support services (e.g., a community cooking group), and includes minimal evaluation of service outcomes (e.g., asking participants if they enjoyed the group activity). By comparison, *light* or *medium* SP (Comparable to Haslam et al., 2024's Tier 2), which tend to be the most common types of SP services, involve referring service users to specific programmes designed to achieve a specific objective with distinct outcome measures (e.g., exercise on prescription). Evaluation may include a short survey at the end of SP participation asking participants broadly about their health and wellbeing. Contrasted with these three types of SP is *holistic* SP (comparable to Haslam et al., 2024's Tier 3), which involves a long-term partnership between primary care and voluntary services, the latter of which take an active role in encouraging service users to manage their own conditions, with formal and holistic referrals (i.e., looking at all service user needs beyond the initial reason for their referral; see Kimberlee, 2015), and preventative approaches. Typically, *holistic* SP has developed out of evolved SP projects that may have previously been defined as *signposting, light* or *medium* (Kimberlee, 2015). Evaluation processes may include survey measures related to specific SP programme outcomes that are then followed up longitudinally (Kimberlee, 2015).

Given the large variations in SP aims, programme design, and evaluation of outcomes (e.g., Bickerdike et al., 2017; Costa et al., 2021; Napierala et al., 2022; Percival et al., 2022), it is evident how a meaningful evaluation of all SP programmes becomes unfeasible. This is because differences in defining the nature of SP makes it difficult to decide what constitutes a good evidence base that captures the complexities of the service (Husk et al., 2019). For example, long-term follow-up with non-holistic forms of SP become impractical if there is no supported form of contact with service users over time. Thus, without good infrastructure, the capacity of organisations making SP referrals is limited when it comes to evaluating programme efficacy in meaningful ways to achieve a robust evidence base (Husk et al., 2019).

Further, extant systematic reviews have not utilised a common framework to synthesise available SP evidence as these guidelines have only recently been established (e.g., see

Cunningham et al., 2023 for newly developed guidelines on synthesising SP findings). This has led to a lack of good quality systematic reviews, which are the gold standard for understanding and improving healthcare interventions (Kunisch et al., 2022), needed to effectively facilitate understanding of SP's benefits and of how different types of SP designs may achieve different outcomes among different groups. In light of their observations, authors such as Bickerdike and colleagues (2017) emphasise the need for focused and standardised evaluations of SP, which are more likely to shed light on how SP works, for whom, and in what contexts (Bickerdike et al., 2017).

### *3.2.4. Applying the Social Identity Approach to Health to Social Prescribing*

Limiting evaluation of SP initiatives further is the lack of theoretical framework that is adopted when interventions are designed and evaluated (Bickerdike et al., 2017; Evers et al., 2024). This has restricted researchers' ability to hypothesise what led to beneficial change following SP participation because the function of groups is not fully understood, and outcome measures that would capture these processes are not utilised (Bickerdike et al., 2017; Stevenson et al., 2019). Underpinning SP initiatives with a theoretical framework would aid in identification of the active mechanisms within SP that lead to the beneficial health outcomes observed and allow these to be replicated across all SP interventions in a consistent manner (Stevenson et al., 2019). It would also allow specific outcome measures to be employed to capture these active mechanisms rather than broadly assessing health and wellbeing as have been previously observed (Thomson et al., 2020; Venter & Buller, 2014; Vogelpoel & Jarrold, 2014). Although some interventions may employ logic models to understand behaviour change mechanisms (Mills et al., 2022), we emphasise the importance of theoretical models here. This is because logic models describe a series of sequential and linear steps. However, it is common for social interventions to have non-linear effects (Iancu & Lanteigne, 2020); non-linear processes which can be better captured through testing theoretical models (e.g., through Structural Equation Modelling) to better isolate and evaluate the contribution of each component of the theoretical model for the success of the intervention. Whilst an established theoretical framework does not yet exist for SP, recent work has identified 11 distinct theories that have been used to understand SP outcomes (Salutogenesis; Self-Determination Theory; Social Cure; Social Innovation), differences in outcomes (Bourdieu's theoretical concepts; Time & Synchronicity; Candidacy), and service implementation (Boundary Spanners; Critical Systems Thinking; Normalisation Process Theory; Social Capital; see Evers et al., 2024). Importantly, this work has begun to highlight the complexity of using theory for SP implementation and evaluation, with all but one theory (Candidacy; Mercer et al., 2017) suggested to be helpful for understanding what leads to beneficial outcomes following SP participation. This demonstrates how identification and conceptualisation of the active mechanisms within SP is not clear-cut. Rather, there are different aspects of SP programmes (e.g., health outcomes, differences in outcomes, and service delivery) that need to be guided by theory, and this theory may be different for each aspect, or require a combination of theories to best explain outcomes observed (Evers et al., 2024).

However, one challenge with the aforementioned theoretical work is the lack of transparency regarding how theory was used to drive different aspects of the SP programmes. Specifically, Evers and colleagues (2024) highlight: 1) Inadequate descriptions of theories used; 2) reporting of results that are detached from their theory; and 3) challenges with the practicality for adopting and operationalising these theories to improve service delivery. Nonetheless, one theory was able to conceptualise key process variables into operationalised, quantitative outcomes which are essential for healthcare service implementation (Guetterman, 2019): Social Cure.

The Social Cure is a branch of the SIAH, and recent work has begun to conceptualise SP using this theoretical approach (e.g., Haslam et al., 2024; Haslam et al., 2018; Stevenson et al., 2019). The SIAH posits that group identification (i.e., a subjective sense of group belonging) unlocks valuable psychological mechanisms (e.g., social support, sense of meaning in life, sense of personal control; Jetten et al., 2017; Wakefield et al., 2019), which in turn benefit health and wellbeing. Recent research has demonstrated that these processes are active within SP programmes (see Kellezi et al., 2019; Wakefield et al., 2020). For example, they highlight not only that SP participation increases quality of life, but that this relationship is serially mediated by belonging, social support and loneliness (Wakefield et al., 2020). Thus, SP enhances health through SIAH mechanisms (see Figure 2.1). Therefore, review of existing SP initiatives through a SIAH lens will contribute towards developing an evidence base that begins to identify the active ingredients of SP, and a potential focal point for future SP programmes.

### *3.2.5. The Current Systematic Review*

Given the lack of theoretical underpinning in extant systematic reviews of SP (e.g., Bickerdike et al., 2017; Reinhardt et al., 2021; Steffens et al., 2021), and the aforementioned potential of the SIAH to allow for active mechanisms within SP to be established (e.g., Kellezi et al., 2019; Wakefield et al., 2020), the current systematic review applies the SIAH to explore its utility for understanding the psychological processes that lead to beneficial outcomes following SP participation. Further, in comparison to other systematic reviews in this area that have a broad focus on the extent to which all types of SP initiatives benefit general health and wellbeing (e.g., Bickerdike et al., 2017; Costa et al., 2021; Napierala et al., 2022; Percival et al., 2022), the current systematic review synthesises evidence from SP programme evaluations that specifically consider social connectedness, belonginess and loneliness within their study design (e.g., Thompson et al., 2023). Whilst SP generally is designed to improve health and wellbeing through increases in social support, a focus on increasing social connectedness is not always explicitly identified and included within evaluation protocols. As such, concentrating on the subset of SP programmes that do consider these constructs (i.e., are focused on increasing social connectedness and reducing loneliness) will allow the review to identify and categorically explore the presence of SIAH mechanisms within SP. In addition, it will allow the systematic review to understand the extent to which (and the psychological process through which) these initiatives predicted *actual* increases in social connection and reductions in loneliness, as well as the extent to which they predicted enhanced health and wellbeing.

Whilst a handful of existing reviews have specifically explored SP programmes designed to address loneliness and social connectedness (Liebmann, 2022; Reinhardt et al., 2021; Steffens et al., 2021; Vidovic et al., 2021), these authors did not ground their reviews within a theoretical framework such as the SIAH. This has prevented researchers being able to establish the mechanisms that predict/produce beneficial change within SP programmes designed to reduce loneliness (Stevenson et al., 2019). Furthermore, whilst Evers and colleagues (2024) have conducted a review of theories informing SP which beneficially identified how theories utilised (of which the SIAH was one) impacted choice of outcome measures and begun to provide a theoretical basis for SP, the nature of their review limits their theorising to those theories identified by the respective authors of articles included. Thus, it does not provide the opportunity to explore in depth the presence of theoretical mechanisms within the work that may not have been identified by the respective authors themselves; alternative theories that may offer a better explanation for the health benefits observed as a result of SP participation. In addition, Evers and colleagues (2024) only included SP programmes that employ link workers. This limits our understanding of the theoretical mechanisms that underpin SP to holistic SP programmes. Thus, instead, the present systematic review not only offers an opportunity to identify active psychological mechanisms within largely atheoretical work, but it also allows us to understand how theory may be applied to a broader range of SP formats (e.g., signposting, light and medium SP); a necessity identified by Evers and colleagues (2024) themselves. To summarise, this will be the first review of SP initiatives that is underpinned by the SIAH: as well as being theoretically novel, this review will enhance understandings of how best to design, implement, and evaluate SP initiatives (Bickerdike et al., 2017).

To further refine this review in light of previously identified limitations (e.g., Bickerdike et al., 2017), only UK-based SP programmes were included in the evaluation as: i) different countries have qualitatively and quantitively different healthcare systems and community resources, and ii) SP aims to identify and address different social and environmental factors that impact wellbeing (Sonke et al., 2023; McIntosh, 2016), and these will differ across countries. The review thus required clearly defined geographical boundaries in order to be focused, and to enable meaningful conclusions to be drawn and recommendations to be made.

In sum, this systematic review aims to: i) identify UK-based SP initiatives that are primarily designed to increase social connection and reduce loneliness (as well as to benefit general health and wellbeing), ii) explore the extent to which the reviewed SP initiatives predict/cause increased social connection, reduced loneliness, and improved health and wellbeing, and iii) apply the SIAH to shed light on the psychological processes at work in the reviewed SP programmes.

## 3.3. Method

### *3.3.1. Design*

After selecting articles for evaluation based on the pre-determined inclusion/exclusion criteria defined below, a formal narrative synthesis was conducted to enable exploration of the psychological mechanisms active within SP programmes that aim to enhance social connectedness and reduce loneliness (as well as the health and wellbeing-related outcomes of these programmes). The synthesis was informed by evidence-based guidance that focuses on enhancing SP through conducting robust evaluation (see Cunningham et al., 2023). This involved analysing the data from each study included in the systematic review to ascertain common themes. Narrative synthesis (unlike meta-synthesis) allows for the combining of qualitative and quantitative data, which provided a deep and rich exploration of the psychological mechanisms that may be producing health and wellbeing-related outcomes among people involved in SP programmes that are designed to enhance social belongingness and reduce loneliness (Snilsveit et al., 2012). A narrative synthesis is appropriate given variations in current SP evaluative research design that may otherwise have hindered formal quantitative or qualitative data synthesis. In particular, the limited number of evaluations of SP initiatives that are specifically designed to reduce loneliness and/or increase social connection, coupled with poor reporting of existing interventions in this area, means there was limited scope for meta-analysis (quantitative synthesis).

### *3.3.2. Inclusion/Exclusion Criteria*

Inclusion criteria for article selection encompassed SP intervention trials as well as both qualitative and quantitative reports pertaining to SP programmes that aimed to reduce loneliness and/or increase social connectedness in their programme definition[7]. Qualitative papers that outlined a want or need for SP, or a general response to SP were excluded. Instead, any qualitative articles included in the systematic review had to be linked to an established and specified SP programme so the review could identify, and evaluate, features of the SP programme (i.e., type of SP, target population, duration etc.) that may have produced the outcomes observed. Qualitative reports can be helpful for identifying active mechanisms within interventions that produce beneficial change because they allow richer exploration of SP experiences beyond pre-defined quantitative measures (e.g., Warren et al., 2020). All population groups within the UK were included, but studies conducted outside of the UK were excluded to eliminate the impact of geographical differences (e.g., disparate healthcare systems, community resources and environmental factors) that may impact health and wellbeing outcomes.

SP programmes that did not explore their effectiveness in relation to reducing loneliness and increasing social connectedness were also excluded to ensure a focused review as the broad focus of previous systematic reviews has been identified as a limitation (Bickerdike et al., 2019). Articles had to be written in English, and had to have been published between May 5th, 2006 (when the Department of Health released a report advocating for the introduction of SP within the NHS) and April 8th, 2024 (when the last search was conducted).

Given the large variations in how SP is both defined and delivered, SP was deliberately defined in very general terms for this review: the process by which primary care, or some form

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[7] Note that inclusion criteria did not require studies to have specific outcome measures of loneliness and/or social connectedness. Rather, the specified Social Prescribing programme just had to be defined as targeting loneliness or social connectedness.

of statutory or clinically commissioned service, connects people to community groups and organisations. This is in comparison to other reviews in this area which have necessitated the involvement of a link worker for a programme to be defined as SP (e.g., Bickerdike et al., 2017; Evers et al., 2024; Morse et al., 2022). This definition also better aligns with established consensus set out by Muhl and colleagues (2022). Whilst the role of the link worker is not to be underestimated, the exact nature of how the SP programmes were delivered was not the focus of this review.

### *3.3.3. Search Strategy*

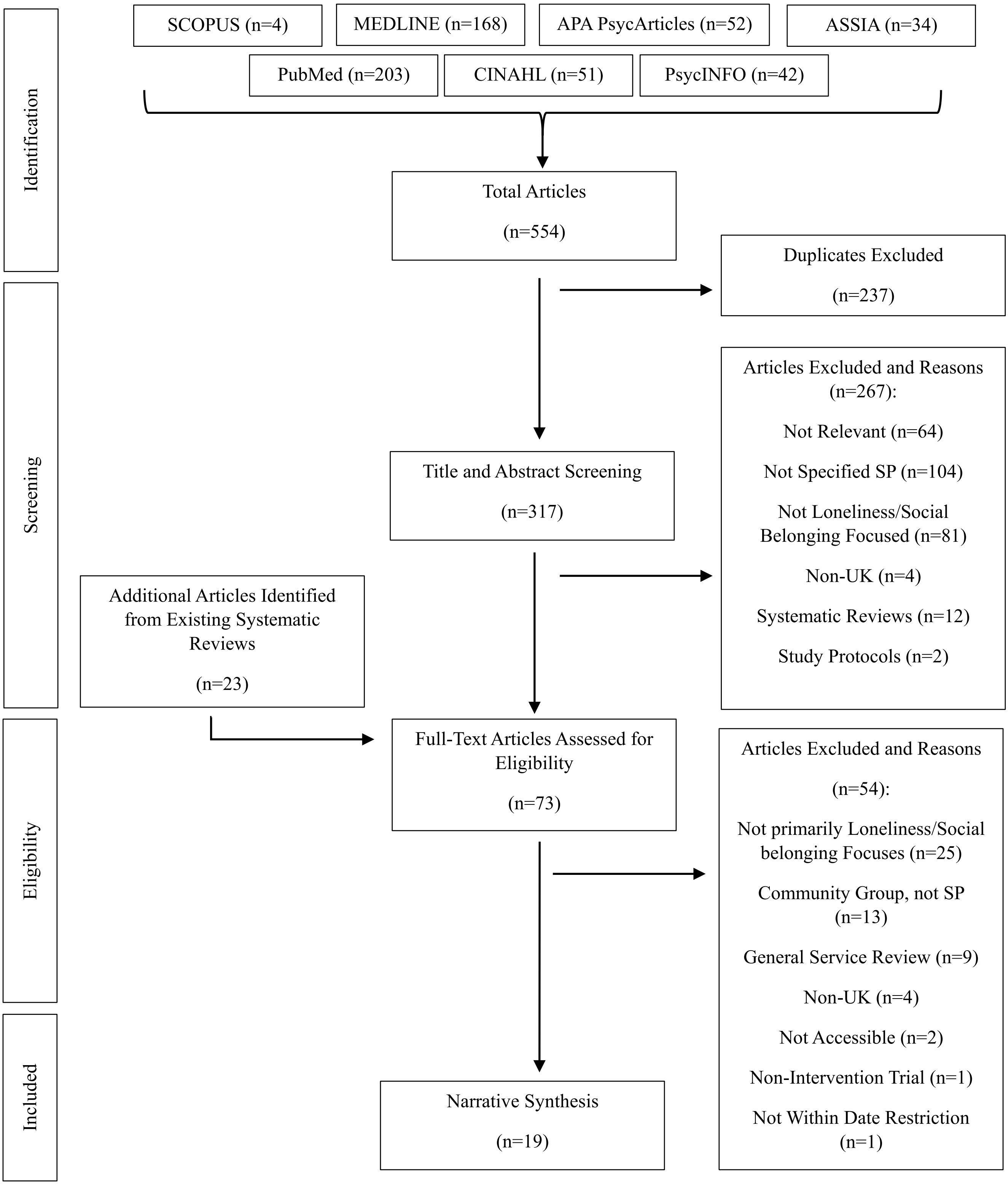
The search strategy was discussed and refined by the research team, drawing specifically on knowledge from an expert (JW) in SP literature. The protocol was pre-registered on PROSPERO (registration number: CRD42023427377), and PRISMA guidelines were used to conduct the review (Moher et al., 2009). The following databases were systematically searched using the search terms ((“Social Prescri*” OR “Social Cure” OR “Non-Medical Prescribing”) AND (“Social Connect*” OR Connect* OR Lonel* OR Wellbeing OR Belong*) AND (UK OR England OR Wales OR Northern Ireland OR Scotland)): Applied Social Sciences Index (ASSIA); Nursing and Allied Health Literature (CINAHL); Social Care Online (SCIE); MEDLINE; APA PsycArticles & PsycINFO through APA PsycNet; Cochrane Database of Systematic Reviews; Cochrane Central Register of Controlled Trials; PubMed; Scopus.

### *3.3.4. Screening, Data Extraction and Synthesis*

Titles and abstracts were screened by the first author (CS, the PhD candidate) to identify studies that met the inclusion criteria. Following this, articles that met the inclusion criteria were downloaded and the full texts were reviewed by the first author to determine inclusion in the systematic review (see Figure 3.1). Extracted data were collated in an Excel spreadsheet. This initial extraction of key information from articles was conducted by the first author, cross-checked by the final author (BAJ), and discussed with the rest of the research team.

**Figure 3.1.**

*PRISMA Flow Diagram.*



### *3.3.5. Narrative Synthesis*

Data extracted are presented in Table 3.1. This includes the type of intervention (e.g., signposting, light, medium, holistic SP), context (e.g., location and setting of SP programme), timing (e.g., length of SP programme, follow-up engagement), and target demographic. This enabled systematic exploration of how these variables are associated with health and wellbeing-related outcomes. Specific outcomes of interest for this review pertained to loneliness and social connectedness. Notes were also taken in relation to any discussion of theoretical underpinnings of SP, although such discussion was anticipated to be limited due to SP being evaluated in largely atheoretical ways. Extraction of this information aided in the identification of SIAH processes at work in SP programmes, as well as what variables may increase the likelihood of such processes occurring.

Following this preliminary synthesis, relationships between different variables were explored (i.e., is the effectiveness of SP dependent on whether the focus is on isolation reduction or enhancing social connectedness?). During this stage, care was taken to acknowledge how methodological differences between studies may affect outcomes.

### *3.3.6. Quality Assessment*

CONSORT-SPI 2018 (a tool developed for transparent reporting of social and psychological interventions; Grant et al., 2018) was used to quality assess selected articles (see Appendix 1). CONSORT-SPI 2018 additionally provides the scope for simultaneously evaluating both quantitative and qualitative evaluations of complex interventions with a focus on theoretical underpinnings and contextual factors; advantageous over other quality appraisal tools (e.g., QuADS) given the aims of this review. In the current systematic review, articles rated as poor quality were intended to be removed however, given the majority of the included articles were rated as such, it was decided not to implement quality rating as an exclusion criterion. Assessment of article quality was conducted by the lead author (CS), cross-checked by the final author (BAJ), and discussed with the rest of the research team.

## 3.4. Results

Initial searches from all databases yielded 554 results. Of these, 19 articles were included in this review, which reported on 18 different SP programmes (see Figure 3.1 for an outline of article elimination processes); two papers reported on the same SP programme, but both were included due to having different conceptualisations of the data (Kellezi et al., 2019; Wakefield et al., 2020). The SIAH was used to understand and illustrate the interrelationship between different factors that impact SP outcomes on domains of loneliness and social connectedness.

### *3.4.1. Characteristics of Included Studies*

Ten studies employed a mixed-methods design, eight employed a qualitative design, and one was a quantitative service evaluation. Publication dates ranged from May 2006 to October 2023. Of the studies included, sample sizes ranged from 6 to 2250 participants. Age of participants ranged from 18 to 85, with most participants being at the upper end of this age bracket (see Table 3.1 for average ages for each study). Six SP programmes were identified as *signposting* SP, where participants were directed towards community groups for general wellbeing needs (one of which also had *holistic* elements), five as *light* SP (where participants were directed towards community programmes designed to target a specific need), three as *medium* SP (where participants were referred to a health facilitator within a GP practice who identified appropriate community activities; one with holistic elements), and the remaining five programmes as solely *holistic* SP (where participants were referred to established SP programmes and their engagement often supported by a link worker).

All included articles that adopted a mixed-methods design combined quantitative and qualitative components. For quantitative elements, WEMWBS (Warwick-Edinburgh Mental Wellbeing Scale; Tennant et al., 2007) and the SWEMWBS (Stewart-Brown et al., 2009; Taggart et al., 2015) were common outcome measures for overall wellbeing, with further wellbeing measures including the Short Form 12 (Ware et al., 1996); Satisfaction with Life Scale (Diener et al., 1985), the Adult Social Care Outcomes Toolkit (Netten et al., 2011), health-related quality of life, as measured by the EQ5D (EuroQol Group, 1990); the UCL Museum Wellbeing Measure (Thomson & Chatterjee, 2015); the Dynamic Observation Scale (Thiele & Marsden, 2003); and the Edmonton Frail Scale (Rolfson et al., 2006). Social identity processes were measured via: Number of group memberships; Community Belonging Single Item Scale (Hayward et al., 2014); the Social Support Scale (Haslam et al., 2005); The Lubben Social Network Scale (Lubben et al., 2006); Practitioner Assessment of Network Type (PANT; Wenger, 1994); and The Medical Outcomes Study Social Support Survey (MOSSS; Sherbourne & Stewart, 1991). Loneliness was measured by: The Campaign to End Loneliness Measurement Tool (Goodman et al., n.d.); UCLA loneliness Scale (Hays & DiMatteo, 1987; Hughes et al., 2004); and the De Jong Gierveld Loneliness Scale (De Jong Gierveld & Van Tilburg, 2006). Depression was measured using the Geriatric Depression Scale (Sheikh & Yesavage, 1986) and the PHQ-2 (Kroenke et al., 2003). Anxiety was measured using the GAD-

7 (Spitzer et al., 2006). One paper (Finn et al., 2023) also measured self-esteem (Self-esteem scale; Robins et al., 2001) and self-efficacy (General Self-Efficacy Scale; Romppel et al., 2013). Health service use (e.g., asking about number of GP visits in past 3 months) was also observed in one paper (Kellezi et al., 2019).

No studies had control groups, however 11 ((Cheshire et al., 2022; Finn et al., 2023 ; Foster et al., 2020; Greaves & Farbus., 2006; Kellezi et al., 2019; Thomson et al., 2020; Todd et al., 2017; Venter & Buller., 2014; Vogelpoel & Jarrold., 2014; Wakefield et al., 2020; Woodall et al., 2018) had longitudinal designs that allowed them to observe changes pre- and post-intervention, as well as sustained benefits at two (Finn et al., 2023) three (Cheshire et al., 2022; Foster et al., 2020; Thomson et al., 2020; Todd et al., 2017; Vogelpoel & Jarrold, 2014), four (Kellezi et al., 2019; Wakefield et al., 2020), six (Greaves & Farbus, 2006; Wakefield et al., 2020; Venter & Buller, 2014), nine (Wakefield et al., 2020), 12 (Greaves & Farbus, 2006) and 18 months (Woodall et al., 2018).

For qualitative elements, interviews and focus groups were most commonly used, including service users, link workers and GPs, as well as other practitioners involved in the SP pathways (e.g., Health Coaches/Coordinators). Two studies included open-ended survey questions to obtain qualitative data (Cheshire et al., 2022; Porter et al., 2023).

### *3.4.2. Quality of Included Studies*

Assessment of article quality was conducted using CONSORT-SPI 2018 (Grant et al., 2018), and each paper was scored on a “0, 0.5, 1” system, where 1 indicated criteria fulfilled, 0.5 indicated partial fulfilment, and 0 indicated not present (see Appendix 1). Where quality criteria were only applicable to quantitative elements, no score was given for qualitative components. To ensure consistency for comparison, percentages were calculated for scores in relation to applicable criteria. Most articles fell within the lower range, with overall scores ranging from 37% to 66%. All articles were retained due to similar performance.

**Table 3.1.**

*Study Characteristics.*

| Author/s & Year | Design | Sample | Target Population | Social Prescribing (SP) Type | Programme Overview | Link Worker (LW) | Completion Rates | Suggested Mechanism of Action | Outcome Measures | Quality Rating |
|---|---|---|---|---|---|---|---|---|---|---|
| **Cheshire et al., 2022.** | Qualitative | Survey: Baseline (n=240), 3-month follow-up (n=187).<br>Interview & Focus groups: n=22.<br>*M age* = 54. | Mild-to-moderate anxiety or depression; social isolation; risk factors for cardiovascular disease; pre-diabetic. | Signposting | Yoga4Health: a 10-week programme of group yoga for all abilities. Each session held max 15 people and were 2 hours each. Sessions consisted of psychoeducation (e.g., deep breathing for relaxation), 1 hour of asana practice, followed by breathing practice, relaxation activities and then finally a group discussion. Home practice was encouraged. | No. | 86% completed at least one session after being booked onto the programme. | Whilst participants initially anticipated physical and MH benefits, it was the value of being part of a group and being more connected that really consolidated the benefit observed. Increased social connectedness led to better management of stress, MH and overall wellbeing, where informational, emotional and social support empowered them to take more control over their health. | Qual themes: Motivation to attend Yoga4Health; Perceived benefits of the Yoga4Health programme (Psychological benefits; Physical health benefits; Social benefits; self-management of health and wellbeing); Barriers and facilitators to engagement (Enjoyment and benefits; Suitability of the class; Practising in a group; Yoga teacher skills and relationship; Course materials). | 49% |

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| **Finn et al., 2023.** | Mixed-methods; Longitudinal | Qual: 13<br>Quant: 27 (week 1); 18 (week 4); 14 (week 8).<br>*M age* = 21. | Young people (aged 16 – 24) living in the UK with anxiety. | Light. | Online dance classes delivered by Dance Base in response to COVID-19. 16 classes in two separate blocks run weekly across a 2-week period. All classes were facilitated by the same dance practitioner. | No. | 33% attrition at 4 weeks, 48% at 8 weeks. | Social Cure. | Quant: GAD-7 (Spitzer et al., 2006) ; UCLA-Loneliness Scale (Hughes et al., 2004) ; PHQ-2 (Kroenke et al., 2003) ; SWEMWBS (Stewart-Brown et al., 2009); Self-esteem scale (Robins et al., 2001); General Self-Efficacy Scale (Romppel et al., 2013); Trust in the Teacher; Inclusion of Other in Self Scale (Aron et al., 1992); One-item group support question; Four-item social identity scale (Doosje et al., 1995); Collective Efficacy (Cruwys et al., 2020).<br>Qual themes: Co-constructing a shared identity (Alternatives to belonging; Symbols of shared identity; Going through shared experiences; The meaning of the group); Improved holistic wellbeing (Psychological; Physical and bodily; Social; Wider behavioural change; Structure and content of the online classes). | 66% |
| **Foster et al., 2020.** | Mixed-Methods; Longitudinal. | Qual (n=50): Service users, volunteers and link workers.<br>Qual follow-up (n=19): service users and link workers. | Young parents; health/mobility issues; recently bereaved; retired. | Holistic | British Red Cross & Co-op partnership's national social prescribing services to address rising levels of loneliness. 37 different sites in the UK. Self and statutory referrals. Paid link-workers | Yes.<br>Paid link workers. | 21.7% only had 1 appointment. | Service users develop a relationship with link workers which is just as beneficial as engagement in SP services. Service users reported this to be central to | Quant : UCLA-3 item questionnaire (Hughes et al., 2004).<br>Qual themes : Shifting support from statutory to community activities; Importance of personalised support delivered by skilled link workers; Issues with service delivery; Improvements in loneliness may not be sustained. | 51% |

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| | | Quant (n=38): 6 responses 1st Survey, 32 responses 2nd Survey. | | | provided personalised care for up to 12 weeks focused on developing confidence and subsequent socialisation and access to community. | | | personalised support specific to their needs. Signposting increased social contacts = reduced loneliness. | | |
| **Giebel et al., 2020.** | Qualitative | 13 middle-aged older adults<br>Aged 44 – 84. | 18+ experiencing loneliness, social isolation and poor wellbeing. | Medium & Holistic | Community Connectors Service: Structured support service enabling access to early intervention and prevention services. Referrals from statutory services for those who are not eligible for weekly assessments; self-referrals. Needs assessed within 48hrs of referral and assigned a "Champion" who provides person-centred support. Low level = meeting person at local organisations; medium= helping with day-to-day tasks; high = providing company on daily tasks and to community groups. 14-week programme. | Yes.<br>“Champions” | N/A. | Increased connection with community directly helped to reduce loneliness and subsequent MH problems e.g., depression. More connection improved wellbeing in all aspects of life through being more self-aware and encouraging self-care. | Qual themes: Falling out of society; Easy self-referral; Structured support service; Reconnecting with community. | 38% |

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| **Greaves & Farbus, 2006.** | Mixed-Methods; Longitudinal. | Qual (n=35): participants, carers & health professionals.<br>Quant: 172 (baseline); 70 (6-month follow-up); 51 (12-month follow-up)<br>*M age* = 77 | Individuals going through life change. | Signposting & Holistic | Upstream Healthy Living: Community-based intervention whereby mentors work closely with participants to re-engage them in life and personal interests through supporting participant-determined activities (e.g., exercise, creative), with an emphasis on social interaction. Regular weekly visits and support from mentors until participants gain confidence. | Yes.<br>"Mentors" | 89% still engaged at 6-months. | Mentors promoted confidence in participants and enabled them to feel cared for. This allowed them to better socially engage and achieve new things. This encouraged long-term maintenance of these activities beyond mentor support. | Quant: Geriatric Depression Scale (Sheikh & Yesavage, 1986); SF12 Health Quality of Life (Ware et al., 1996); Medical Outcomes Social Support Survey (Sherbourne & Stewart, 1991).<br>Qual themes: Psychological and social benefits; Physical health benefits. | 57% |
| **Hassan et al., 2020.** | Qualitative | N=18.<br>Aged 34 – 65. | General public. | Signposting | The Life Rooms Model: Visitors access Life Rooms and are welcomed by staff. Support options available explored with staff experienced in mental health, housing, employment etc. Mainly learning opportunities provided to give advice on how to manage mental | No. | N/A. | The safe space led people to open up and connect with others. This connection validated their personal experiences, improving mental health, confidence and independence. | Qual themes: Social belonging: being able to just 'be'; Resourceful and accessible; Social inclusion and connectedness; Moving forward: self-development and independence. | 38% |

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| | | | | | health alongside social and creative offerings. | | | | | |
| **Kellezi et al., 2019.** | Mixed-Methods | Qual: GPs, health coaches, link workers & patients (n=35).<br>Quant: 630 (baseline), 176 at T1 (4-month follow-up).<br>Aged 22 – 85. | People with chronic illness who are experiencing loneliness. | Holistic | East midlands programme that aims to increase participants illness self-management and address psychosocial needs with the intention to reduce primary care usage. HC assesses patient and provides either self-care or refers to LW who provides holistic support for up to 8 weeks. | Yes.<br>"Health Coaches (HC)" | Quant: 176 at follow-up compared to baseline (630). | LW promoted confidence which allowed participants to connect with similar others in the group. This alleviated loneliness and enhanced social connectedness. Group memberships positively predict sense of community belongingness which leads to lower levels of loneliness. | Quant: Number of group memberships; single item measure of community belonging (Hayward et al., 2014); ULS-8 (Hays & DiMatteo, 1987); Health service use (Kellezi et al., 2016).<br>Qual themes: GP perspective: Social factors and the need for a holistic service; LW perspectives: social needs and the community; Patients' perspective: relationship with LW and building social connections. | 62% |
| **Moore & Thew, 2022.** | Qualitative | N=6.<br>Aged 18 – 24. | Young adults. | Signposting | Occupation-based community intervention; gardening. | No. | N/A. | Self-efficacy and confidence increased through group participation. | Qual themes: Social belonging and connection; A safe space; Sense of achievement from active engagement; the facilitatory aspect of nature. | 37% |
| **Orellana et al., 2020.** | Mixed-Methods | Quant: N=23.<br>Qual: N=16.<br>Aged 68 – 101.<br>*M age* = 83. | Older people who are socially isolated. | Signposting | Day centres for older people: referrals from local authority with maximum of 10 people per day centre. | No. | N/A. | Connecting with similar others increased their social connections and fun. This reduced social isolation and improved wellbeing. | Quant: Adult Social Care Outcomes Toolkit (Cresswell, 2013); Edmonton Frail Scale (Rolfson et al., 2006); SWEMWBS (Taggart et al., 2015); Practitioner Assessment of Network Type (Wenger, 1994).<br>Qual themes: Day centre attendance provided access to social participation and companionship; Day centres provided something (different) to do; Day centres provided the opportunity | 51% |

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| | | | | | | | | | to go out and have a change of environment; Improved mental wellbeing and health; Practical support, information and access to other services; Physical wellbeing, health and safety; Having a meal (food and drink); Accommodation cleanliness and comfort; Personal cleanliness and comfort; Process outcomes. | |
| **Porter et al., 2023.** | Qualitative. | Qual survey: n=93.<br>Qual interviews: n = 21.<br>*M age* = 66. | Men who experience loneliness and social isolation. | Light. | Men's Sheds: a UK based association that offers community spaces for men. They maintain the shed and also make and mend things for the community. | No. | Yes. | Health and wellbeing of shed members if improved through transforming stereotypes on masculine behaviour in positive ways that allow them to normalise reflecting on their own health and wellbeing and discussing this with other members in an informal space. | Qual themes: Experience of joining a shed; Success factors and risks of social prescribing; We care but we're not carers. | 45% |
| **Redmond et al., 2017.** | Qualitative | N=1272. | People with low mood, recent bereavement or socially isolated. | Signposting | Art Lift: Arts of referral. Patients referred from primary care for low mood, bereavement and being socially isolated. Art | No. | N/A. | The group setting allows them to feel connected to others in a way that promotes trust. They are able to | Qual themes: Being with others; Being on my own; Doing something for me; Losing oneself; Threshold. | 38% |

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| | | | | | sessions led by a skilled artist: drawing, mosaics, painting and creative writing. 8 - 10 week course. Group interaction is encouraged but not mandatory. | | | connect with similar others due to the group being for a specific set of people, but focused on a specific activity i.e. art which helps them feel confident and like they are doing something for themselves rather than typical support groups which have a heavy focus on diagnosis. | | |
| **Roberts & Windle, 2019.** | Mixed-Methods | 120 for both methods. | Older people experiencing isolation and loneliness. | Holistic | Cadwyn Mon (Anglesey Links/Chain): aims to reduce loneliness of older people through volunteers offering companionship and support to increase confidence, social networks and independence. Clients meet with volunteers once a week for 15 weeks. | Yes.<br>"Volunteer Coordinators". | 66% retained at follow-up. | Volunteer coordinators promoted confidence in participants which enabled them to join community and social groups that they had been signposted too. Qualitative data suggests they were well matched to clients to help provide support and guidance that | Quant: De Jong Gierveld Loneliness Scale (De Jong Gierveld & Van Tilburg, 2006); Lubben Social Network Scale (Lubben et al., 2006); Satisfaction with Life Scale (Diener et al., 1985).<br>Qual themes: Psychological effects; Lifestyle effects. | 59% |

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| | | | | | | | | increased their confidence. This engagement increased wellbeing through enhancing social participation in life. | | |
| **Simpson et al., 2020.** | Qualitative | 5 people living with Motor Neurone Disease. 4 link workers (n=9).<br>Aged 40 – 79.<br>*M age* = 56. | People living with Motor Neurone Disease. | Holistic | Primary Care mental health service for plwMND (16+): The Modified Interest Checklist was used to choose specific interventions and participants were supported to pursue activities of their choice with support from an occupational therapist and link worker. | Yes. | 4 participants due to their condition worsening or declining support. | Connecting with others enhances one's self concept and acknowledging that you are participating in life rather than doing it on your own. Link workers were instrumental for boosting participants' confidence to engage with these activities. | Qual themes: Participation; Aids and adaptations; Confidence; Stigma; Link workers' experiences; Training needs. | 49% |
| **Thomson et al., 2020.** | Mixed-Methods | Qual: 16<br>Quant: 20<br>*M age* = 53<br>Aged 44 – 70 | Vulnerable, disadvantaged adults who accessed MH services. | Medium | Not So Grim Up North initiative; 'GROW: Art, Park & Wellbeing' (specific programme). Combined engagement in horticulture, creative and art-based activities. Groups met at the park and utilised | No. | Phase 1 attrition (10 participants). | Wellbeing improved through improvements in social engagement and reductions in social isolation. | Quant: UCL Museum Wellbeing Measure (Thomson & Chatterjee, 2015).<br>Qual themes: Sense of community; Decreasing social isolation; Self-esteem. | 48% |

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| | | | | | museum spaces to connect indoor and outdoor activities. 2-hr sessions including talks, demonstrations and practical activities held on consecutive Tuesdays for 10 weeks. | | | | | |
| **Todd et al., 2017.** | Qualitative | N=20.<br>Aged 66 – 85. | Isolated older people. | Light | Museums-On-Prescription (MoP). 12 museums, each providing different activities dependent on available expertise and resources, but with the overall intention to enhance engagement and participation. Activities included object handling, crafting, singing and music, tours. 2-hr sessions across 10 weeks. | Not strictly – but group facilitators helped promote social engagement in activities. | N/A. | Educational aspect of MoP increased self-esteem through enhancing knowledge and values. Increased self-esteem and confidence (also helped by the group facilitator) enhances social engagement and subsequent engagement in the programme. Positive evaluations are increased through this along with wellbeing. | Qual themes: Interacting social context; Evaluating self and others; Communicating; Social engagement; Sharing experiences; Museum as a positive enabler; Enabling; New experience; Role of facilitator; Activities; Physical space; Individual journey; Activity levels; Emotion; Health; Expectation; Relational Processes; Judging others; Influence. | 47% |
| **Venter & Buller, 2014.** | Mixed-Methods | Qual: 6<br>Quant: 44<br>Aged 25 - 45 | Individuals with mild-to-moderate mental health problems. | Light | Arts on Referral (AoR). Individuals referred to regular arts groups to improve confidence and social | No. | N/A. | Social support gained from groups suggested to mediate relationship between AoR and beneficial health | Quant: WEMWBS (Tennant et al., 2007).<br>Qual themes : Differences by gender: normalizing emotions; Differences my ethnicity: the importance of breaking social isolation; Art as therapy. | 57% |

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| | | | | | networks, and reduce healthcare costs. | | | outcomes. Social context encouraged them to develop sense of pride in their work which increased self-esteem. | | |
| **Vogelpoel & Jarrold, 2014.** | Mixed-Methods | 12 participants across all methods. | Older people with MH problems, social isolation, and sensory impairment. | Medium | Arts-on-prescription: GPs referred patients to Voluntary Action Rotherham who were then referred to a project coordinator who initiated personal recruitment process and navigated needs. Regular contact maintained throughout programme. | Yes.<br>“Project Coordinator” | N/A. | Increased confidence as a result of encouragement from the Project Coordinator led to more engagement in group discussions and subsequently more social connections. | Quant: WEMWBS (Tennant et al., 2007) ; Dynamic Observation Scale (Thiele & Marsden, 2003).<br>Qual themes : Increased self-confidence; Reduced social isolation; Establishing new friendships, belonging and group cohesion; Mental wellbeing; Art-making, self-value. | 38% |
| **Wakefield et al., 2020.** | Quantitative | 630 (baseline), 176 at T1 (4-month follow-up).<br>Aged 22 – 85. | People with chronic illness who are experiencing loneliness. | Holistic | (see above). | Yes. | Continued attrition: T0 = 630 pts, T1 = 176 pts, T2 = 63 pts (retained). | Group memberships gained from participation increased QoL but only indirectly. This relationship was serially mediated by increases in social support and reductions in loneliness. | Quant: Number of group memberships; Community belonging (Hayward et al., 2014); Social support (Haslam et al., 2005); ULS-8 (Hays & DiMatteo, 1987); EQ5D (EuroQol Group, 1990). | 58% |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Woodall et al., 2018.** | Mixed-Methods | Qual: N=26.<br>Quant: N=436, 342 at follow-up (18-months).<br>*M age* = 53. | 14+, registered with a GP. | Light | Wellbeing coordinators offer support and provide advice on local community groups. Wellbeing coordinators assess patients and then individuals then referred into relevant activities. Self-referral into the programme, or GP referral. Typically 6 sessions to avoid over-dependence. Mean length of time in service = 10 weeks. | Yes.<br>“Wellbeing Coordinator”. | 436 at baseline comparted to 342 with complete data at post (18-months) - with approx. 2250 - 3750 service used in contact during that time. | Increased social connectedness as a result of participation increased confidence and sense of purpose which overall increased wellbeing. Increased confidence also strengthened existing interpersonal relationships. Wellbeing Coordinators were fundamental for getting participants involved in activities that alleviated feelings of isolation. Made participants feel cared for. | Quant: WEMWBS (Tennant et al., 2007); EQ5D (EuroQol Group, 1990); Campaign to End Loneliness Measurement Tool (Goodman et al., n.d.).<br>Qual themes: Wellbeing; Health and functioning; Social networks; Use of GP services; The attributes of the Wellbeing Coordinator; Engaging men; Flexibility and Duration of the Service; Understanding the voluntary and community sector. | 44% |

### *3.4.3. Findings from the Narrative Synthesis*

Findings were synthesised in tabular format (see Table 3.1), and themes developed in relation to the research aims. The presence of SIAH processes is discussed throughout all themes:

1. Theme 1: 'Good Quality' Social Connection
    a. Felt Understanding and Shared Experiences
    b. Link Workers as Engagement Facilitators
    c. Self-Efficacy as Central for Sustained Social Prescribing Benefits
2. Theme 2: Distinguishing Between Social Connection, Social Isolation, and Loneliness

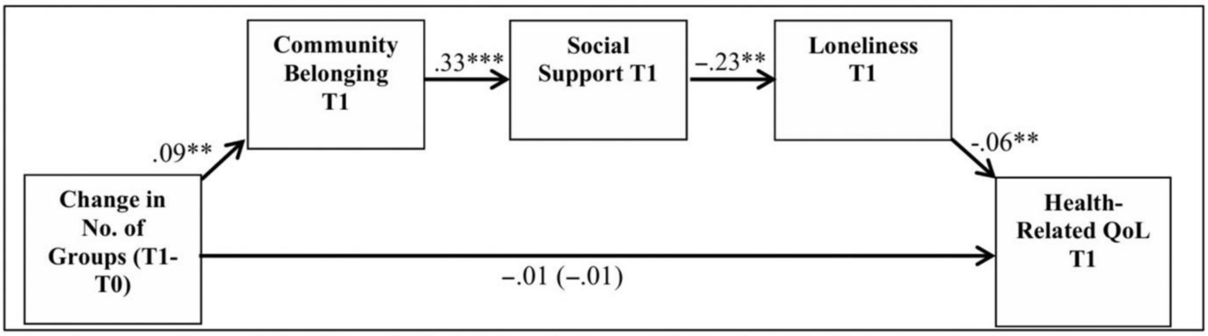
#### 3.4.3.1. Theme 1: 'Good Quality' Social Connection.

One aim of this systematic review was to identity SP initiatives focused on enhancing social belongingness and decreasing loneliness, as well as evaluating the extent to which they achieved these aims. All papers discussed improvements in participants' social connection and overall wellbeing, and all but four (Cheshire et al., 2022; Moore & Thew, 2022; Orellana et al., 2020; Simpson et al., 2020) reported reductions in loneliness following the SP programme. However, the degree to which each SP programme achieved these outcomes was determined by the programme's ability to elicit good quality social connections between group members, defined as those connections with others that were meaningful and relevant.

Indeed, SP research that was underpinned by the SIAH demonstrates serial indirect-only mediation between the number of group memberships and quality of life via stronger identification with the community that in turn increases sense of belonging and reduces loneliness (see Figure 3.2; Wakefield et al., 2020). This emphasises that it is not just the quantity of group memberships alone that lead to beneficial outcomes, but rather the quality of those relationships that allow an individual to feel connected to other group members in order to access psychological resources (also see Kellezi et al., 2019 for similar findings on outcome measures of primary care usage). Thus, SP needs to support beneficiaries' joining (and continued membership of) groups they perceive to be psychologically meaningful. This review identifies several ways in which this can be attained.

**Figure 3.2.**

*Serial Mediation Model Taken From Wakefield et al. (2020).*



*Supplementary Figure 3.* T0/T1 ($n = 178$): Serial mediation model. *C* path: total effect outside brackets, direct effect inside brackets. Control variables (age, gender, relationship status, education level, T0 community belonging, T0 social support, T0 loneliness, T0 health-related quality of life) are not pictured. Note: *** $p < .001$, ** $p \leq .01$.

### *3.4.3.1.1. Sub-Theme 1a: Felt Understanding and Shared Experiences.*

One element that was key for developing good quality social connections was how strongly individuals felt other group members empathised with and shared similar experiences; experiences which had often been psychologically challenging for them (e.g., anxiety; Cheshire et al., 2022). Sharing these challenging experiences increased their sense of shared identity, which SIAH literature indicates is fundamental for feeling a sense of belonging with other group members (i.e., enhanced group identification) and therefore being able to effectively draw on the psychological resources, such as social support, that groups can provide (Jetten et al., 2017; Neville et al., 2021). This psychological process was exemplified by participants in Thomson and colleague’s (2020) mixed-methods paper:

> *“It was very important to relate to people, that we had a common ground factor and that was our mental health experiences. Any other art group that wasn’t focused around mental health, I would never be able to have the same chats and the same connection and the same understanding and empathy”* (Thomson et al., 2020).

It is this sense of psychological connection to other group members, as opposed to just an increased number of group connections, that allows individuals to reap group benefits. Indeed, in a considerable number of papers which had qualitative elements (Finn et al., 2023, Hassan et al., 2020; Kellezi et al., 2019; Orellana et al., 2020; Porter et al., 2023; Redmond et al., 2017; Simpson et al., 2020; Thomson et al., 2020), participants discussed how sharing similar experiences with other group members allowed participants to feel a sense of trust and mutual understanding which enabled them to be emotionally authentic with other group members. This is because group spaces built on shared understandings validate and normalise personal experiences, as most clearly demonstrated in the following excerpt from a participant in Hassan et al.'s (2020) study:

> *"When you're going through mental health issues, you feel so isolated – you are the only person that this has happened to – until you come to places like this and you think, 'Oh…I'm not'…that feeling of isolation can sort of go then"* (Hassan et al., 2020).

Thus, for SP to reduce loneliness, SP must go beyond arbitrary groupings and instead provide participants with an opportunity to make meaningful social connections that they perceive as being valuable and of high quality; a central argument of the SIAH which argues that group identification (e.g., perceiving a sense of belonging) unlocks health and wellbeing benefits associated with group life (Jetten et al., 2017; Wakefield et al., 2020). Referring individuals to groups where they share similar experiences with others is one way of achieving this.

#### ***3.4.3.1.2. Sub-Theme 1b: Link Workers as Engagement Facilitators.***

Another route for facilitating high quality engagement with social groups is through the provision of a link worker. To date, SP research has been unable to reliably establish the beneficial role of the link worker for SP outcomes (Bickerdike et al., 2019). However, whilst the role of the link worker was not the central focus of this review, data synthesis demonstrated that out of the 10 SP programmes that included a link worker in some form (also referred to as: "Champions"; Giebel et al., 2020; "Mentors"; Greaves & Farbus, 2006; "Health Coaches"; Kellezi et al., 2019; "Volunteer Coordinators"; Roberts & Windle, 2019; "Group Facilitators"; Todd et al., 2017; "Project Coordinator"; Vogelpoel & Jarrold, 2014; and "Wellbeing Coordinators"; Woodall et al., 2018), eight reported on their centrality for facilitating group engagement (Foster et al., 2020; Greaves & Farbus, 2006; Kellezi et al., 2019; Roberts & Windle, 2019; Simpson et al., 2020; Todd et al., 2017; Woodall et al., 2018; Vogelpoel & Jarrold, 2014). Specifically, studies by Foster et al. (2021), Greaves and Farbus (2006), and Kellezi et al. (2019), indicate that the ability of link workers to impart empathetic and tailored support provided the space and understanding service users needed to reflect on the progress they were making during SP participation. As illustrated by participants in Kellezi and colleagues' (2019) paper:

> *"I felt as though they gave me the chance to reason out that I was getting better. I listened to them. I knew what was going on in my head, but I couldn't always, I didn't always want to tell anyone. I seemed, with the link-worker, I seemed as though I could get over that more quickly. He wasn't demanding. He was very quiet and very gentle with it, and that is the way that I needed somebody to be, to maybe listen to me, really listen to me, and hear what I was saying, if you can understand that"* (Kellezi et al., 2019).

This empathy in link worker-client relationships was made possible through good matching of link workers to clients (Roberts & Windle, 2019). Similar to the previous subtheme, this allowed the relationship to be built on a sense of trust and mutual understanding that allowed clients to be heard, cared for and supported by their link worker. Feeling understood and seen subsequently increased an individual's confidence and sense of purpose in life, as demonstrated by participants in Greaves and Farbus' (2006) study:

> *"The fact that somebody was going to come and see me on a regular basis because the other thing that I've suffered really with is a fear of abandonment.... It makes you feel ...like somebody's bothered about you. Yes, somebody cares. I would say it's things like that that give people a bit of purpose, a bit of encouragement.... Going back to [all the new things I've be doing], I wouldn't have the confidence to do half those things a couple of months ago"* (Greaves & Farbus, 2006).

As a result of this good relationship with the link worker, participants self-efficacy increased which enhanced their engagement with group activities (Greaves & Farbus, 2006; Kellezi et al., 2019; Simpson et al., 2020). This is because link workers allowed clients to feel valued and believe they had the capabilities to engage in group settings. Coupled with link workers' support in finding similar others to connect to within the group (e.g., Kellezi et al., 2019; also see previous subtheme), clients were able to draw on the psychological benefits of group life (e.g., social support, sense of meaning in life; Jetten et al., 2017; Wakefield et al., 2019).

#### *3.4.3.1.3. Sub-Theme 1c: Self-Efficacy as Central for Sustained SP Benefits*

The final point highlighted as important for ensuring good quality social connections was self-efficacy. As discussed in the previous subtheme, link workers can help promote self-efficacy which encourages initial group engagement. However, self-efficacy also continues to develop throughout (i.e., if participants have good group experiences) and beyond (i.e., through continued participation in community groups) the SP programmes. Important to note at this juncture is that across articles reviewed, the terms *self-confidence* (Greaves & Farbus, 2006; Hassan et al., 2020; Kellezi et al., 2019; Moore & Thew, 2022; Redmond et al., 2017; Roberts & Windle, 2019; Simpson et al., 2020; Vogelpoel & Jarrold, 2014; Woodall et al., 2018) and *self-esteem* (Todd et al., 2017; Venter & Buller, 2014) were often used to refer to this facet. However, following analysis and synthesis, it was concluded that participants' experiences relating to these factors better reflected the concept of self-efficacy, where self-efficacy is defined as an individuals' belief in their capacity to execute the necessary behaviours to achieve an outcome (Bandura, 1998). This is different from self-esteem, which is not task-specific and instead outlines one's general evaluation of their self-worth (Bandura, 1998; Lane et al., 2004; Malureanu et al., 2021). In a similar vein, self-confidence refers to one's holistic belief about their ability to exert control over their behaviour and social environment; there is no set direction (unlike self-efficacy which has an outcome or goal, Bandura, 1998).

Specifically, self-efficacy was central to participants' experience of SP, and from which they perceived all other benefits as stemming. This is because feeling understood and supported by group members became a basis for empowerment (e.g., "*I feel more empowered to do better things and improve my life. I've got more confidence to do things*"; Giebel et al., 2020). Feeling empowered allowed participants to develop their skills in the area that the group activity was based on (e.g., social skills and team building through a horticultural workshop; Moore & Thew, 2022). This increased self-efficacy by allowing participants to achieve new things, and then applying these new skills in other areas of their life:

> *"I was able to develop my horticultural skills and learn social skills that I could transfer into my life and work – they can even help with getting a job [pause]….. It helped me with teambuilding and leadership skills. As a care leaver [erm], we don't get support, so this has been a real good experience for me!"* (Moore & Thew, 2022).

As demonstrated above, the development of a specific skill, social skills in this instance, through participation in SP, increased capacity to have successful social interactions across several domains of their life. Whilst increases in self-esteem and self-confidence complimented these changes, these improvements were directly related to increasing valued social engagement: a specific activity rather than a general self-confidence and thus reflective of self-efficacy.

As mentioned, SP programmes facilitated this self-efficacy initially from interactions with link workers who encouraged participants to engage in social activities. Continued engagement with SP allowed participants to build on this themselves, prompting them to engage in additional social groups and activities beyond their completion of the SP programme, thereby allowing them to "*build relationships outside of the group*" (Moore & Thew, 2022). Self-efficacy most importantly gave participants autonomy to take back control in their lives: control of their physical environments, their health, and their emotions. Thus, not only did participants experience sustained SP benefits through extending their engagement with social groups independently, but also by leading them to take better care of their physical and mental health:

> *"What it made me do was reassess my life and how important actually I am, and how I need to give myself something…I reassess my life basically, and how important it was for me to find time for me to do stuff. To be a bit more autonomous in my own healthcare"* (Cheshire et al., 2022).

Thus, the role of self-efficacy becomes central to SP because it facilitates both active engagement in SP and a continued self-engagement in social settings beyond programme completion by increasing participants' perceived capacity to achieve this (also see Frings & Albery, 2015). In this way, self-efficacy is two-fold. Having good quality social connections with group members through feeling understood and link worker encouragement allows self-efficacy to develop, and once developed, self-efficacy is the basis for maintaining these good quality connections long-term.

#### 3.4.3.2. Theme 2: Distinguishing Between Social Connection, Social Isolation, and Loneliness

Through applying a SIAH lens to the articles reviewed, theme one has highlighted how good quality social connections, over the number of social connections, are the determining factor for positive SP outcomes. Whilst novel for much SP research, Liebmann and colleagues (2022) have highlighted the need to acknowledge this difference through distinguishing between *loneliness* and *social isolation* within SP research. Loneliness refers to the *perceived* mismatch between one's actual and desired social engagement (an unwanted experience of social isolation; Haslam et al., 2024; Perlman & Peplau, 1981), whereas social isolation refers to an absence or paucity of opportunities to socially connect (Gardiner et al., 2018). The former relates to the quality, and the latter to the quantity, of social connections. Through a SIAH lens, this distinction is important because if an individual feels that they do not have good quality social connection, not only do they have a perceived lack of social connection, but they also lose access to key psychological resources that are beneficial for health and wellbeing (Haslam et al., 2024; Haslam et al., 2022; Hayes et al., 2022). Nonetheless, across the literature, these concepts are often viewed synonymously despite being conceptually different. For example, three papers (Kellezi et al, 2019; Orellana et al., 2020; Wakefield et al., 2020) specifically measured quantity of social groups (which has no bearing on the quality of the relationships) and a further eight papers conceptualised their findings in relation to social isolation (Cheshire et al., 2022; Greaves & Farbus, 2006; Porter et al., 2023; Simpson et al., 2020; Thomson et al., 2020; Todd et al., 2017; Venter & Buller, 2014; Vogelpoel & Jarrold, 2014). Thus, studies may be, inadvertently, exploring the effectiveness of SP for social isolation rather than the psychologically valuable component that has a bearing on individuals' ability to access key psychological resources; loneliness.

Failing to distinguish between social isolation and loneliness means that reduced levels of either loneliness or social isolation are both interpreted to be indicative of beneficial increases in social connection. In line with this, nine papers (Hassan et al., 2020; Kellezi et al., 2019; Roberts & Windle; Thomson et al., 2020; Todd et al., 2017; Venter & Buller, 2014; Vogelpoel & Jarrold, 2014; Wakefield et al., 2020; Woodall et al., 2018) conceptualised social connectedness and loneliness/social isolation as correlating negatively with each other. That is to say that as an individual shows increases in social connectedness, decreases in loneliness/social isolation were expected. However, this definition and understanding of social connection is problematic because it means that one could be highly socially connected to groups to which one feels no sense of belonging. That is, social connectedness ignores the psychological aspect of group membership (i.e., feeling connected and a sense of belonging with other group members); the aspect the SIAH argues is vital for reducing loneliness and promoting wellbeing (Haslam et al., 2024; Haslam et al., 2018; Jetten et al., 2017) and as evidenced in theme one of the current systematic review. This is because the degree to which an individual identifies and connects with other group members has a direct impact on the health and wellbeing benefits they experience as a result of SP participation. Consequently, utilising outcome measures that do not capture this sense of connection and receipt of psychological resources from other group members limits our ability to correctly identify those SP programmes that do achieve these benefits. Whilst quantitative data may indicate that number of group memberships is a positive predictor of community belonging (i.e., the quality of relationships; Kellezi et al., 2019; Wakefield et al., 2020), this cannot be assumed in all cases. As noted by Giebel and colleagues (2020), just because an individual is more socially engaged does not mean that they are automatically less lonely.

Conceptualisations of social connectedness in this way meant that loneliness, social isolation and social connectedness were all used synonymously and as such were largely reflective of social isolation rather than adequately capturing the quality of relationships developed during SP. The challenges of this became clear. For example, a reviewed article which used social isolation as a proxy for an absence of social connectedness (Roberts & Windle, 2019) failed to account for the possibility that an individual who scores low on levels of social isolation (i.e., they have several opportunities to socially connect) may not automatically feel more socially connected and may still experience loneliness (perhaps because they do not feel a sense of identification and belonging with these prescribed groups; see Haslam et al., 2024). Whilst the authors did also measure loneliness, they argued that the most successful part of the SP programme was its ability to facilitate opportunities for social relationships to develop, yet there was very little consideration of the service-users' perceived *quality* of these relationships. The limitations of this become clear when the authors concluded that although there were significant improvements in all measures of wellbeing following the SP intervention, including loneliness and social isolation, the mean score for loneliness was still low, indicative of persistent high general levels of loneliness. Thus, reducing social isolation does not always predict beneficially significant increases in social connectedness and reductions in loneliness, perhaps in view of the fact that arbitrary provision of social groups (which would address social isolation) does not provision groups from which psychological resources can be accessed (see Haslam et al., 2024; Hayes et al., 2022)

Like in theme one, this distinction between loneliness and social isolation underscores the importance for SP evaluations to focus on how beneficiaries perceive and experience the quality of the social connections they develop during SP, rather than solely considering the quantity of groups or group members to which an individual is connected. This begins by distinguishing between loneliness and social isolation in order to focus SP evaluations on psychologically valuable outcomes (e.g., social connectedness; group identification; social support etc; Haslam et al., 2024). Nonetheless, even among research that does conceptually differentiate between loneliness and social isolation (e.g., Foster et al., 2020), and suggestions from qualitative findings indicating the importance of meaningful connections with others (see theme one), SP research does not always include quantitative measures of SIAH process variables that would capture relationship quality. This, in part, can be attributed to the lack of theoretical underpinnings of existing research that has prevented researchers acknowledging their potential role within SP. For example, apart from the three papers that used SIAH hypotheses to guide their research (Finn et al., 2023; Kellezi et al., 2019; Wakefield et al., 2020), only six (Finn et al., 2023; Foster et al., 2020; Kellezi et al., 2019; Roberts & Windle, 2019; Wakefield et al., 2020; Woodall et al., 2018) of the 11 papers with quantitative elements explicitly measured loneliness. Out of those, four (Finn et al., 2023; Kellezi et al., 2019; Roberts & Windle, 2019; Wakefield et al., 2020) simultaneously included measures pertaining the quality of those relationships (i.e., through perceived social support; Roberts & Windle, 2019; or sense of community belongingness; Kellezi et al., 2019; Wakefield et al., 2020) that would allow relationship quality to be identified as a mediating factor between group engagement and meaningful reductions in loneliness. A further three papers (Thomson et al., 2020; Venter & Buller, 2014; Vogelpoel & Jarrold, 2014) focused solely on wellbeing as an outcome measure, and two looked at depression and anxiety (Greaves & Farbus, 2006; Finn et al., 2023). As such, the outcome measures used for SP evaluations for articles included in this review mostly fail to acknowledge the importance of quality over the quantity when it comes to social connections, thereby being unable to account for the mediating processes (e.g., social support, sense of belonging, group identification; Haslam et al., 2024) that may be consequential for beneficial health and wellbeing outcomes often observed in the included articles.

Future SP research should adopt the SIAH when designing their interventions and select variables capable of assessing SIAH variables. A good example of this included within this systematic review is that by Finn and colleagues (2023), demonstrating how utilising a SIAH lens and focusing on Social Cure processes such as constructing a shared group identity can facilitate reductions in loneliness and improvements in general wellbeing and mental health outcomes.

### 3.5. Discussion

Previous literature has highlighted the challenges of SP implementation and evaluation (Adams et al., 2019; Bickerdike et al., 2017; Cunningham et al., 2023). The NHS (2014; 2017) has also advocated the need for more robust evidence regarding the efficacy of SP to produce evidence-based initiatives. One challenge has been in substantiating the theoretical underpinnings of SP to understand what works, for whom, and in what circumstances (Bickerdike et al., 2017). To achieve this, extant literature has advocated the need for focused and standardised systematic reviews (Bickerdike et al., 2017; Costa et al., 2021; Napierala et al., 2020; Percival et al., 2022). The present systematic review accomplished this by applying a theoretical framework, SIAH, to review evaluations of a subset of SP programmes that aimed to enhance social belongingness and reduce loneliness (see Stevenson et al., 2019 for the benefit of applying the SIAH to understand and evaluate SP programmes). In the current study, the SIAH was demonstrated to provide a compelling approach for identifying the active mechanisms of SP interventions that focus on alleviating loneliness and enhancing social connection given that it explained how social processes (e.g., social support, self-efficacy, sense of belongingness etc.) associated with valuable group memberships can lead to improvements in health and wellbeing. In light of the themes identified as a result of applying a SIAH lens, there are a number of implications.

### *3.5.1. Implications for Social Prescribing*

One implication relates to the intended aim of SP programmes. To date, SP has been focused on the provision of social groups with limited understanding as to what factors make these group spaces more or less beneficial for those involved. However, as evidenced in the current review, a SP programme must not only facilitate opportunities for social engagement, addressing social isolation, but it must also have a cognitive impact on the individual by alleviating feelings of loneliness. In essence, SP should positively affect an individual's perception of their social connections, rather than merely providing opportunities for social engagement to occur; a key argument of the SIAH (Wakefield et al., 2019) and a finding also reflected in the Australian context (Dingle & Sharman, 2022). Importantly, these social connections must allow a sense of trust between group members to be developed in order for SP to be most effective (Dingle et al., 2024). To achieve this, SP groupings must transcend mere arbitrary or proximal associations and instead provide group members with a common ground that is both psychologically significant and relevant to them. It is this sense of psychological connection that promotes a sense of shared identity (also see Jetten et al., 2017; Neville et al., 2021) and allows group members to unlock valuable psychological resources such as increased social support, trust and a sense of belongingness (see *The Social Support Hypothesis*; *The Identification Hypothesis*; Jetten et al., 2017; also see Wakefield et al., 2020).

Link workers can play a key role here, identifying groups that they feel will benefit the individual most and allow them to connect to similar others. This is key, particularly where many individuals being referred to SP programmes are vulnerable (Cruwys et al., 2018), and subsequently may struggle with stigma, mistrust and fears of negative evaluation that can impede their engagement and connection with other group members (Dingle & Sharman, 2022). Thus, inclusion of a link worker in all SP programmes where resources allow is recommended for enhancing engagement with SP; a benefit that has been captured in previous research (albeit limited; Sharman et al., 2022).

As suggested by previous research, the psychologically valuable components should also be communicated to participants to enhance their engagement with these key proponents (see Kellezi et al., 2019; Wakefield et al., 2020), for example, making them cognitively aware of the changes that are occurring as a result of their participation. This cognisance is central to increasing an individuals' self-efficacy, where self-efficacy is suggested to be fundamental for long-term SP benefits (e.g., Giebel et al., 2020; Hassan et al., 2020; Moore & Thew, 2022) and allows participants the autonomy to manage their own health (e.g., Cheshire et al., 2022; also see Schunk & DiBenedetto, 2021 on the role of self-efficacy for increasing personal autonomy). Again, link workers are key here for enhancing self-efficacy through allowing this space for self-reflection that allows the participant to observe self-growth. Importantly, whilst SP is seen as context dependent because it relies on local community resources (Sonke et al., 2023; McIntosh, 2016), self-efficacy can be transferred between contexts and maintained over time (Schunk & DiBenedetto, 2021). As such, enhancing self-efficacy and acknowledging the centrality of it within SP can be beneficial for enhancing SP's long-term and widespread positive outcomes (see Figure 3.3[8]).

These sustained benefits are of utmost importance given funding challenges within the NHS (e.g., NHS, 2014; 2019), and the commitment within the NHS' long-term plans (NHS, 2019) to move away from short-sighted approaches and instead adopt longer-term sustainable programmes. Further, SP programmes are often time-limited in nature, in part because of resource challenges both within the NHS and the voluntary sector (Bickerdike et al., 2017). Thus, future SP development, particularly in places where social and economic deprivation are pervasive (Watt et al., 2020), would gain from enhancing the aforementioned elements.

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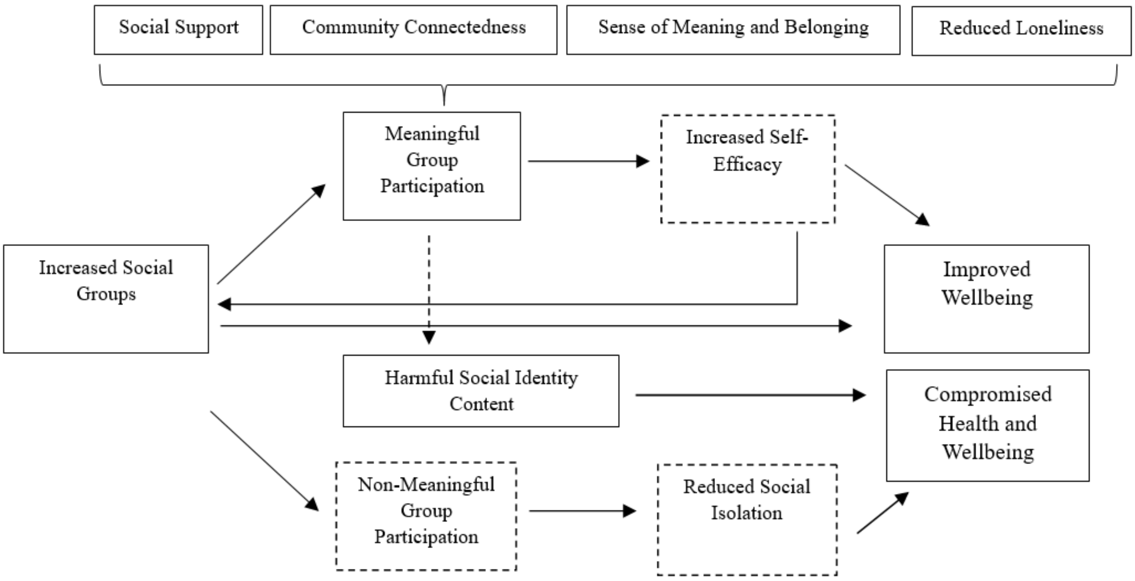
[8] An adapted version of this model, informed by empirical insights across the thesis, is presented in Chapter 9 (see Figure 9.1)."

**Figure 3.3.**

*Adapted Version of SIAH Mechanisms Active Within SP Programmes Based on Synthesis of Reviewed Articles.*



*Note.* Dashed boxes highlight key changes made to existing models of SP e.g., Haslam et al., 2024.

### *3.5.2. Implications for Research*

Importantly then, changes with SP programme delivery to enhance health benefits observed must also be reflected in research outcomes. This is because without adequate measures of relationship quality, the centrality of this for achieving good SP outcomes cannot be established. As demonstrated within the findings, SP programmes to an extent do achieve good quality relationships, however the degree to which they all achieve this is unknown; knowledge which is needed in order to further understand the conditions under which these good quality relationships can be continuously achieved rather than them occurring by chance. It is this consistency that is key for establishing a strong evidence base for SP (Bickerdike et al., 2017; Dingle et al., 2024). One way of capturing this is through the inclusion of SIAH outcome measures such as community connectedness, self-efficacy, loneliness and social support simultaneously (e.g., Finn et al., 2023; Wakefield et al., 2020) to demonstrate the mediating role of relationship quality between SP participation and positive health outcomes. In the current systematic review, this was demonstrated among qualitative components of the included articles. However, quantitative evidence was lacking due to specific outcomes measures not being employed; a notion similarly echoed by Zurynski and colleagues (2020) in the Australian context and the global evidence base at large (Sonke et al., 2023). With a preference for quantitative findings to support healthcare programme implementation

(Guetterman, 2019), it is key that these concepts are measured within quantitative work to provide rigorous support for these elements and their role in SP efficacy so that future research can enhance their centrality. However, as highlighted by Dingle and colleagues (2024), it is of increasing importance that these outcomes are followed up over extended periods of time, particularly where different formats (e.g., online vs. community-based) can have different time parameters for beneficial effects to be observed. Overall, a focus on longitudinal SIAH elements, rather than general health outcomes (e.g., wellbeing) would be a beneficial step for moving the focus of SP evaluations away from social isolation and towards loneliness reduction and social connection enhancement; a conceptually advantageous shift based on the findings of this systematic review.

### *3.5.3. Implications for Theory*

Altogether, these findings have implications for theory development. As demonstrated, the SIAH was a useful tool for coherently understanding a broad range of findings and has shed light on how SIAH processes can help us to understand the benefits observed as a result of SP participation. Understanding these processes also helps researchers understand how these beneficial effects can be consistently enhanced and tailored for specific groups. Resultant inclusion of SIAH process variables is a necessary step in substantiating the SIAH as a theoretical basis for SP (see Kellezi et al., 2019; Wakefield et al., 2020 for early examples of this).

However, this review has also highlighted some of the shortcomings of the SIAH centred around the confused and limited role of self-efficacy. This has implications for both theoretically underpinning SP and also for adapting SIAH theory. For example, qualitative findings within the reviewed articles highlight the potentially mediating role of self-efficacy between SP group engagement and long-term benefits, which is often missed from quantitative elements. As depicted in Figure 3.3, and drawn from qualitative data in the reviewed papers, it can be suggested that self-efficacy has a more central role in producing beneficial SP outcomes than is currently presented within both research and SIAH models because it allows participants to acknowledge their own potential for advancing their social engagement and exploring this with the support of other group members to achieve new things (also see Frings & Albery, 2015 on the role of social identities for developing self-efficacy). This is demonstrated in human motivation research, specifically Bandura's (1997; 1998) Social Cognitive Theory whereby feeling one has the capabilities to perform actions, in this instance social engagement, can encourage motivational and affective processes (Schunk & DiBenedetto, 2021); central for increasing an individual's overall wellbeing (Jiang & Ngien, 2020). Thus, it can be suggested that a reconsideration of the role of self-efficacy within SP and SIAH models could elevate the long-term benefits achieved from SP; long-term benefits that existing research has emphasised a need to understand (see Foster et al., 2020). Nonetheless, this review demonstrates the SIAH is an appropriate framework for grounding SP programmes, as suggested by previous literature (e.g., Haslam et al., 2024; Stevenson et al., 2019). Adopting a SIAH lens allowed this review to identify why some SP programmes are more efficacious than others, and therefore allowed the research to draw the above recommendations. Future SP programme delivery should therefore consider SIAH processes when designing SP programmes to enhance the beneficial health outcomes that can be achieved.

### *3.5.4. Wider Implications and Future Directions*

This review focuses on SP programs within the UK. However, the UK's adoption of SP is not unique; other countries are also beginning to employ these models to address holistic healthcare needs and inequalities (Morse et al., 2022). Although the UK pioneered the popularization of SP, it is now implemented in at least 17 countries (Morse et al., 2022). In particular, Australia is emerging as a significant contributor to research on the Social Identity Approach to Health (SIAH; e.g., Haslam et al., 2018; Jetten et al., 2017) and its recent applications to SP (Haslam et al., 2024; also see Kellezi et al., 2019; Wakefield et al., 2020 for applications within the UK). Additionally, the Groups 4 Health initiative, originally from Australia, is now being extended to the UK, Germany, and Switzerland (Haslam et al., 2019; The University of Queensland, 2018).

Consequently, the implications for SP implementation, research, and theory discussed here have broader ramifications. For example, while the UK is beginning to see theoretically underpinned SP initiatives (e.g., Kellezi et al., 2019; Wakefield et al., 2020), and more globally we are observing the early development of SIAH models of SP (Haslam et al., 2024), several initiatives in other countries are still not grounded in this evidence base (e.g., Men's Sheds; Foettinger et al., 2022; also see Ito, 2024 on Men's Sheds, Japan). This gap is problematic, especially given the aforementioned international rollout of SP programs (e.g., Groups 4 Health; Haslam et al., 2019), as it limits our understanding of how to successfully transfer and implement these initiatives across countries. Thus, the points raised here can guide a more consistent and theoretically informed implementation of SP programs both within and outside the UK.

However, the context-specific nature of SP and the need for tailoring programs to specific subpopulations (Husk et al., 2020; Morse et al., 2022) raises questions about whether theoretical mechanisms hold across countries and cultures. Indeed, Evers and colleagues (2024) identified 11 distinct theories explaining the health outcomes of SP participation, indicating a lack of global consensus on the active mechanisms of SP. This divergence leads to different formats of delivery and outcome measures, complicating cross-country comparisons and international implementation. Positively however, despite the more recent emergence of SP within Australia (in comparison to the UK), several of our findings mirror their own: Quality over the quantity of social groups (Dingle et al., 2024); the key role of the link worker (Sharman et al., 2022); and the need for standardised outcome measures (Zurynski et al., 2020). In view of the fact that SIAH work emerging from Australia is extensive, it can be argued that this theoretical basis does indeed explain the active mechanisms of SP across contexts. Overall, then, collaborative global efforts, such as those by the Global SP Alliance and the International SP Network, are essential. These endeavours would ensure the development and evaluation of SP programs based on a common body of knowledge, enabling cross-cultural comparison and validation of theoretical suggestions across geographical boundaries.

Lastly, both SP and SIAH research are rapidly moving fields. Consequently, future research needs to be responsive to this. For example, whilst the present research was under peer review, Haslam and colleagues (2024) developed newly defined categories of SP that better align with the SIAH. In line with Open Research principles, it was decided not to change the definition and categories of SP for this review given: 1) intervention format (e.g., signposting, light, medium, holistic SP; Kimberlee, 2015)) was a key category of extracted data; 2) invention format did, in part, have a bearing on the success of SP Interventions (e.g., holistic SP and the role of the link worker for achieving good quality social connections); and 3) the SP programmes reviewed often drew on Kimberlee’s (2015) definitions. Having said that, it is clear how Haslam and colleagues (2024) definition complements this existing work. Future research may wish to move towards adoption of Haslam and colleagues (2024) definitions and categories of SP, particularly for SIAH work in this area.

### *3.5.5. Strengths and Limitations*

To the authors’ knowledge, this is the first review of SP programmes focused on reducing loneliness and increasing social connectedness that applies a SIAH lens to interpret the data. This theoretical foundation is much needed and is fundamental for improving future development of SP (Evers et al., 2024; Stevenson et al., 2019). The strengths of a mixed-methods appraisal of the literature were also apparent where qualitative findings were more readily able to illuminate the presence of SIAH processes within SP in comparison to quantitative elements which often did not include direct measures of SIAH process variables (e.g., Greaves & Farbus, 2006; also see Sonke, 2023).

Due to the poor quality of the articles included within this review, direct comparisons between studies were challenging given the variation within outcome measures and variables of interest, as well as how concepts were operationalised. This has previously been identified as a limitation when attempting to synthesise SP literature (e.g., Bickerdike et al., 2017; Costa et al., 2021; Liebmann, 2022; Napierala et al., 2022; Percival et al., 2022; Reinhardt et al., 2021). This variation may also be reflective of the extensive search strategy employed with the intention to limit missing key articles for inclusion. However, in the current review, application of the SIAH gave the researchers a common framework to draw together the evidence for a more comprehensive synthesis than has been possible with previous reviews.

Finally, it must be noted that whilst this work begins to provide a theoretical grounding for SP, building on existing research (Haslam et al., 2024; Kellezi et al., 2019; Wakefield et al., 2020), several additional challenges for SP implementation and evaluation still need to be addressed. For example, there are unresolved questions relating to structural elements of SP. That is to say that we do not yet understand how to best integrate SP into existing healthcare services to create holistic and complementary healthcare systems. Whilst SP may be delivered within a primary care practice, at current, these are only tangentially related services (e.g., Westlake, 2023). Thus, further work that takes a systems-level approach to SP (rather than intervention-level) is needed (also see Husk et al., 2016; 2019). This includes evaluation of all components of SP programmes beyond health outcomes, for example, what leads to differences in outcomes across groups?; How well do staff understand SP?; and what are the best referral mechanisms for successful delivery? (Evers et al., 2024).

### 3.6. Conclusion

The implementation of SP is rapidly advancing without a concomitant evidence base to support its effectiveness. One of the key challenges relates to a lack of consistency both across SP programme delivery and in its subsequent evaluation. Prior systematic reviews advocate the need for SP to be comparative by design. This systematic review was able to address these concerns by reviewing the available evidence in relation to a common theoretical framework; the SIAH. Not only did this enable this review to identify how Social Cure processes are central to SP health and wellbeing benefits, but it was also able to categorically examine a mixed range of evidence and provide guidance for future SP delivery and evaluation. This guidance highlights the key role of facilitating shared understanding among SP participants for enhancing health benefits obtained. This can be achieved through the provision of empathetic link workers referring service users to appropriate groups with similar others and encouraging the development of self-efficacy to maintain health improvements long-term. Subsequent evaluations of SP programmes can capture these health changes by including SIAH process variables to illuminate how relationship quality mediates participation in SP and associated health benefits.

# Chapter 4

## Methodology

### 4.1. Introduction

Based on the systematic review findings in Chapter 3, the following chapters outline how these insights informed the development of the empirical studies that comprise this thesis. While methodology chapters are typically presented before study findings, this thesis first introduced the systematic review in Chapter 3. This deliberate structuring reflects the role of the systematic review as a theory-testing and scoping exercise. Specifically, the review examined whether the SIAH could meaningfully explain the mechanisms through which SP supports health and wellbeing. Findings demonstrated that SP is most effective when it's based on developing *meaningful* social connections in line with predictions set out by the SIAH. This knowledge provided critical conceptual grounding for the empirical work that follows. Informed by the systematic review's identification of meaningful group connections as central to SP's impact, the studies presented in Chapters 6 to 8 were designed to explore how TGDYP experience meaningful social connectedness, and how these experiences could be translated into a practical and inclusive SP pathway.

This chapter therefore outlines the methodological rationale, design choices, and analytic frameworks that guided the empirical studies, demonstrating how the research evolved iteratively from conceptual foundations to applied exploration. The following chapter (Chapter 5) describes the novel development of an analytic framework that supported our data analysis. Further details of methodological decisions can be found within the methods section of each empirical chapter.

### 4.2. Research Design

#### *4.2.1. Ontological and Epistemological Positioning*

Ontology and epistemology are philosophical concepts that guide research. Ontology concerns the nature of reality (i.e., what is reality), whereas epistemology refers to the nature of knowledge (i.e., how do we know what we know; Al-Ababneh, 2020). Ontologically, different perspectives on what individuals *believe* exists (e.g., is there an objective reality, or is everything shaped by social context) determines what is defined as reality and therefore how we collect data on human phenomena (i.e., our epistemological stance; Al-Ababneh, 2020). For example, researchers who believe there is an objective reality (referred to as *realism*; Haig, 2021), are likely to adopt a positivist epistemology where there is deemed to be objective, universal truths regarding human behaviour, uncovered through quantifiable data (Haig, 2021). However, researchers who adopt a *relativist* or *constructivist* ontological position (i.e., that reality is socially or individually constructed) are likely to consider alternative forms of knowledge production such as an *interpretivist epistemology.* Within this approach, data collection methods such as interviews or open-ended responses are used to understand *how* people construct meaning in their lives (Chen et al., 2011).

Historically, the distinction between ontological and epistemological positions has divided and, at times, constrained researchers by forcing alignment with fixed philosophical paradigms. Researchers have often had to choose between opposing world views, such as positivism vs. interpretivism, which limited methodological flexibility and discouraged integration of diverse approaches (Omodan, 2024). In recent years, however, there has been a growing shift toward *pragmatic* research approaches. Pragmatism emphasises practical solutions to research problems and values both objective and subjective forms of knowledge (Morgan, 2014). Ontologically, pragmatism allows for a flexible view of reality, acknowledging that truth may be both constructed and observable, depending on context (Morgan, 2014). Epistemologically, this pragmatic approach enables researchers to select methods based on their utility in addressing the research questions (Morgan, 2014). This flexibility makes pragmatism particularly valuable in applied research contexts, such as healthcare, where the need for practical, actionable insights often requires integrating multiple data collection and analysis strategies (Allemang et al., 2021; Long et al., 2018).

For example, in relation to this thesis, SP interventions can be evaluated in terms of observable effects, such as self-reported improvements in health outcomes. However, qualitative data can explain *how* individuals experience these interventions, providing insight into why they are effective and for whom, reflecting the pragmatic view that reality can also be constructed and context-dependent. Responsively, this thesis adopts a pragmatic approach, enabling the research to address real-world challenges without the methodological constraints imposed by a fixed philosophical paradigm.

#### *4.2.2. Qualitative Sequential Design Overview*

Since the benefits of SP have been observed (see Chapter 1), yet its context-dependent nature is underexplored (e.g., Bickerdike et al., 2019) and its application to TGD communities is novel, this thesis adopted an exploratory sequential qualitative design. A qualitative design was most suited given this research aimed to understand *how* and *why* SP works to provide an explanatory model of SP that could be tailored to trans and gender diverse young people (TGDYP; see Renjith et al., 2021 on the utility of qualitative research for designing health interventions). The sequential approach allowed each study in this thesis to build on its predecessor(s), with findings from earlier phases informing the design and focus of successive phases. As presented in Chapter 3, the systematic review of SP through a SIAH lens allowed the research to understand *why* SP works and for *whom*[9] (see Chapter 3). Identifying that *meaningful* social connections are central to SP's benefits, Study 2 explored how meaningful social connections are experienced by TGDYP and how these insights could inform the development of a SP intervention. Due to the complexity of the research questions and the richness of the data, Study 2 was divided into two parts: Part 1 focuses on applying the SIAH to understand what social connections are meaningful to TGDYP (Study 2, Part 1; see Chapter 6), while Part 2 explores how these findings can be translated into an effective SP intervention for TGDYP (Study 2, Part 2; see Chapter 7).

While Study 2 indicated that meaningful connections are often formed with other TGDYP, and that there is a desire for such support to be embedded within gender-affirming care through SP, it also raised concerns about mistrust in the NHS (e.g., Herlitz et al., 2024) and whether 'prescribed' social support can be perceived as meaningful rather than artificial. Responsively, the final empirical study (see Chapter 8) conducted a service evaluation of one gender clinic in England that has begun to integrate social support as part of their care model to determine whether SP as a similar model would be up taken and have meaningful benefits. Overall, this sequential approach ensured that the research evolved progressively, allowing the thesis to address the complexity of the research questions while refining the research focus of each phase.

#### *4.2.3. Methodological Pluralism*

Given these multiple, unexplored avenues for integrating SP within TGD healthcare, this thesis embraced methodological pluralism (i.e., a core component of pragmatic research; Morgan, 2014), integrating multiple qualitative data collection and analysis methods to answer the research questions. Moreover, in line with the pragmatic view that theory and practice are interconnected (Buch, 2024), the analyses combined both inductive and deductive approaches

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[9] While the systematic review did not focus on TGD individuals, the majority of the studies included in the review involved minoritised and vulnerable groups (e.g., young people, those with poor mental and physical health, and those undergoing significant life changes). Given the overlap between these populations and TGDYP, the mechanisms of change identified in the review were considered relevant and applicable to TGDYP whom are the focus of this thesis.

(using the SIAH framework). This allowed the proposed SP intervention to be informed by established theory while remaining flexible and grounded in real-world experience.

### *4.2.4. Co-Production and Stakeholder Involvement*

This research was co-produced with key stakeholders to ensure its feasibility, relevance, and meaningfulness in practice. From the outset, two UK Gender Identity Clinics (GICs) were involved in co-designing the research and SP initiative. Acting as advisory boards, the clinics contributed feedback during bi-annual meetings timed with existing multidisciplinary team schedules. This approach enabled structured input across a range of professionals (e.g., clinicians, nurses, GPs) without placing additional demands on their time, supporting more diverse and sustainable involvement.

Recognising that TGDYP are often excluded from healthcare planning, even when their wellbeing is the focus, this thesis also adopted a participatory-informed approach to research design. Rather than relying on continuous input from a formal youth advisory board, TGDYP were engaged through in-depth interviews and open-ended surveys; a more accessible and less burdensome method for gathering insights from this often-over-researched group. These data shaped the design and proposed delivery of the SP model, ensuring it reflected TGDYP's needs, preferences, and lived experiences.

To balance professional and youth perspectives, open-ended surveys were also conducted with healthcare providers within Study 2. These insights were synthesised using the Qualitative Triangulation Framework (QTF; see Chapter 5), which highlighted points of divergence between professionals and TGDYP, ensuring youth perspectives remained central. This multi-level approach, supported by the PhD Candidate's embeddedness within TGD communities, enabled the research to be co-developed with, rather than merely for, those it aimed to serve.

## 4.3. Participants and Recruitment

TGDYP and professionals working across Health, Social, and Voluntary care sectors in England, were recruited for the empirical studies in this thesis (Chapters 6 to 8). This thesis defines young people as those aged 18 – 29. This age range was selected for three reasons. First, individuals under 18 were excluded due to ethical concerns surrounding consent, and the political challenges of researching gender-affirming care for minors (Budge et al., 2024). Second, although policy restrictions on child and adolescent gender identity services primarily affect minors, their impact persists into adulthood. Many TGDYP entering adult services today have already experienced prolonged disruptions in care, delayed gender affirmation, and postponed psychosocial development (Horton et al., 2024). By focusing on 18–29-year-olds, this thesis captures the long-term effects of these systemic barriers and explores how SP can address the resulting psychosocial challenges. Third, emerging research suggests that sociopolitical and healthcare conditions have contributed to an extended phase of emerging adulthood, spanning 18–29 rather than the conventional 16–25 age range (Arnett et al., 2014; Eisenberg, 2010; Higley, 2019). Many TGDYP experience a delayed adolescence due to restricted access to gender-affirming care, further extending their psychosocial development (Horton et al., 2024). Including participants up to age 29 thus ensures a more accurate representation of TGDYP navigating these unique challenges. By centring this research on the 18–29 age group, this thesis explores how SP interventions can be tailored to mitigate the long-term psychosocial consequences of systemic barriers and provide meaningful, developmentally appropriate support.

### *4.3.1. Study 2 Participants*

Study 2 (Chapters 6 and 7) recruited both TGDYP (aged 18 – 26[10]) and Health, Social, and Voluntary care professionals working with these groups.

#### 4.3.1.1. TGD Young people

Young people self-identified as TGD and were not required to have a formal diagnosis of Gender Incongruence as per the ICD-11 (World Health Organisation, 2022). This approach enabled the inclusion of a diverse range of TGDYP identities and transition experiences, including individuals who were pre-, during, or post-medical transition, as well as those not seeking medical transition. Capturing this variation was important for exploring when, and for whom, SP might be most beneficial; for example, whether SP is most supportive for those not engaged in medical transition, those on waitlists, or those receiving concurrent medical care. Recruitment was facilitated by sharing the research on social media platforms (Reddit, Facebook, Instagram), and dissemination of research posters (printed and digitally) by local community organisations (e.g., LGBT Foundation) and two GICs within England (referred to as GIC 1 and GIC 2 for privacy purposes). Participants registered their interest by emailing the PhD candidate (CS) who subsequently arranged a suitable time for interview. Participants were also asked to pass on the recruitment material to other TGDYP they felt would be interested in taking part.

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[10] While our intended age range was 18 – 29, this reflects the age of *actual* participants recruited.

#### 4.3.1.2. Health, Social, and Voluntary Care Professionals

Professionals were recruited from across primary (e.g., GPs), tertiary (e.g., GICs) and voluntary or community sectors to reflect the diverse systems of care that TGDYP may interact with. This range was important, as those in statutory healthcare roles may hold more medically oriented perspectives, while those in community or voluntary settings may focus more on social or peer-based support. Including professionals from these varied contexts enabled a more comprehensive understanding of how TGDYP engage with support services across different areas of their lives, for instance, contrasting what they may disclose in clinical settings versus within community-based spaces. All professionals were required to be over 18 years of age. Recruitment was facilitated by the same platforms/avenues as for TGDYP in this study. However, rather than contacting the PhD candidate to arrange a time for interview, recruitment material for professionals included a link to an online survey for them to complete.

### *4.3.2. Study 3 Participants*

Study 3 (Chapter 8) recruited TGDYP (aged 18 – 28[10]) who were receiving care through GIC 2 (location redacted for privacy reasons). Distinct from Study 2, this meant all participants had received a diagnosis of Gender Incongruence per the ICD-11 (World Health Organisation, 2022) and were within a GIC care pathway. This care included, but was not limited to, medically-focused care (e.g., hormones, surgery, tracheal shaves, facial restructuring), counselling, and group-based support (e.g., voice training workshops). Given this specific GIC also facilitated recruitment for Study 2, it is possible that participants from this study also took part in Study 2. However, given the pseudonymised and anonymised nature of studies 2 and 3 respectively, it is not possible to identify these instances. Recruitment was facilitated by GIC 2 through three channels: 1) posters displayed in waiting rooms and on the GIC 2 website; 2) mentions of the study during appointments with Care Navigators; and 3) SMS messages sent to eligible participants. Participant were routinely reminded that their participation was voluntary, and that neither their participation nor the nature of their responses would impact the care they received from the GIC 2.

## 4.5. Procedure and Data Collection

This section outlines the procedures and data collection tools used for each empirical study in this thesis.

### *4.5.1. Chapter 6 and 7: Study 2 – A qualitative exploration of meaningful social connections among TGD youth for informing Social Prescribing*

#### 4.5.1.1. TGD Young People

Participants contacted the first author via email to express their interest in the study and received an information sheet and consent form (see Appendix 2 & 3). To participate, participants were required to return a completed consent form, including key demographic details (e.g., age, gender, sexuality), via email to the PhD Candidate. A date and time for interview was then arranged via email, and confirmed by the PhD Candidate who then sent a MS Teams meeting link.

The PhD Candidate conducted all participant interviews online via MS Teams. Online interviews were chosen to reflect the preferred engagement pattern of TGDYP (McInroy et al., 2019) and to prevent geographical limitations on participation. Participants had the choice of whether they kept their cameras on or not. Prior to commencing the interview, the PhD Candidate reminded the participant of the study aims, their right to withdraw, and what they should do if they feel uncomfortable or do not wish to answer specific questions. Following this, the first author obtained verbal informed consent from participants before starting the recording and proceeding with the interview questions.

Interviews were semi-structured. Thus, while an interview schedule was used (see osf.io/xqp9h), the order of questions and prompts on the interview schedule did not dictate the interview. Instead, interview questions were open-ended and exploratory in nature to allow participants to guide the conversation and highlight aspects most salient to them. The PhD Candidate adapted the sequence and phrasing of questions in response to the flow of the conversation and participant comfort. Probes were included to encourage elaboration and clarify responses where appropriate (e.g., "*I'd love to hear more about [participants experience]*"; "*how did that make you feel*?").

The development of the interview schedules was guided by the research aims of Study 2 to understand *how* TGDYP experience meaningful social connections, how these can be translated into meaningful social groups as part of a SP initiative, and how this would address existing challenges TGDYP are currently experiencing in gender-affirming care. This was informed by previous research that had identified key challenges experienced by TGDYP (e.g., Crowley et al., 2021) and SIAH literature (e.g., Haslam et al., 2024). This enabled the interviews to focus on underpinning psychological mechanisms that lead to health and wellbeing benefits as a result of meaningful group memberships (e.g., sense of meaning in life, social connection, self-efficacy; Haslam et al., 2024), and consider how these psychological mechanisms could help TGDYP navigate key challenges (e.g., discrimination, healthcare access). Interview schedules were refined through conversations with the supervisory team. Overall, the interview schedule allowed the interview to maintain focus while facilitating participant-led discussions of their relevant experiences (Bearman, 2019).

#### 4.5.1.2. Health, Social, and Voluntary Care Professionals

Professionals self-selected into the study after encountering a publicly available survey link hosted on Gorilla Experiment Builder. Upon accessing the link, participants were presented with a participant information sheet (see Appendix 4 & 5), outlining the study's purpose, voluntary nature, confidentiality, and data protection measures. Informed consent was obtained digitally at the start of the survey through a tick-box format, which participants were required to complete before progressing to the open-ended questions. Basic demographic information (e.g., age, job role, sector) was also collected at this stage.

An open-ended survey format was chosen to offer flexibility and reduce time burden, recognising the demanding schedules of professionals. It was originally anticipated that professionals would take part in focus groups. However, due to scheduling constraints, there was no uptake and therefore focus groups were not conducted. Instead, online surveys enabled participants to provide in-depth, reflective responses at a time and pace convenient to them, while still generating rich qualitative data.

Survey questions mirrored those presented to TGDYP (see 4.5.1.1. TGD Young People), with slight adaptations to question phrasing to align with professionals' perspectives. The survey explored professionals' perspectives on meaningful social connection for TGDYP, their experiences supporting these groups, and views on the feasibility of SP within their specific sectors (see osf.io/xqp9h).

Prompts were embedded to encourage elaboration, though participants were free to skip questions or respond briefly. The survey was refined with input from the supervisory team for clarity, relevance, and alignment with the study's aims. Overall, this method provided a low-barrier, context-sensitive way to gather diverse insights from professionals working across health, social, and voluntary sectors with TGD people.

### *4.5.2. Chapter 8: Study 3 – A service evaluation of social support pathways in gender-affirming care.*

Data for Study 3 were originally intended to be collected through semi-structured interviews conducted online via Microsoft Teams. The interview schedule was developed to explore young TGDYP's experiences of social support pathways within GIC 2. Interviews were designed to last approximately one hour and covered themes such as participants' current engagement with NHS gender services, experiences at GIC 2, access to and perceptions of social support, and overall wellbeing outcomes.

However, despite sustained efforts to recruit participants via GIC 2's established communication channels (e.g., SMS invitations, posters, mentions in clinical appointments), no requests for interview were made. This was likely due to engagement fatigue within TGDYP communities, which coincided with a particularly challenging political climate that had increased scrutiny and public discourse around trans rights and healthcare (Horton, 2024). As such, it was deemed ethically and practically appropriate to modify the data collection strategy.

Instead of interviews, data were collected via an open-ended online survey and allowed participants to respond either in written format or by submitting an audio recording of their responses (see https://osf.io/37hzg/files/). This approach diverges from traditional online surveys which typically only allow written responses. Instead, developing the survey on Gorilla Experiment Builder meant written and audio response buttons could be selected for each question, permitting flexibility in engagement. These methods reduced participant burden by enabling individuals to engage at a time and pace convenient to them, while still ensuring depth and richness of data. The survey followed the same structure and question framework as the originally designed interview schedule, covering the same core themes and allowing for comparability with the original evaluation aims.

Before accessing the survey, participants were presented with a digital participant information sheet outlining the aims of the evaluation, their rights (including the right to withdraw), and data handling procedures (see Appendix 6 & 7). Informed consent was obtained at the start of the survey via tick-box confirmation. Participants were also reminded that their participation was entirely voluntary and would not affect the care they received from GIC 2.

This flexible and responsive approach to data collection ensured that the service evaluation could still centre the voices and lived experiences of TGDYP, while remaining sensitive to community needs and broader socio-political pressures.

### 4.6. Data Analysis

This section outlines the analytical approaches used in the empirical studies presented in this thesis, with attention to how these align with the pragmatic epistemology that underpins the research.

### *4.6.1. Chapter 6 and 7: Study 2 – A qualitative exploration of meaningful social connections among TGD youth for informing Social Prescribing*

Data in Study 2 were analysed using Reflexive Thematic Analysis (RTA; Braun & Clarke, 2022a). RTA was selected for its conceptual flexibility and its capacity to generate rich, latent themes that go beyond surface-level description (Braun & Clarke, 2021). Consistent with a pragmatic epistemology, RTA enabled a focus on the meanings participants attributed to their experiences, while allowing theoretical concepts to inform interpretation where relevant.

Given the distinct stakeholder groups in this study, namely TGDYP and professionals working with this population, triangulated analysis was employed to explore both convergence and divergence across perspectives. This was particularly important in light of research suggesting that professionals and TGDYP may hold different understandings of what constitutes health-enhancing practice (e.g., Jackson et al., 2023; Scheim et al., 2024). Triangulation was therefore not only a matter of methodological robustness, but a necessary strategy to uncover the tensions, misalignments, and agreements between groups.

To support this aim, a novel analytic tool, the Qualitative Triangulation Framework (QTF), was developed specifically for this research. The QTF builds on established triangulation theory (e.g., Campbell et al., 2018; Farmer et al., 2006) and offers a structured yet flexible process for identifying and interpreting patterns within and across participant groups. Its purpose is not simply to document similarity or difference, but to generate nuanced, latent themes that reflect the complexity of stakeholder experience. The framework supports reflexive interrogation of silences, contradictions, and tensions, supporting deeper engagement with the data. A full account of the development, rationale, and application of the QTF is provided in Chapter 5.

### *4.6.2. Chapter 8: Study 3 – A service evaluation of social support pathways in gender-affirming care.*

Data in Study 3 was analysed using Framework Analysis as described by Gale and colleagues (2013). Framework Analysis is particularly well-suited to qualitative health research, especially in applied settings such as service evaluations (Gale et al., 2013). Unlike some other qualitative methods, it is not bound to a specific epistemological stance, making it flexible and compatible with a range of data types and research designs (Goldsmith, 2021).

The PhD Candidate developed a coding framework through a process of data familiarisation and initial inductive coding. This preliminary framework was then refined in consultation with staff at GIC 2 via email, ensuring that it reflected both participant perspectives and organisational relevance. This refinement included adding an additional coding category, ‘Improving Psycho-Social Support’ to capture key priorities for GIC 2 to focus on during service developments.

While distinct from the QTF used in Study 2, Framework Analysis similarly allowed the research to capture the complexity of health systems and the lived experiences of service users, including the expression of contrasting viewpoints. However, its structured and goal-oriented nature made it particularly well-suited for this service evaluation. Compared to more exploratory approaches like thematic or content analysis, Framework Analysis is explicitly designed for applied research with clear objectives. This makes it especially valuable in contexts where findings must be transparent and actionable (Goldsmith, 2021).

It is also worth noting that the data in Study 3, while valuable, was less rich and detailed than the predominantly interview-based data in Study 2. This difference in data quality further reinforced the appropriateness of Framework Analysis over Reflexive Thematic Analysis, as its structured, pragmatic approach is particularly suited to datasets that prioritise breadth and applicability over depth. This decision was also consistent with the pragmatic epistemological stance of the research which accommodates movement between interpretivist approaches (as in Study 2) and more descriptive, applied approaches as adopted here, depending on what best serves the research aims.

Importantly, the systematic and auditable nature of Framework Analysis provided a clear trail from data to interpretation, which is crucial for demonstrating to key stakeholders how conclusions were reached. This level of transparency enhances the credibility and utility of the findings in informing future service development (Gale et al., 2013; Goldsmith, 2021).

### 4.7. Ethical Considerations

A favourable ethical opinion was sought and granted by Nottingham Trent University’s Research Ethics Committee for all empirical studies in this thesis. For Study 3, NHS Health Research Authority guidelines were reviewed due to the study's focus on a specific clinical service. However, this research fell within the remit of a service evaluation, as defined by the NHS Research Ethics Committee (see Appendix 8), and thus NHS ethical approval was not required. Nonetheless, a collaboration agreement was established between the research team and GIC 2 to ensure ethical integrity and clearly outline responsibilities.

Following a favourable ethical opinion, and prior to participation, all participants were provided with an information sheet and gave informed consent. Written informed consent was obtained for all studies. For interview-based research, verbal consent was also confirmed at the start of each interview. In survey-based studies, participants were required to check a consent box before proceeding. Contact details for the PhD Candidate and Director of Studies (BAJ) were provided on all participant materials (information sheets, consent forms, debrief forms) to support transparency and enable follow-up if participants had questions or concerns. After participation, all participants were debriefed (see Appendix 9 through 11) and signposted to appropriate support services (e.g., Mermaids, Samaritans).

Participation in all empirical studies was entirely voluntary and did not impact participants' access to gender-affirming care. This, along with the right to withdraw without explanation, was communicated clearly at multiple stages. Participants had a 2-week window post-participation to request withdrawal of their data; no such requests were received.

In Study 2, data were *pseudonymised* by replacing identifiable information (e.g., names, job titles, locations) with placeholders. The data could not be fully anonymised for two key reasons: (1) the PhD candidate met participants during interviews, enabling potential recognition; and (2) professional participants provided detailed job descriptions that could allow reidentification, even after redaction. This aligns with Irti's (2022) distinction between anonymised and pseudonymised data. Raw data were stored securely in a password-protected OneDrive folder at Nottingham Trent University. Once pseudonymised, data were imported into NVivo for analysis. Pseudonymised data were not made publicly available. Instead, as outlined in the participant information sheet, all participants explicitly consented to sharing for: (1) individual scrutiny, or (2) future research purposes aligned with the study's aims (i.e., work that affirms and supports TGD communities). Data access can be requested through contacting the PhD candidate via email. Access is granted on a case-by-case basis.

In Study 3, data were fully *anonymised*. Unlike Study 2, the PhD candidate did not meet participants, and once identifiable information was removed, individuals could no longer be linked to their responses. While email addresses were collected for incentive distribution[11], these were stored separately and never linked to survey data. All identifiers were deleted following voucher distribution. Initially, data were hosted securely on Gorilla Experiment Builder before being downloaded and transferred to a password-protected OneDrive folder. After anonymisation, data were analysed using NVivo. In line with open science principles, anonymised data were shared under safeguarded access via the UK Data Service for the 25 out

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[11] Specific details regarding participant remuneration can be found in the methods sections of each empirical chapter.

of 30 participants who provided optional consent (available at https://dx.doi.org/10.5255/UKDA-SN-857823).

## 4.8. Reflexivity

Given the qualitative, participatory, and identity-relevant nature of this thesis, reflexivity was not treated as a discrete stage, but as an ongoing, iterative process. While each empirical chapter includes its own reflexive engagement with study-specific decisions, this section focuses on my broader positionality and how it shaped the design, development, and direction of the research as a whole.

As a gay trans man with prior involvement in community-based TGD health advocacy, I approached this research with both personal investment and a commitment to producing work that was accountable to the communities it aimed to serve. Acknowledging that a perfect world does not exist, particularly in relation to TGD healthcare, a pragmatic worldview has helped me navigate both personal challenges and broader systemic gaps in this sphere. Pragmatism also guided my research decisions, allowing me to draw on existing evidence and real-world needs to explore how we might meaningfully support TGDYP within the current social and political climate.

At the same time, I recognise that my position afforded certain forms of privilege, particularly in terms of institutional access and proximity to healthcare professionals. My academic affiliation and advocacy background enabled a level of engagement with systems and stakeholders that many in the TGD community are not granted. This access deepened my understanding of service structures, policy tensions, and institutional constraints, which informed both the development of research questions and the interpretation of findings. However, I was mindful that this privileged standpoint also brought with it responsibilities; to remain accountable to participants whose experiences with these systems were shaped by exclusion, and to avoid allowing institutional logistics to overshadow community perspectives. Balancing insider knowledge with a commitment to critical inquiry required an ongoing attentiveness to how power operated within both the research and the systems it examined.

Given the increasing barriers associated with medically focused care (Hajek et al., 2023), SP emerged as a valuable opportunity to leverage the kinds of community support I have seen make a meaningful difference in the lives of TGDYP. Against the backdrop of pervasive loneliness experienced by this population, SP offered a way to explore alternative, relational modes of care that respond to lived experiences rather than pathologising them.

However, this work also unfolded within a wider landscape of increasing misinformation and political hostility toward TGD communities (Meade et al., 2023; Szilagyi, 2023). Advancements in TGD healthcare have been publicly questioned and, in some cases, restricted, often without adequate scientific basis (Szilagyi, 2023). In this climate, I was conscious of how my own positionality might affect perceptions of the research's credibility. I am aware that for some, my personal investment may lead to assumptions that the work is driven by self-interest rather than scientific integrity. While the personal relevance of this topic is undeniable, it does not override my commitment to rigour, critical inquiry, and accountability to both participants and the broader academic community.

In response, I adopted an open research approach that prioritised transparency in both process and interpretation. While data itself was not made publicly available in full (to protect participant safety), I made efforts to clearly communicate my analytic decisions and methodological choices. For example, the development and application of the Qualitative Triangulation Framework (QTF; Chapter 5) offered a systematic yet reflexive tool to guide analysis in Study 2, allowing for the integration of multiple stakeholder perspectives while remaining grounded in the data. Similarly, Framework Analysis was selected over more opaque methods such as Content Analysis for Study 3, as it provides a clear, auditable trail from raw data to thematic interpretation.

These methodological choices were not only strategic, but also ethical. They allowed me to manage the influence of personal experience on analysis without erasing it, and to produce findings that are both credible and deeply attuned to participant voice. In doing so, I aimed to demonstrate that personal proximity to a topic can be a strength when paired with transparent, reflexive, and methodologically rigorous research practices.

## 4.9. Chapter Summary

In sum, this chapter has outlined the pragmatic, participatory, and pluralistic methodological foundations of this thesis. These approaches were selected to ensure the research remained flexible, responsive, and grounded in the lived experiences of TGDYP. The following chapter builds on this methodological groundwork by presenting the development of a novel analytic tool, the Qualitative Triangulation Framework (QTF), which enabled nuanced, multi-stakeholder analysis of the empirical data. This tool was instrumental in operationalising the thesis's commitment to stakeholder co-production and methodological rigour.

# Chapter 5

## The Development and Application of the Qualitative Triangulation Framework (QTF) for Exploring Tension Within and Across Qualitative Data Sets: Case Studies of Trans and Gender Diverse Youth’s Healthcare Experiences

This chapter has been published in the *International Journal of Qualitative Methods* as: **Staras, C.,** Wakefield, J., McDermott, D., & Jones, B. (2025). The Development and Application of the Qualitative Triangulation Framework (QTF) for Exploring Tension Within and Across Qualitative Data Sets: Case Studies of Trans and Gender Diverse Youth’s Healthcare Experiences. *International Journal of Qualitative Methods, 24*. https://doi.org/10.1177/16094069251371463

This chapter is largely the same as the publication. Small changes to style and formatting have been made to ensure the chapter is consistent with the rest of this thesis.

**Statement of Authorship:**

*Methodological Conceptualisation:* CS.

*Data collection:* CS.

*Data synthesis and interpretation:* CS, BJ, JW, DM.

*Drafting of article:* CS.

*Article editing and revisions:* CS, BJ, JW.

## 5.1. Abstract

**Background:** Global health and social research have advocated for community-engaged research methods to better address minoritised group needs. However, conventional research practices, often influenced by positivist traditions, tend to prioritise convergence, overlooking critical tensions within and across data sets. Resultantly, changes within healthcare and policy have not been matched with parallel benefits for minoritised groups. These disparities underscore the need for research methods that adequately give voice to multiple stakeholder groups and understand these discrepancies.

**Methods:** In response, the present study introduces the novel development of the Qualitative Triangulation Framework (QTF). Extending previous triangulation methodologies, the QTF provides a framework for exploring both agreement and disagreement within and across qualitative data sets from multiple stakeholder groups.

**Results:** Developed in the context of research with trans and gender diverse youth, the QTF was valuable for revealing both inter- and intra-group differences in what they deemed health-enhancing. Thus, the QTF enhances the actionability of qualitative findings, allowing for the development of more effective policy recommendations that can better address these overlooked tensions.

**Conclusion:** Beyond applications to TGD healthcare, the QTF provides a replicable model for amplifying minoritised voices in research with other underserved populations, advancing equity in healthcare research and practice. Extension of the QTF for systematically exploring competing perspectives beyond minoritised groups are also discussed. Overall, the QTF represents a significant advancement in qualitative methodologies, offering a powerful tool for researchers seeking to navigate complexity, reconcile conflicting viewpoints, and drive meaningful change.

**Key Words:** Triangulation; Qualitative Research; Trans and Gender Diverse; Marginalized Groups; Healthcare.

## 5.2. Introduction

Qualitative research has long been a critical tool for amplifying the voices of individuals and communities whose experiences are often overlooked in mainstream discourse (Lim, 2024). These minoritised groups include, but are not limited to, ethnic minorities, LGBTQ+ individuals, people with disabilities and socioeconomically marginalised populations (Cheraghi-Sohi et al., 2020). These minoritised groups have historically been underrepresented in research or included in ways that fail to adequately reflect their lived realities (Crenshaw, 1991; Collins, 2000; Hassler et al., 2024). While research has begun to increase the representation of minoritised experiences (e.g., Lovell et al., 2023; Zacharias & Aitken, 2025), positivist epistemologies that dominate research practices have limited the utility of these research findings for creating actionable and meaningful change (Campbell et al., 2018). This is because positivism strives for objectivity, reliability and generalisability which can oversimplify complex human experiences (Omodan, 2025).

Despite qualitative approaches advocating for an interpretivist stance (i.e., a focus on context, subjectivity, and multiple perspectives for understanding human behaviour), positivism creep (the subtle infiltration of positivist principles in research practices; Braun & Clarke, 2022a) can narrow the scope of knowledge production. For example, positivism can encourage the quantification of qualitative research, whereby increased pressure to translate rich qualitative findings into measurable variables often reduces complexity and meaning (Braun & Clarke, 2022a; Lee, 2025; Omodan, 2025). An emphasis on generalisability can also lead to a tendency to favour broad, widely applicable conclusions over context-specific insights (Braun & Clarke, 2022a; Lee, 2025). Collectively, this can lead to a devaluation of critical and interpretative approaches, favouring dominant perspectives (i.e., ideas generally expressed by the group studied) while sidelining more situated and experiential knowledge (i.e., differential experiences within the group studied; Campbell et al., 2018; Ohmer et al., 2023).

This emphasis on dominant perspectives within qualitive enquiry has increased the marginalisation of minoritised voices, either through tokenistic inclusion, selective interpretation of data, or methodological approaches that do not fully account for power imbalances between researchers and participants (Lim, 2024). In response, scholars have increasingly advocated for community-engaged, participatory, and decolonial approaches that centre knowledge and agency of minoritised communities (Ohmer et al., 2023). These approaches seek to challenge traditional hierarchies of knowledge production and ensure that research is conducted with, rather than about, these communities.

### *5.2.1. Minoritised Voices in Healthcare Research*

One area of research that particularly overlooks the needs of minoritised communities is healthcare. Within healthcare research, the need to prioritise minoritised voices is especially urgent given persistent health disparities and systemic barriers to care (Kerr et al., 2024; Macias-Konstantopoulos et al., 2023; Vela et al., 2022). However, healthcare research remains heavily influenced by positivist traditions, which privilege quantitative metrics and outcome-based evaluations over the lived experiences of patients (Park et al., 2020; Smith & Hasan, 2019). This positivist emphasis risks reducing minoritised experiences to statistical categories that may fail to capture interpersonal dimensions of healthcare inequities (Ohmer et al., 2023).

In an effort to address these disparities, global health research is increasingly drawing on community-engaged methods (i.e., methods that draw on the knowledge of the target population) to improve the development of healthcare pathways that better meet client needs (Hickey et al., 2022). Advocated by the National Institute for Health Research (NIHR), the requirement for community engagement within the research they fund reflects the commitment of funding bodies towards an evidence base in line with the call named “Leave No One Behind”, championed by Sustainable Development Goals (NIHR, 2019). The aim of this UK initiative is to improve the health and wellbeing of minoritised populations (NIHR, 2019), defined as individuals who are socially separated or seen as subordinate in comparison to other members of society (Wingrove-Haugland & McLeod, 2022).

Despite the widespread importance of community-engaged research methods, attested to by the development of multiple guidelines and standards (e.g., Bedson et al., 2020; World Health Organisation, 2017; also see Hickey et al., 2022), understanding what constitutes effective community-engaged research is lacking (Hickey et al., 2022; Kantamneni et al., 2019). Moreover, heedless of the intended meaning of community-engaged research methods for addressing health disparities between minoritised and non-minoritised populations (NIHR, 2019), we often see inclusion without voice (Pratt, 2019). In essence, minoritised individuals are present within research discussions, but their opinions and perspectives are not afforded equal weighting in comparison to non-minoritised individuals (Da’as & Slobodin, 2024; Onwumere et al., 2023). This can result in the development of healthcare services which, whilst anticipated to address the needs of minoritised communities, fall short of addressing health disparities between minoritised and non-minoritised groups (Han et al., 2021; Horton, 2024).

Evidencing this matter, research with ethnic-minority communities frequently notes misunderstandings and tensions between service users and professionals (Gaya-Sancho et al., 2021). Similarly with LGBTQ+ communities, training programmes on LGBTQ+ health are suggested to improve the knowledge, attitudes, and skills of health professionals (Damery et al., 2025), yet LGBTQ+ individuals consistently report health inequities and type-cast treatment plans that do not consider intra-group differences (Hascher et al., 2024; Kelsall-Knight, 2021; Subirana-Malaret et al., 2023). These are just two examples. Nonetheless, it indicates how professionals may misunderstand the needs of minoritised groups, where healthcare policy changes are not matched by parallel benefits for health outcomes. These disparities underscore the need for research methods that can integrate, and adequately give voice to, multiple stakeholder groups. This would mark a step towards reducing the marginalisation of minoritised groups within healthcare research and practice.

### *5.2.2. Reducing Marginalisation Through Triangulation Research Designs*

Triangulation offers a promising pathway to integrate multiple perspectives and navigate divergent understandings between stakeholders in research. Triangulation within research refers to the process through which multiple methods and perspectives are used to study a topic (Heale & Forbes, 2016). Typically, triangulation has been used for validating findings, whereby converging results from different data collection methods or samples enhance the rigour of a research study (e.g., using qualitative data to better substantiate the processes that underly observed quantitative outcomes; Heale & Forbes, 2016): a positivist approach. However, *divergent* perspectives between data sets can offer more insight into novel ways to understand a topic (Campbell et al., 2018; Heale & Forbes, 2016). Nonetheless, divergent perspectives are rarely reported within triangulation research (due to positivism creep), and, when they are, they are often presented without further interrogation of their underlying meaning (Howe, 2012; Morgan, 2018; Morse, 2015). This is problematic because disparate findings can be indicative of underlying tensions and differential expectations between two or more groups (Campbell et al., 2018; Farmer et al., 2006; Green, 2007; Sands & Roer-Stier, 2006). For example, when findings do not converge, particularly where they have implications for policy, it can lead us to question which findings are credible and actionable (Campbell et al., 2018). In this way, triangulation is not just a method of data integrity, but it also presents an opportunity to evaluate what data collection methods and population samples offer the most usable data for implementing beneficial policy changes: an interpretivist approach.

Distinctly, within social sciences and health research, the variable nature of social phenomena means that there are actually more ways for data not to converge than to converge (Campbell et al., 2018; Flick, 1992; Mathison, 1988). Consequently, the positivist notion that triangulation is a method through which research findings can be verified or falsified limits the utility of triangulation for better understanding social phenomena. Instead, then, there is an increased call for research adopting triangulation methods to move beyond documentation of convergence, and instead begin to challenge the notion of clean-cut research findings (Campbell et al., 2018). By explicitly analysing both convergences and divergences through an interpretivist lens, triangulation allows researchers to understand why stakeholders interpret the same issues differently (e.g., why changes in LGBTQ+ healthcare policy do not improve healthcare experiences for LGBTQ+ individuals) and how these interpretations influence healthcare practices.

### *5.2.3. Limitations of Existing Triangulation Methods*

Although existing triangulation methods have permitted researchers to integrate multiple methods and perspectives, as mentioned, these are largely focused on convergence rather than divergence (Campbell et al., 2018). This can be limiting as it does not allow researchers to appreciate the complexity of experiences within the group they are studying (Campbell et al., 2018). Further, while some triangulation methods have begun to explore the role of divergence, these too have their shortcomings.

For example, Campbell and colleagues (2018) developed a triangulation system that built on the work of prior triangulation theorists (e.g., Denzin, 1978; Farmer et al., 2006; Sands & Roer-Stier, 2006). Their aim was to coalesce multiple strategies from previous research for interrogating divergent data points across multiple methodologies and stakeholder groups. However, given the copious amounts of data in Campbell and colleagues' (2018) study, themes from qualitative data were used as key arguments/data points to be triangulated with other forms of data (e.g., quantitative and archival records). Although practical, it meant that their triangulation system was applied after data analysis. This overlooks divergent data points that may have been present within qualitative data, for instance, intragroup differences that may have been filtered out through the convergent nature of qualitative theme generation (Braun & Clarke, 2022a; Mathison, 1988).

In a similar vein, Reicher and Sani (1998) introduced Structural Analysis of Group Arguments (SAGA). SAGA aims to identify the different arguments that ingroup members construct to justify the in-group stereotype (i.e., what ingroup members should be doing, thinking, and feeling: Haslam et al., 2008a). In short, it considers whether ingroup members have divergent perspectives on what thoughts and behaviours constitute their social identity. However, although SAGA identifies key divergent arguments between group members, it does not propose strategies for interrogating potential reasons why we might observe this divergence. This is a significant drawback, particularly in comparison to Campbell and colleagues' (2018) triangulation methods, because it limits researchers' ability to understand *why* group members disagree, and therefore how this dispute can be resolved (Campbell et al., 2020; Farmer et al., 2006; Green, 2007; Sands & Roer-Stier, 2006). Furthermore, dissimilar to prior triangulation theorists (e.g., Denzin, 1978; Campbell et al., 2018; Farmer et al., 2006; Sands & Roer-Stier, 2006), SAGA does not consider the salience of an argument (i.e., is it common within one group, across both groups, or neither?), just that an argument exists. This is limiting because they may analyse/present arguments that do not represent the group at large. Instead, they may only demonstrate individual meanings. Resultantly, SAGA is unable to determine whether arguments are common across groups or within groups and, therefore, how divergent understandings can be best resolved (e.g., is there disagreement among minoritised group members, or between minoritised groups and professionals working with them?).

Overall, these challenges reflect the requirement for a qualitative data triangulation method that explores divergence and convergence on a level closer to the original data (i.e., during the data analysis stage of qualitative research rather than post analysis), whilst simultaneously considering the salience of key arguments within and across stakeholder groups. Such a method would enable researchers to focus on meaningful divergences both within and across stakeholder groups to understand how they can impact healthcare outcomes. This paper presents the Qualitative Triangulation Framework (QTF) to address these aforementioned limitations.

## 5.3. Development and Application of the Qualitative Triangulation Framework (QTF): Healthcare experiences of Trans and Gender Diverse Youth

To illustrate how the QTF was developed, as well as its potential for uplifting minoritised voices within healthcare research and practice, the context in which the QTF originated is presented.

### *5.3.1. Context*

The QTF was developed to assist and enrich the first author's (PhD Candidate) analysis of data generated from a research study (see Chapters 6 & 7 for empirical findings). The study aimed to explore the healthcare and social engagement experiences of trans and gender diverse young people (TGDYP), with a specific focus on how social interventions, such as SP, could improve their health outcomes. Such interventions could complement existing Gender Identity Clinic (GIC) services by addressing non-medical aspects of care. This may be particularly valuable for individuals who do not wish to medically transition or are navigating extended GIC waitlists (Hughto, 2017; Radix, 2016; Cipolletta et al., 2017). These interventions also provide vital support for individuals whose health precludes them from accessing medical care (i.e., because they are deemed 'unfit' for medical intervention; see Chapters 6 & 7). The development and utilisation of the QTF was felt to be important given the marginalisation of TGDYP across multiple aspects of their life, including their healthcare experiences, which are often misunderstood by professionals (Horton, 2024). Explanation of this marginalisation is provided in further detail below to provide key contextual information for understanding the utility and application of the QTF.

### *5.3.2. Marginalisation of TGD Youth*

While TGDYP face pervasive marginalisation across many aspects of their lives, healthcare settings exacerbate this marginalisation, where barriers such as infantilisation, doubts about their mental capacity to consent, and mandatory parental approvals impede their access to gender-affirming care (Carlile, 2019, Horton, 2024). This lack of access not only hinders timely care but also restricts social engagement and authentic gender expression, leading to broader exclusion from societal participation (Chapter 6 & 7).

These challenges are mirrored in healthcare research and practices, where systemic changes often fail to adequately incorporate TGD perspectives (Horton, 2024). For example, recent shifts in the UK such as decentralizing care from youth Gender Identity Clinics (GICs) to regional multidisciplinary teams (NHS, 2023a, 2023b) have inadvertently created disjointed care pathways (see Chapter 7). Poor coordination between services has resulted in disruptions to continuity of care, heightened uncertainty, and elevated anxiety for TGDYP (see Chapter 7; Horton, 2024). Resultantly, young TGDYP's healthcare needs are largely unmet (Horton, 2024), indicated by healthcare policy 'improvements' not being reflected in TGDYP's health outcomes (Jackson et al., 2023; Scheim et al., 2024). This highlights how the perspectives and needs of TGDYP are often overlooked during the planning and implementation of such policies (Horton, 2024; Jackson et al., 2023; Scheim et al., 2024).

Crucially, this disconnect extends beyond practical healthcare delivery to fundamental differences in how TGDYP and healthcare professionals understand and articulate key issues in the UK. Professionals often frame challenges in terms of logistical barriers such as waitlists and resource shortages, while TGDYP emphasize the psychological toll of navigating these systems (see Chapter 7). This misalignment can result in well-meaning but ineffective interventions, as healthcare policies frequently address surface-level symptoms rather than the deeper systemic and emotional challenges faced by TGDYP (Horton, 2024). Addressing this gap is critical for ensuring healthcare reforms genuinely enhance outcomes for this vulnerable population.

### *5.3.3. Logic Behind the QTF*

Given these differences in perspectives between TGDYP and the professionals working with them, we anticipated that the QTF would provide a framework for understanding where these two stakeholders agree (converge) and disagree (diverge). For example, in the context of TGD healthcare issues, divergent data might reveal why professionals perceive waitlist reductions as a solution, while TGDYP highlight ongoing struggles with bureaucratic processes that extend far beyond initial healthcare access. These insights can help identify critical gaps and tensions, such as unmet psychological needs or unacknowledged systemic biases that hinder the effectiveness of current policies.

For TGDYP, this approach is essential to ensure their voices are neither ignored nor over-simplified in research aimed at improving their wellbeing. Indeed, an over-emphasis on producing efficient and actionable research (due to positivism creep) can mean that even the most well-intentioned researchers who aim to capture complex lived experiences may over-simplify their findings (Keenan, 2022). Resultantly, the QTF granted value in both convergence *and* divergence that allowed the research to challenge the notion of clean-cut research findings (Campbell et al., 2018). Instead, the nuanced understanding that the QTF proffered was critical for comprehending how to develop truly inclusive and effective healthcare practices. The following research questions were of interest:

1) Can the QTF shed light on how and why the perspectives of TGDYP and professionals working with them converge and diverge?

2) How can the QTF improve the co-creation of knowledge between TGDYP and professionals to produce better health outcomes?

## 5.4. Methods

### *5.4.1. Participants, Design, and Data Collection*

Data were gathered from two stakeholder groups residing in England: (1) Twenty TGDYP (aged 18-26) and (2) Eight healthcare, social, and voluntary sector professionals who work with TGDYP. Semi-structured interviews and open-ended survey responses were employed respectively to collect qualitative data from both groups, allowing for a rich exploration of their perspectives. Interviews and open-ended surveys covered the same topics to ensure consistency (see osf.io/xqp9h for the interview schedule and survey questions). These topics included social engagement patterns of TGDYP (e.g., "*what social and community groups are you involved with?*"), the benefits of social support (including how it could facilitate better navigation of healthcare challenges; e.g., "*how have these social groups been helpful during your transition?*"), and barriers to accessing this support (e.g., "*what barriers have you experienced when trying to engage with social and community groups?*"). These schedules were developed though an iterative process, informed by reviewing relevant literature (i.e., social identity processes and social engagement patterns of TGDYP) and the research questions.

The inclusion of these two groups ensured a balanced understanding of healthcare and social engagement experiences, incorporating insights from both service users and providers. A qualitative approach was chosen to obtain richer data than that which could be achieved with quantitative data. This richness was needed not only to give adequate voice to both samples, but to allow for a detailed exploration of sources of tension between the two samples; to understand the *why* of the convergence and divergence observed.

### *5.4.2. QTF Development*

An adapted version of Campbell and colleagues' (2018) triangulation process was developed. Their approach combines interview, observation, and archival data from multiple stakeholder groups to understand divergence and convergence within the data, and includes guidance on how to determine data credibility, and its usability for the development of policy. We felt that adopting a similar process, whilst addressing the aforementioned limitations of existing triangulation frameworks, would be appropriate for the present study.

Campbell and colleagues' (2018) triangulation process was deemed to be more suitable for adaptation in the current context than other triangulation methods (e.g., SAGA; Reicher & Sani, 1998) given: 1) its focus on triangulating data for improving policy development, which is similar to our intention to improve healthcare pathways, and 2) its ability to interrogate underlying reasons behind divergent data. Nonetheless, we identified a limitation with Campbell et al.'s (2018) method, which, as previously mentioned, involved them triangulating the data after analysis. To address this, we introduced triangulation earlier within the data analysis process. This meant comparing key arguments between data sets (i.e., stakeholder groups) prior to developing themes. Themes were thus developed after triangulation so that they reflected both divergence and convergence, enabling us to capture the richness of our data. Building on the limitations of SAGA, we also considered the salience of each argument (i.e., is it common within one group, across both groups, or neither?), and what can be inferred from this (see Sands & Roer-Stier, 2006 for a similar approach).

### *5.4.3. QTF Process*

Prior to triangulation, data from both groups were analysed using Reflexive Thematic Analysis (Braun & Clarke, 2022a) to generate codes, but not formal themes. To move from coding to nascent themes, triangulation was used to develop themes that were reflective of the whole data corpus. To accomplish this, codes were organised into *Main Codes* (e.g., Barriers to Social Engagement) and *Sub-Codes* (defining codes that fell under/helped to explain a Main Code; e.g., Anxiety, Lack of Community Spaces; see Table 5.1).

The triangulation process involved the authors classifying each Main Code and Sub-Code into one of four categories: A) *consistent within and present across groups* (i.e., most TGDYP and most professionals discuss this Main Code/Sub-Code); B) *consistent within and not present across groups* (i.e., most TGDYP discuss this Main Code/Sub-Code, but it is not discussed by professionals, or vice versa); C) *inconsistent within and present across groups* (i.e., some TGDYP and some professionals discuss this Main Code/Sub-Code, but this is not discussed consistently within either group); and D) *rarely mentioned in either group* (i.e., only one/a few individuals from one of the groups discuss this Main Code/Sub-Code).

This classification system facilitated a systematic exploration of convergence (through category A codes) and divergence (through category B and C codes). Divergence was examined using interpretative strategies to explore reasons for the disagreement and to identify actionable insights (see Campbell et al., 2018; Farmer et al., 2006; Sands & Roer-Stier, 2006). For example, are there different perspectives across stakeholder groups?; Does each sample have different knowledge about the same topic?; Is one group unwilling to talk about something, but the other group is (e.g., is something alluded to, but participants express apprehension around the topic)? This allowed us to develop themes that captured nuanced understandings (See Figure 5.1 for a schematic overview of the QTF process and how it extends core stages of Reflexive Thematic Analysis).

**Table 5.1.**

*An example excerpt of the triangulation table adapted from Campbell and colleagues (2018) used to triangulate the two data sets.*

| Main Code | Sub-code | Within Group | Across Groups | Triangulation Category |
|---|---|---|---|---|
| **Young People** | | | | |
| **Barriers to Social Engagement** | Anxiety | X | | B |
| | Childcare | | | D |
| | Chronic/social fatigue/physical health | X | X | A |
| | Cis-het spaces cognitively and emotionally exhausting | | | D |

*Notes*. Main Codes and Sub-Codes can be found in columns one and two respectively. The coding categories for triangulation were as follows:

A) *Consistent within and present across groups* (i.e., most young people and most professionals discuss this Main Code/Sub-Code).

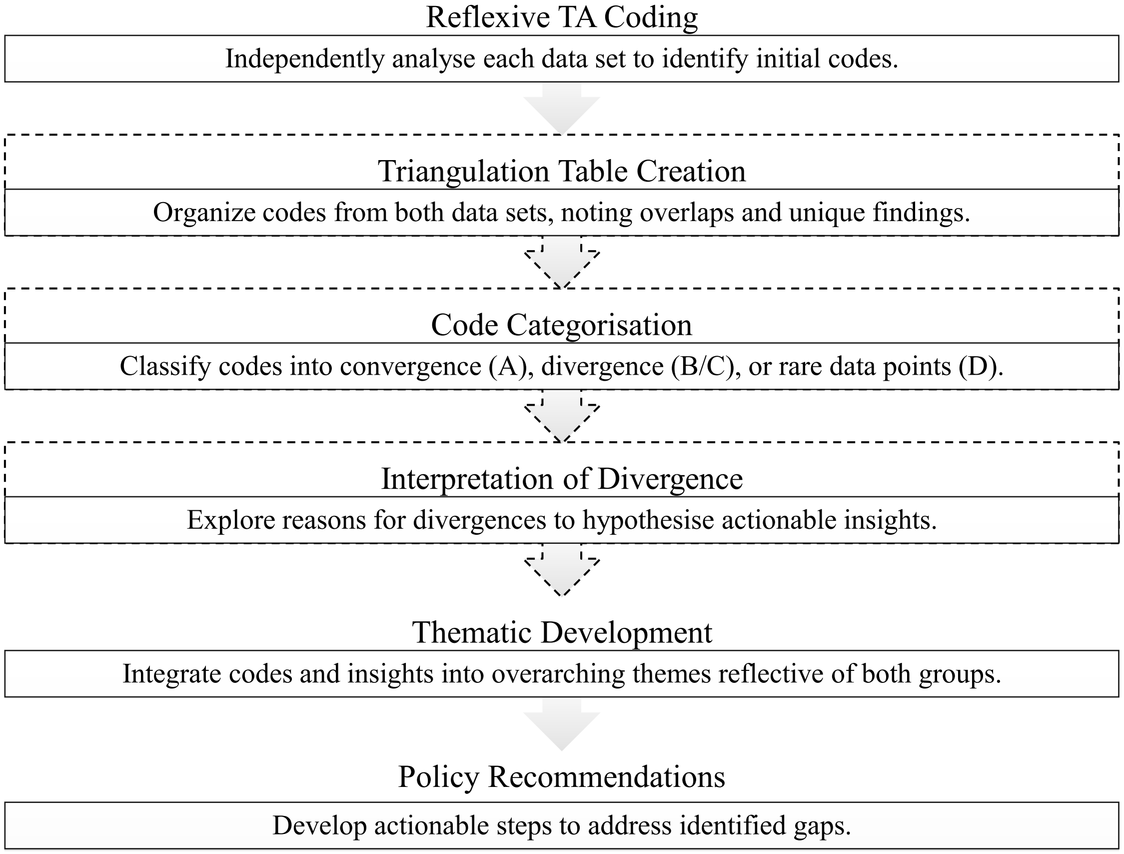
B) *Consistent within and not present across groups* (i.e., most young people discuss this Main Code/Sub-Code, but it is not discussed by professionals, or vice versa).

C) *Inconsistent within and present across groups* (i.e., some young people and some professionals discuss this Main Code/Sub-Code, but this is not discussed consistently within either group).

D) *Rarely mentioned in either group* (i.e., only one/a few individuals from either group discuss this Main Code/Sub-Code).

It is important to clarify that while this grouping method might seem quantitative (or "small q"; see Braun & Clarke, 2022a), its purpose is not to count code occurrences to identify themes, as in content analysis. Instead, it serves as a tool to explore similarities and differences both between groups (e.g., TGDYP and professionals) and within groups (e.g., among TGDYP themselves). The goal is to develop deeper, latent themes rather than surface-level, descriptive ones, thereby aligning with the principles of Reflexive Thematic Analysis (RTA; Braun & Clarke, 2022a). Thus, the QTF is suited to qualitative methods that aim to generate nuanced themes (e.g., RTA, IPA) rather than simply patterns and trends within the data (e.g., content analysis).

**Figure 5.1.**
*Triangulation process flow diagram illustrating Reflexive Thematic Analysis (RTA) steps and QTF-Specific Extensions.*



Reflexive TA Coding

Independently analyse each data set to identify initial codes.

Triangulation Table Creation

Organize codes from both data sets, noting overlaps and unique findings.

Code Categorisation

Classify codes into convergence (A), divergence (B/C), or rare data points (D).

Interpretation of Divergence

Explore reasons for divergences to hypothesise actionable insights.

Thematic Development

Integrate codes and insights into overarching themes reflective of both groups.

Policy Recommendations

Develop actionable steps to address identified gaps.

Note. Steps presented in dashed boxes are unique to the QTF. All other steps are shared. RTA steps are presented sequentially for visual clarity, but are inherently iterative and reflexive in practice. The QTF adopts the same iterative analytic approach; therefore, the simplified presentation does not reflect a substantive methodological difference between frameworks.

## 5.5. Results

To illustrate the utility of the QTF, a series of case studies examining each of the triangulation categories will be presented to demonstrate how the questioning of divergent/convergent data points extended understandings of TGDYP’s health and social engagement experiences.

### *5.5.1. Incomplete Understandings: A Case Study of Triangulation Categories A & B*

In fields where research has practice and policy implications, the consequences of implementation errors (e.g., policy-makers neglecting an aspect of healthcare that is perceived as crucial by service-users, and/or vice versa) are heightened. This is because it can lead to changes within service delivery that do not lead to improvements in outcome measures of interest (e.g., Jackson et al., 2023; Scheim et al., 2024; White et al., 2023). However, the reasons for disagreement or misunderstanding between TGDYP and the professionals involved in implementing healthcare changes have not been identified. Whilst intergroup tensions have been noted (e.g., Bartholomaeus et al., 2020; Vance et al., 2015), the specific point at which understandings diverge is unclear. For example, is it that TGDYP and professionals have different understandings of the health and social needs of TGDYP, or is it that they have similar understandings but their interpretations of how best to address these needs differ? Examination of triangulation categories A and B begins to provide an answer.

Convergent data points (A) revealed that both TGDYP and healthcare professionals consistently identified bureaucratic challenges as a significant factor impeding access to care and overall wellbeing. These barriers included excessively complicated administrative, governmental, and legal procedures that limited timely access to care. However, divergences (B) were identified in terms of how these different stakeholder groups perceived and experienced these barriers. Professionals largely focused on systemic-level issues, such as long waitlists and widespread discrimination. In contrast, TGDYP highlighted the psychological burden of repeatedly navigating healthcare systems. TGDYP described how the continual need to manage intricate processes such as correctly completing forms, meeting stringent eligibility criteria, and facing repeated gatekeeping at different stages resulted in feelings of frustration, helplessness, and diminished agency. Thus, unlike the professionals, TGDYP perceived the challenges they experienced as extending beyond the initial point of referral. Indeed, the recurrent process of learning how to ‘correctly’ navigate complex systems was deemed to be more psychologically challenging than long waitlists themselves (see Chapter 7). As a result, policies aimed at solely reducing waitlists or improving resource allocation may fall short of addressing the barriers impacting TGDYP’s healthcare access.

Triangulation was thus useful in highlighting the possibility that professionals may not fully understand the underlying factors that are exacerbating TGDYP's negative health outcomes. Further, exploring A and B triangulation categories together highlights the nuances of the groups' convergences and divergences. Practically speaking, this allows TGD healthcare professionals and policy makers to identify aspects of, and priorities in, healthcare delivery policy that fail to address the healthcare issues experienced by TGDYP, and to alter these policies accordingly. Specifically, our data suggest that adaptations to service delivery need to focus on simplifying GIC processes in ways that are transparent and easily comprehensible to TGDYP.

### *5.5.2. Intra-Group Conflict: A Case Study of Triangulation Category C*

As discussed above, triangulation categories A and B allow researchers to identify where there is agreement and disagreement between two or more stakeholder groups. This information is key for hypothesising reasons why changes made by one group (e.g., professionals and policy makers) may not be perceived/received as expected by another group (e.g., service users). However, divergence in understanding health and social needs are not just observed across groups, but also within groups. Thus, even among TGDYP, there may be discrepancies and disagreements.

Within qualitative research, despite its interpretivist epistemology, the preference for presenting convergent findings to ensure results are reflective of the group's general experiences can mask such intragroup discrepancies (Hanson, 2006). This can often lead to *positivism creep* (Braun & Clarke, 2022a), the result of which is insufficiently processed themes that are generic and descriptive rather than meaningful and insightful (Finaly, 2021). Given that TGDYP are not monoliths, masking intragroup discrepancies through only documenting convergent findings and claiming this meaningfully captures the nuanced experiences of all group members is unrealistic. This leads us to question how we can go about fruitfully capturing intragroup differences, whilst still ensuring that the claims made are grounded in evidence. Triangulation category C can help us achieve this.

Triangulation category C reflects data which are partially present across both stakeholder groups whilst not being consistently mentioned within either group. The inconsistent mention of these data within groups suggests ingroup members have different experiences. One example of this was discrepancies between social experiences of binary and non-binary trans individuals. Specifically, the latter (compared to the former) expressed social support as being more important for their health/wellbeing. This was for two reasons: 1) social support was often described as being the primary form of affiliation and validation for non-binary individuals who are not seeking medical transition; and 2) because non-binary individuals are subject to more pervasive discrimination and exclusion than binary individuals, even within TGD-specific spaces, thus leading non-binary individuals to particularly value social support (e.g., McCormick & Barthelemy, 2020; also see Chapter 6).

The fact that this broader topic of non-binary exclusion within the wider TGD community fell into triangulation category C suggests that neither TGDYP nor professionals considered it to be a particularly significant issue. However, making this assumption would mask the fact that the profound impact of intragroup discrimination was frequently discussed by non-binary TGDYP, and by some professionals (see Chapter 6; McCormick & Barthelemy, 2020). Further, given that the issue of non-binary exclusion crossed group boundaries (i.e., it was mentioned by both stakeholder groups), it suggests that its occurrence is not arbitrary (Liddell, 2022). Based on this possibility, we begun to consider whether, rather than being perceived as an unimportant issue, the partial silence within both groups regarding non-binary exclusion indicated some individuals' reluctance to discuss it.

Drawing on our strategies to interrogate divergent data (e.g., are there different perspectives and understanding within and across stakeholder groups?; is one group unwilling to talk about something?), and viewing non-binary exclusion as an 'incomplete' data point (i.e., because non-binary exclusion appeared to be common knowledge based on its presence across both groups, yet was not discussed by many members of each group; also see Farmer et al., 2006), we considered reasons for reluctance by some individuals to discuss non-binary exclusion.

To illustrate, a few participants explained that one of the reasons that non-binary individuals are subjected to discrimination (even within TGD communities) is deep-rooted cisnormativity. This is because norms relating to congruent gender identity and expression, even for those who are TGD, can influence perceptions of what is deemed to be an (in)authentic identity (see Chapter 6). Simply put, cisnormative discourse can lead to the discreditation of non-binary identities because, unlike binary trans identities, they do not align with traditional binary notions of gender. Evidencing this, some binary trans participants discussed how cisnormative discourse prompted them to view binary trans identities as more valid than non-binary individuals, despite also reflecting on the discomfort of these internalised norms (also see Bockting et al., 2020; Scandurra et al., 2018). Thus, silence on this issue does thus not necessarily imply unimportance, but rather an unwillingness by some binary trans people to acknowledge their internalisation of the very same traditional notions of gender that marginalised them. The QTF was thus able to provide a systematic strategy for questioning why not all participants within each group converged on this data-point, despite the topic being common knowledge across both groups. Without the QTF, non-binary exclusion could have easily been overlooked as a present, but insignificant, issue.

### *5.5.3. Embellishment or Irrelevant Data?: A Case Study of Triangulation Category D*

In our efforts to capture a nuanced understanding of TGDYP health and social engagement experiences, the coding process was iterative and extensive (see Chapter's 6 & 7 for further details). Resultantly, some codes were only relevant to very specific, individual circumstances, often denoted as triangulation category D (e.g., childcare being a barrier to social engagement). Whilst relevant to the individual, not all data points provide grounds for purposeful discussion and inclusion within the final thematic structure. However, as demonstrated in the above discussion of triangulation category C, only through questioning these points can we decipher what is significant or not. Thus, whilst not all triangulation category D data points were incorporated into the final thematic structure, either because they were not of key importance for answering the research questions or we did not yet have enough data on the topic to make actionable recommendations regarding them, some category D data points embellished the key themes that were discussed (see Chapter's 6 & 7 for discussion of these themes).

One example of this is the code *"cis[normative] het[erosexual] spaces are cognitively and emotionally exhausting"*, a data point categorised as D due to its presence in only a handful of TGDYP's interviews. This data point outlined how the psychological strain caused by entering social spaces populated by people who did not share their experiences of gender and sexuality led to participants' avoiding such spaces. The negative health/wellbeing-related impacts of entering non-TGD spaces that this data point highlights shows that it is not just a preference for TGDYP to engage with similar others (i.e., other TGDYP) but a psychological need. This reinforces the need for TGD-specific spaces, since without them, loneliness, exclusion, and poor health/wellbeing are often inevitable.

In addition to these divergences explored within the case studies, we note additional instances in which triangulation was valuable. Whilst the focus of this chapter is not thematic findings, we include these examples to illustrate the value of these methods for better understanding qualitative data (see Table 5.2).

**Table 5.2.**

*Exemplar divergences and their implications for thematic findings and practice.*

| Divergence | Triangulation Category | Thematic Relevance | Practical Implications |
|---|---|---|---|
| The Role of Familial Support | C | While many young TGD individuals prioritize forming new connections with other TGD peers, some value retaining familial ties. However, professionals note that friendship groups often provide more reliable emotional support during transitions, particularly when family dynamics shift. | Maintaining family relationships may help mitigate identity loss, but building meaningful connections within TGD communities remains essential for overall wellbeing. |
| Community-based vs. Medical Professionals | C | Community-based professionals (e.g., youth group workers) better recognize the benefits of TGD peer engagement than medically based professionals. They emphasize how these groups offer safety and affirmation, enabling young people to live authentically and craft positive life narratives. In contrast, medical professionals often underappreciate the significance of these connections, raising concerns about their ability to refer effectively under the NHS's evolving psycho-social model of gender-affirming care. | These discrepancies highlight the need for training with medical professionals that emphasises the importance of meaningful social support for health outcomes. |
| Knowledge Sharing Tools | A & B | While both TGD youth and professionals agree on the lack of informational resources about transitioning, they differ in their views on peer knowledge. Professionals question the reliability of peer-shared information, whereas young people find emotional reassurance in learning from others within their community. | Practically, this underscores the importance of delivering transition-related information in TGD community spaces where shared identities foster trust. |

## 5.6. Discussion

Within this study, we wanted to extend the literature on the utility of data triangulation for understanding discrepancies within and across qualitative data sets. We adapted existing triangulation systems used within political sciences (Campbell et al., 2018; Farmer et al., 2006; Sands & Roer-Steir, 2006) to achieve this, culminating in the development of the QTF. We demonstrate how interrogation of divergent data can shed light on why research-based 'improvements' to healthcare systems and/or policy may not lead to benefits being observed within evidence-based practice. TGDYP served as an illustrative example of this to showcase the QTF's potential to address healthcare marginalisation. These findings underscore the importance of moving beyond surface-level consensus to interrogate the underlying factors driving divergent experiences and perspectives.

### *5.6.1. Understanding Divergence and Its Implications for TGD Youth and their Healthcare*

Understanding divergence within our data through utilisation of the QTF had several implications. We provide an overview here how QTF's ability to offer insight into stakeholder tensions permitted us a more nuanced understanding of the challenges within TGD healthcare, and the impact of this on future TGD healthcare provision.

Firstly, divergence between professionals and TGDYP regarding bureaucratic challenges illustrates a fundamental gap in understanding. While professionals often conceptualise these challenges as logistic hurdles that can be addressed through systemic changes, TGDYP emphasise the emotional and psychological toll of navigating these systems. This mismatch has significant implications for policy and practice, as interventions targeting structural barriers (e.g., long waitlists) may fail to alleviate the cumulative stress experienced by TGDYP. Effective reforms must therefore address both the systemic and emotional/psychological dimensions of care delivery.

Intragroup dynamics were also identified as a critical area of concern, particularly the exclusion of non-binary individuals within TGD communities. Importantly, this issue was evident across both participant groups, suggesting it functioned as a shared or taken-for-granted aspect of community experience. It was therefore notable that some binary trans participants did not address non-binary exclusion directly. Rather than indicating irrelevance, this pattern appeared to reflect differential ways of engaging with a common issue, with related concerns often discussed indirectly through adjacent experiences such as questions of legitimacy, recognition, or belonging. Triangulation enabled these patterns to be examined across data sets, revealing that what initially appears as absence was better understood as selective or displaced articulation of a shared concern. This highlights the value of the QTF for identifying under-discussed or uncomfortable intragroup tensions that may otherwise be overlooked. Recognising and addressing these dynamics is essential for creating genuinely inclusive spaces and interventions.

Overall, the QTF allowed us to develop themes that were reflective of the nuances both within and across stakeholder groups. For example, ‘Identity Loss During Transition’ became ‘The Ambivalent Nature of Transition-Related Identity Loss’, which allowed us to capture differential experiences and perspectives of familial support. Moreover, ‘Non-Binary Exclusion’ was extended to ‘Non-Binary Exclusion: Perceived Violation of Binary Ingroup Norms’ to better capture the processes that lead to non-binary exclusion. This meant we could develop suggestions for TGD healthcare that were 1) more diverse and personalised, and 2) that better reflected the reasons behind negative health outcomes in order to more effectively address them. Comprehensively, then, the QTF provides a compelling framework for not only understanding divergence within qualitative data, but also for developing more actionable recommendations than those which could be achieved without this in-depth exploration of the data.

### *5.6.2. Wider Implications*

#### 5.6.2.1. Relevance to Other Minoritised Populations

Whilst the present paper has explored the utility of the QTF for research with TGD populations, this is not its only purpose. As outlined in the introduction, there are multiple minoritised groups who would benefit from research approaches that value both divergence and convergence. This would allow minoritised voices, which are often overlooked or undervalued (Han et al., 2021; Horton, 2024; Pratt, 2019), to be better acknowledged and thus to make a more meaningful contribution in the research process. Thus, the QTF, demonstrated to be effective for TGD research, presents itself as a promising tool for research with other minoritised groups.

By way of illustration, individuals with chronic illness (Doherty et al., 2022; Natafgi et al., 2022), ethnic minorities (Gaya-Sancho et al., 2021), and broader LGBTQ+ communities (Damery et al., 2025; Hascher et al., 2024) all report similar challenges to TGDYP in relation to the perceived lack of benefits they experience after the implementation of healthcare policy ‘improvements’. Resultantly, future research would benefit from adopting the QTF as a tool for developing actionable insights that address these challenges. For instance, the QTF could be applied to explore disparities in mental health services for ethnic minority communities (Thomeer et al., 2022). This could be achieved by using the QTF to examine differing perceptions about mental health held by ethnic minorities and by the healthcare professionals who care for them, thereby highlighting what ethnic minority service users prioritise as essential for addressing their mental health needs, and how this compares to the priorities of professionals. Similarly, misalignments between chronically ill people and their care providers can complicate care management. For example, service users may prioritise quality of life and symptom management, whereas providers may emphasise adherence to clinical guidelines. The QTF could systematically identify these misalignments, leading to recommendations for shared decision-making models that better align with service user priorities.

Further to these examples, several other populations may also experience differential understandings of their healthcare needs, yet these may not be reported in literature given the predominantly convergent and positivist nature of research designs (e.g., positivism creep; Braun & Clarke, 2022a). Thus, data triangulation and questioning of divergent data, particularly when conducting research with groups that experience both inter- and intra-group discrimination, can facilitate the unpacking of these experiences. Altogether, the present findings underscore the value of the QTF for acknowledging and uplifting minoritised voices within research.

#### 5.6.2.2. Extending the QTF: Data Sets in Tension

While the present study has focused on the application of the QTF for amplifying minoritised voices, particularly within TGD healthcare research, its utility extends beyond research with minoritised populations and healthcare settings. Any qualitative research that involves multiple stakeholder groups, competing perspectives, or divergent interpretations can benefit from an approach that systematically interrogates both convergence and divergence. For example, in fields such as public policy, organisational studies, and interdisciplinary health research, tensions frequently emerge between different groups who may not be minoritised but hold conflicting perspectives (Abelson et al., 2013). This can be due to different institutional roles, disciplinary boundaries, and lived experiences (Abelson et al., 2013). For instance, in public health policy, researchers and policy makers often interpret healthcare needs differently from frontline practitioners and service users (Abelson et al., 2013; Holman et al., 2021). Similarly, within organisational change, executives might highlight the increased productivity and cost savings of implementing new technology systems. However, frontline employees might express frustration over inadequate training, unrealistic performance expectations, and increased stress (e.g., Wijethilake et al., 2021).

By applying the QTF to these contexts, researchers can uncover the reasons why different stakeholder groups interpret the same issues in contrasting ways. Rather than viewing divergence as a barrier to consensus, the QTF allows for a more productive interrogation of why disagreements exist and how they might be resolved. This approach ensures that research findings are not oversimplified into a singular narrative but instead reflect the complexities of real-world decision making. Ultimately, the broader application of the QTF demonstrates its potential as a methodological tool for any research that seeks to navigate conflicting perspectives within and across qualitative data sets. By moving beyond a sole focus of minoritised voices, the QTF contributes to a richer, more nuanced understanding of stakeholder dynamics across diverse fields of research and practice.

### *5.6.3. Strengths and Limitations*

To the authors' knowledge, this QTF represents a distinct extension of existing triangulation approaches used within the social sciences. Whilst qualitative data triangulation has been utilised when combining interview data with documentary analysis (e.g., Campbell et al., 2018; Farmer et al., 2006), the same has not been replicated for the synthesis of two primary qualitative data sets within the data analysis stage. Similarly, although SAGA (Reicher & Sani, 1998) presents a type of triangulation, it does not integrate multiple data sets. Rather, it only explores arguments present within a single data set. In this respect, the QTF advances existing work by offering a systematic framework for comparing and synthesising two or more primary qualitative datasets during analysis, enabling the identification of convergence, divergence, and tension across stakeholder perspectives.

It is relatively common to see integration of quantitative and qualitative data in mixed-methods designs, where qualitative research is helpful for illuminating the underlying psychological processes of an observed change within quantitative outcomes (Ahmad et al., 2019). However, by design, this methodology tends to place emphasis on converging data. This desire for convergence, in part, stems from a response to the quantitative/qualitative divide within research, where neat, actionable qualitative findings that reflect broad groups are suggested to be comparable to quantitative work (Hanson, 2006; also see Braun & Clarke, 2022a on *positivism creep*). However, considering that this divide is often more political than intellectual (Hanson, 2006), and as suggested by the aforementioned case studies, convergent findings are not always the most useful for inspiring practical action. Instead, the reality for social sciences and healthcare research is that there are a multitude of social, political, and economic factors that impact lived experiences across multiple domains; complexity that is often filtered out through convergent research designs, and therefore is often ignored within the practical recommendations that emerge from such research (Mathison, 1988).

Having said that, it is not our intention here to discredit prior triangulation work, particularly where this has paved the way for coalescing quantitative and qualitative research to produce grounded mixed-methods research designs (Valencia, 2022). Rather, we envisage a new way for conceptualising qualitative research findings using the QTF; one that highlights sources of tension between stakeholder groups that, if overlooked, can have negative implications for policy and practice (as demonstrated in the analysis of triangulation categories A and B). Crucially, it is only through the comparison of two or more sets of *qualitative* data that we can begin to understand the *'whys'*. Why do these groups understand the same experience differently? Why do we not always see practical benefits when healthcare practices are 'improved'? Why do minoritised communities still feel marginalised? Discerning these differences can help researchers and policymakers to move forward effectively.

Finally, while this paper provides valuable insights, it is not without limitations. First, while the QTF offers a more fine-grained approach to qualitative synthesis by explicitly retaining convergence *and* divergence, it also demonstrated that no analytic framework is exhaustive. Some experiences, such as caregiving or parenting, were raised by only one participant and were therefore classified as minority data points. Despite the QTF's sensitivity to low-frequency data, these perspectives were not foreground analytically, illustrating how even enhanced triangulation approaches may overlook issues that are structurally important but weakly represented within a given sample. This highlights the importance of interpreting minority data points (i.e. data point D) in relation to sample composition, rather than frequency alone, when considering their potential relevance for policy and practice.

Second, although interviews and surveys are different methods and generated data of varying depth, both instruments were designed to address the same core questions and analytic constructs. This ensured conceptual alignment across datasets, even where the level of elaboration differed. While interviews allowed for probing and clarification, open-ended survey responses were necessarily more concise; however, because participants were responding to the same underlying prompts, the substantive focus of responses remained comparable. This pragmatic design choice supported broader participation but may have limited the extent to which some experiences were fully elaborated in survey data. Accordingly, findings should be interpreted as reflecting shared core responses across methods, while recognising that some nuance may have been more fully articulated in interview accounts.

Third, the QTF, while effective, has not been rigorously tested across diverse data sets. Rather, it has been novelly applied to two new data sets to strengthen the actionability of our analytical claims. Nonetheless, it is anticipated that the present paper's worked examples of data point examination highlight the applicability of the QTF for enhancing data analysis. Moving forward, adoption of the QTF when conducting research with minoritised populations and stakeholders in tension would benefit researchers whilst simultaneously establishing an evidence base for the QTF.

### 5.7. Conclusion

This research underscores the critical role of triangulation as a methodological tool in research. Specifically, development of the QTF demonstrated how systematic categorisation and interrogation of data can move beyond surface-level findings to uncover the dynamics that shape stakeholder experiences. Traditional research methods often prioritise positivism and convergence to validate findings, yet this study highlights the power of divergence and interpretivism in capturing the complexity of marginalised experiences. By examining discrepancies, such as differing interpretations of systemic barriers or intra-community dynamics, the QTF offers a framework to generate richer, more actionable insights that conventional methods may overlook. Whilst we demonstrate the effectiveness of the QTF for TGD populations, the methodological contributions of this study extend beyond minoritised populations and healthcare settings. Triangulation provides a replicable process for integrating multiple perspectives, promoting inclusivity, and addressing overlooked tensions in research with other marginalised populations and stakeholder groups in disagreement. This demonstrates that adopting innovative approaches can not only amplify diverse voices but also enhance the depth and impact of research in multiple settings. Following this methodological discussion, the next two chapters (Chapters 6 and 7) present the empirical findings that resulted from application of the QTF. Specifically, and building on the systematic review findings presented in Chapter 3, Chapter 6 explores how TGDYP experience *meaningful* social connections. Chapter 7 then aims understanding how the health benefits of these meaningful social connections can be harnessed through SP interventions, and *how* SP might be feasibly integrated into gender-affirming care.

# Chapter 6 (Study 2, Part 1)

## "Being queer is many things, but one of the things we need is community": A Social Identity Approach to Health-Informed Thematic Analysis of Community Engagement Among Trans and Gender Diverse People in England.

### Availability of Data and Materials

In accordance with Open Science Framework (OSF) guidelines and NTU's IRep depository, pseudonymised transcripts will be made available on request for two purposes: 1) for the purposes of individual scrutiny, and 2) for the purposes of reproduction and/or research in a direction consistent with this research (i.e., to be of benefit to TGD communities in ways that affirm their identities). Permission to access will be on a case-by-case basis. Supplementary documents, including interview schedules, have been made available on the OSF and can be accessed at: osf.io/xqp9h

The findings from Chapter 6 (Study 2, Part 1) have been presented at the following academic conferences:

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, July). *Improving Healthcare for Trans and Gender Diverse People: Exploring the Utility of Social Prescribing Pathways.* An invited presentation for Nottingham Young People's Gender Service CPD training session.

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, May). Improving Healthcare for Trans and Gender Diverse people: Exploring the Feasibility of Social Prescribing Pathways. An invited presentation for the University of Exeter. Oral Presentation.

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2024, November). Improving Healthcare for Trans and Gender Diverse People: Adapting and Testing the Effectiveness of Social Prescribing Initiatives. An invited presentation for the British Association of Gender Identity Specialists, Nottingham, UK. Oral Presentation.

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2024, October). Being queer is many things, but one of the things we need is community": A Social Identity Approach to Health-Informed Thematic Analysis of Community Engagement Among Trans and Gender Diverse People in England. An invited presentation for the National Autonomous University of Mexico. Oral Presentation.

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2023, August 22nd). Improving Healthcare for Trans and Gender Diverse People: Adapting and Testing the Effectiveness of Social Prescribing Initiatives. An invited presentation for the University of Toronto, ON. Oral Presentation.

## 6.1. Abstract

**Background:** The poor mental and physical health of trans and gender diverse young people (TGDYP) is well established and has been attributed to experiences of gender minority stress. Recent work has begun to explain how social support can mediate this relationship. However, a theoretical framework had not yet been applied to explain the psychological processes through which social support reduces minority stress and improves wellbeing. We argue that the Social Identity Approach To health (SIAH) is such a framework.

**Methods:** To test SIAH's appropriateness in this context, we used it to analyse interview data from 20 TGDYP (aged 18 – 26 years) and 8 Health, Social, and Voluntary care professionals working with this population. We aimed to explore participants' perceptions of social support, including how valuable TGDYP deem this beneficial to their health and what psychological processes lead to it benefitting TGD people's health.

**Results:** Our results demonstrate that whilst social group membership loss is common, the social connections TGDYP make with other TGDYP as they develop their authentic self across the course of their transition outweighs this loss. Specifically, these connections provide them with a sense of felt understanding, increasing access to psychological resources such as safety, a sense of meaning in life, and emotional reassurance. Whilst intragroup discrimination can undermine these benefits, we outline potential ways of overcoming this.

**Conclusion:** Future research should consider how this health-enhancing social support can be integrated into a holistic model of TGD healthcare.

**Key Words:** Trans and Gender Diverse; Young People; Social Identity; Social Cure; Triangulation

## 6.2. Introduction

The poor mental and physical health of TGD populations has been long documented. For example, increased rates of mental health distress (Miller et al., 2023; Reisner et al., 2016; Scheim et al., 2024), loneliness (Hajek et al., 2023); substance use and abuse (Reisner et al., 2016; Scheim et al., 2024), sexually transmitted infections (Reisner et al., 2016), and poor health-related help-seeking behaviours (e.g., delay and avoidance of accessing healthcare services; Pandya & Redcay, 2021; Thomas et al., 2024) are commonplace. Collectively, health disparities between TGD and cisgender populations has led researchers to address this health gap.

### *6.2.1. Gender Minority Stress Theory*

Gender Minority Stress Theory (GMST; Hendricks & Testa, 2012; Meyer, 2003) is often used to explain these health disparities. GMST emphasises that TGD individuals, given their minority status, encounter unique life stressors, such as discrimination and violence (Hendricks & Testa, 2012; Vries & Hannema, 2023). Distal stressors, including interpersonal challenges (e.g., lack of social support) and systemic barriers (e.g., difficulties obtaining legal recognition), hinder TGD individuals' ability to live authentically (Bouman et al., 2016; Hendricks & Testa, 2012; Puckett et al., 2021). Proximal stressors, such as fear of rejection, rumination over past discriminatory experiences, and internalised transnegativity reflect internalised conflicts stemming from these external events (Meyer et al., 2015; Puckett et al., 2021; 2023).

### *6.2.2. Gender Minority Stress, Poor Health, and Social Support*

Minority stress is hypothesised to drive poor health outcomes (both physical and mental; Puckett et al., 2021), partly via over-activation in the hypothalamic-pituitary-adrenal (HPA) axis: a bodily system implicated in mental and metabolic conditions (Ahmed et al., 2023; also see Meyer, 2003 on stress-related health problems). However, mixed evidence for the relationship between minority stress and poor health outcomes, and knowledge that this pathway does not fully explain health outcomes, suggests additional mediators (Diamond & Alley, 2022).

One mediator is social support. The Psychological Mediation Model (Hatzenbuehler, 2009; Timmins et al., 2017) proposes that minority stress disrupts social relationships, which in turn undermines health. For TGD people, minority stress can erode belonging and reduce access to the psychological resources usually provided by group life (Diamond & Alley, 2020; Haslam et al.., 2018; 2024; Wilson & Liss, 2022).

Diamond and Alley (2020) extend this theorising, introducing the concept of *social safety*, which outlines one's sense of social connection, inclusion, and protection. They suggest that diminished social safety is as consequential for health as minority stress itself. This is because, even in the absence of long-term, salient minority stress, the lack of social safety minoritised individuals experience fosters a chronic vigilance of one's social surroundings. For TGD individuals, they may feel compelled to constantly evaluate their social environments for threats and anticipate others' judgements of their gender, with potential consequences of rejection and violence (Brumbaugh-Johnson & Hull, 2018). Such vigilance has long-term cognitive, emotional and immunological costs, reducing overall health (Wilson & Liss; 2020). In this way, social relationships mediate the relationship between minority stress exposure and negative health outcomes.

Conversely, supportive social environments can buffer minority stress and enhance wellbeing (Austin & Goodman, 2016; Elmer et al., 2024; Hajek et al., 2023; Sherman et al., 2020; Wall et al., 2022). This is because supportive environments decrease proximal stress (Wall et al., 2022) and increase access to key psychological resources that groups provide (e.g., belonging, sense of control, and meaning in life; Haslam et al., 2018; 2024). Put simply, if an individual feels they have good social relationships, the impact of gender minority stress (e.g., discrimination, perceived marginalisation) on health may be reduced through increases in social support, safety and belongingness.

### ***6.2.3. Limitations of Gender Minority Stress Theory***

Whilst GMST highlights and explains health disparities between TGD and cisgender groups, its largely quantitative focus limits understandings of *how* and *why* social ties protect health (Austin & Goodman, 2016; Dowers et al., 2020; Rimmer et al., 2022). This is a key limitation, particularly where not all social ties are equally helpful for reducing minority stress (Chi, 2023; Rimmer et al., 2022). Speaking to this issue, Puckett and colleagues (2019) propose that the qualitatively different nature of the multiple groups to which we each belong (e.g., friends, family, colleagues) means that the support offered by each of these groups impacts wellbeing in differing ways. Bowling and colleagues (2020) shed light on this, demonstrating how 'chosen families' play a particularly critical role for many TGD individuals, often providing more affirming and reliable support than families of origin. Their findings highlight the importance of recognising non-traditional kinship networks as key sources of resilience and wellbeing. Thus, research needs to carefully unpick *what* types of social support are psychologically valuable for TGD communities and *why* (see Bowling et al., 2020 on chosen families).

Further, despite social support being protective against minority stress (Pflum et al., 2015), TGD individuals receiving similar levels of social support as their non-heterosexual cisgender counterparts (e.g., cisgender LGBQ individuals) still report higher loneliness (Puckett et al., 2021; 2023). This suggests GMST, adapted from LGBQ models (e.g., Minority Stress Theory; Meyer, 2003) may not capture stressors unique to TGD lives. One such stressor is *transitioning identity stress*, which reflects the challenges of bodily and social change during transition, such as negotiating gendered spaces (e.g., bathrooms; Dubois et al., 2017; Puckett et al., 2021; 2023).

Finally, while reducing minority stress is important, this deficit-focused approach risks foreclosing narratives of trans joy (Gosling et al., 2022; Lewis et al., 2023; Shuster & Westbrook, 2022). Given social support is not only a buffer against minority stress, but also a mechanism to enhance quality of life among minoritised populations (Carnes et al., 2017; Gleibs et al., 2011; Morton et al., 2015), there is a need to apply theories that explain both health protective and promotive processes. We propose that the Social Identity Approach to Health can allow us to achieve these aspects.

### *6.2.4. The Social Identity Approach to Health*

The Social Identity Approach to Health (SIAH; Haslam et al., 2018; 2024; see Figure 2.1) explains when groups help or harm health. In its *Social Cure* arm, identification with meaningful groups provides resources such as social support, meaning in life, and personal control that buffer stress and lead to better health (Jetten et al., 2017; Haslam et al., 2024). These social ties also reduce the perceived threat of stressful situations (primary stress appraisal) because approaching challenges as a member of a group increases the psychological and practical tools available to manage them (secondary appraisal; McKimmie et al., 2019; van Dick & Haslam, 2012). For example, TGD peers may help reframe hostile healthcare encounters more positively, reminding one another that the problem lies in systemic prejudice rather than personal failure. In this way, what might otherwise feel like an isolating attack can instead be interpreted as a shared societal challenge, reducing its perceived threat and bolstering collective resilience (Wakefield et al., 2020; Sherman et al., 2020). Thus, Social

Cure processes explain *how* social support can be protective for health, as postulated, but not fully explained, in GMST (e.g., Wall et al., 2022).

In its *Social Curse* arm, groups can also harm health (Haslam et al., 2024; Kellezi & Reicher, 2014). For example, when intragroup exclusion delegitimises certain identities because they are perceived to violate ingroup norms (e.g., non-binary people), it strips individuals of belonging and meaningful social identities (Kellezi & Reicher, 2014; Vincent, 2021). Similarly, when harmful ingroup norms take hold, such as pressures around substance use or rigid expectations of ‘authentic’’ transness, members may feel compelled to conform in ways that damage wellbeing (Kellezi & Reicher, 2014; Livingstone et al., 2011). Finally, groups can become saturated by collective trauma, where continual focus on marginalisation and hardship reinforces distress rather than fostering resilience (Kellezi et al., 2019). This helps us to understand why not all group memberships have been demonstrated helpful for TGDYP (e.g., Rimmer et al., 2022). These dynamics highlight that groups are not inherently protective. The same processes that generate solidarity can also amplify vulnerability. Understanding *when* and *why* group memberships give way to Social Cure and Social Curse processes is therefore essential for designing TGD spaces that genuinely promote health and belonging. However, the contexts in which group memberships provide value may shift during the profound life transitions that TGDYP undergo (Doyle et al., 2023). The Social Identity Model of Identity Change (SIMIC) builds on the SIAH by examining how such transitions reshape group memberships.

#### 6.2.4.1. The Social Identity Model of Identity Change

The SIMIC (Jetten et al., 2014; see Figure 2.2) is a core extension of the SIAH, focusing on how life transitions affect group memberships and therefore health. SIMIC proposes that transitions often involve the loss of old identities, threatening wellbeing, but that this can be offset through identity continuity (maintaining pre-transition groups) or identity gain (acquiring new groups). The greatest protection occurs when old and new groups are compatible, providing stability and continuity across change.

For TGD people, this model is especially relevant. Gender transition entails profound physical, social, and psychological change, meaning compatibility between old and new identities can be harder to achieve than in many other populations (Arnoldussen et al., 2022). Shifts in appearance or self-definition may alter how others perceive them, straining or severing pre-existing ties (Doyle et al., 2023). This raises central questions for research: if TGD people maintain pre-transition relationships, do these still confer the same psychological benefits? Or is wellbeing better supported through the acquisition of new, more affirming identities? Further, given pervasive loneliness reported among TGD people, it is not always clear whether they have sufficient relationships to maintain in the first place (Doyle et al., 2023; Scheim et al., 2024). Using the SIMIC as an analytical framework can help us to answer these questions.

Overall, the SIAH allows us to build on GMST, as it provides explanation as to *how* social groups are protective against societal discrimination (e.g., minority stress) but also *how* these groups can enhance and/or hinder social connectedness and health (e.g., Haslam et al., 2018; 2024; Kellezi & Reicher, 2012). Understanding the experiences and health-related outcomes of the TGD community through the lens of the SIAH is thus an important step in moving TGD research away from deficit reduction approaches such as the GMST, whilst still acknowledging that minority stress is a factor that will impact the quality (and therefore the health-related benefits) of these social relationships.

### ***6.2.5. Present Study***

In response to GMST's limited ability to shed light on the psychological processes through which social support protects health, this study applied the SIAH to examine how TGD people experience group-based support. Specifically, it explored how Social Cure, Social Curse, and identity transition processes (SIMIC) shape the environments in which social group memberships are helpful or harmful, and how these dynamics shift over the course of transition. The following research questions were explored:

1. How do TGDYP experience group-based social support in the context of their continually changing social identities?
2. What are TGDYP's perceptions of their group memberships and the psychological resources they do/do not provide?

The study focused specifically on TGD young people (TGDYP) aged 18-29 as justified in Chapter 1 of this thesis. This group was prioritised because emerging adulthood is a critical developmental period for identity formation and social belonging (Kirkbride et al., 2024; Muhl et al., 2025). These years often coincide with delayed opportunities for authentic adolescence due to restricted healthcare access, making group memberships especially consequential (Horton 2022a, 2022b). Extending the upper age limit to 29 allowed inclusion of those whose developmental trajectories may be prolonged by these delays. This reasoning also aligns with emerging research identifying how demographic trends (e.g., longer education periods, later entry into marriage and parenthood) have contributed to a new life stage of emerging adulthood at ages 18 – 29 (as opposed to 16 – 25; Arnett et al., 2014; Eisenberg, 2010; Higley, 2019). We opted not to include individuals under 18 due to safety and ethical concerns regarding consent processes.

In addition to TGDYP, professionals working with these communities were included to provide a multi-perspective view of social support. This helped contextualise TGDYP's accounts within the structural conditions of care, while also reducing the pressure on TGDYP to explain systemic barriers themselves. Comparing these perspectives allowed for a more balanced understanding of what forms of support are perceived as health-enhancing across contexts.

### *6.2.6. Study Context*

Initially, recruitment targeted both England and Wales, given the shared legal and health systems for TGDYP distinct from Scotland (Scottish Government, 2022) and Northern Ireland (Fynes, 2014; Wilkinson, 2021). However, as all participants were based in England, the chapter focuses on this context.

At the time of data collection (July – November 2023), gender-affirming care (GAC) in England was undergoing rapid and contested change. The closure of the Tavistock and Portman's GIDS (previously the sole NHS gender service for those under 18), coupled with the Cass Review's recommendations (Cass, 2024a) and the ban on puberty blockers (Department of Health and Social Care, 2024), created widespread uncertainty and service disruption. In addition to these disruptions, existing GICs were already limited in scope, largely focused on medical intervention with little provision for those not pursuing medical transition (Toze, 2019; Wall et al., 2023). This left many TGDYP without affirming support during critical periods of identity development. With current service changes further heightening uncertainty and unmet need, understanding how TGDYP experience and benefit from social support has become increasingly important.

## 6.3. Methods

### *6.3.1. Design*

This research adopted a qualitative design; suited for novelly applying the SIAH (Haslam et al., 2018). This allowed the present research to move beyond quantitative associations between social support and health, and to instead capture the psychological processes through which group memberships protect or undermine wellbeing. This study was also grounded in emancipatory principles to generate knowledge that benefits TGDYP and recognises the multiplicity of their lives (Henrickson et al., 2020; Singh et al., 2013). To this end, data were gathered from TGDYP *and* health, social and voluntary sector professionals working with TGDYP. This dual sample served two purposes; 1) it reduced the burden on TGDYP to be sole knowledge providers; and 2) it allowed professionals to highlight the structural contexts that shape access to support, such as funding constraints and service availability (Strang et al., 2019).

### *6.3.2. Participants and Recruitment*

#### 6.3.2.1. Trans and Gender Diverse Young People

Twenty TGDYP (aged 18 – 26[12]) were recruited. Eligibility was open to those who had and had not accessed NHS GICs to capture diverse experiences of support and how social support needs may vary across transition. Participants varied in their engagement with gender-affirming care, including those accessing NHS Gender Identity Clinics, private pathways, both, or neither, as well as individuals not seeking medical intervention. Living arrangements and employment status also differed, reflecting varied life circumstances in early adulthood. While most participants identified as White British, the sample nonetheless captured diverse experiences of transition, service engagement, and social support needs, which informed the subsequent analysis.

#### 6.3.2.1. Health, Social, and Voluntary Care Professionals

Eight health, social, and voluntary care professionals residing in England and working with TGDYP participated in the study[13]. Professional's spanned primary care (e.g., General Practitioners), tertiary care (e.g., GIC Clinicians), and community organisations. This heterogeneity was intentional: medical professionals often bring clinically focused perspectives, while community-based workers highlight relational and psychosocial contexts. Including this variety allowed us to contextualise TGDYP's accounts within wider service

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[12] Although our intended age range was 18–29 as previously justified, the upper limit of 26 reflects the age of the oldest participant recruited.

[13] Numbers are reflective of average participant samples for healthcare research with TGD populations (see Velasco, 2022 for TGDYP populations; and see Kirlew et al., 2022; Mikulak et al., 2021 for TGD health professional populations).

landscapes. Table 6.1 and Table 6.2 provide the demographic information for all participants in this study.

#### 6.3.2.3. Recruitment

Both participant groups were recruited using opportunity and snowball sampling. For TGDYP, this is common (Hughes et al., 2021) given research participation barriers such as lack of trust in researchers (Owen-Smith et al., 2016). The same approach was adopted for professionals because of their limited capacity to contribute to research given the burden of their workload (Mikulak et al., 2021). The research was advertised on social media platforms (Facebook; Twitter), and through recruitment posters at the PhD Candidate's institution. A favourable ethical opinion was obtained from the BLSS Research Ethics Committee at Nottingham Trent University.

### *6.3.3. Data Collection*

The study collected data using semi-structured interviews with TGDYP and open-ended surveys with professionals. Whilst it was anticipated that both groups would engage in the research via interviews (and/or focus groups for professionals), the increasing demand placed on professionals working with TGDYP (e.g., Mikulak et al., 2021) limited their availability for a focus group. Consequently, we opted to use open-ended surveys to increase flexibility in their participation, where modest data, in comparison to that which can be obtained using interviews, was seen as favourable over no data for this population.

#### 6.3.3.1. Interviews

Online semi-structured interviews with 20 TGDYP residing in England were conducted and recorded using Microsoft Teams. Interviews had a mean duration of 50 minutes, with lengths ranging from 21 to 91 minutes. This data collection method was most suited to understand *how* TGDYP experience group spaces and the psychological processes through which health benefits are achieved. Online interviews prevented geographic limitations on the sample, and also reflected the preferred engagement patterns of TGDYP (McInroy et al., 2019). The interviews focused on participants' current involvement with social and community groups, barriers to participation, access issues, and preferences for future social engagements. To capture SIAH variables, interview questions (see osf.io/xqp9h for the interview schedule) specifically explored how these groups foster a sense of belonging (e.g., "*how do these social groups promote a sense of social belonging?*"), how participants connect with others (e.g., "*how are the people in these groups important to you?*"), and how these connections have changed during transition (e.g., "*Have these social groups been helpful during your transition*"). Immediately after conducting interviews, the PhD Candidate made notes of their thoughts in relation to the research questions that could be returned to reflexively during the analysis stage. Interview recordings were transcribed verbatim in Microsoft Word by the PhD Candidate and transcripts uploaded to NVivo14 for analysis.

**Table 6.1.**

*Socio-demographic information for young TGD participants.*

| Pseudonym | Age | Gender Identity | Pronouns | Transition Stage | Ethnicity | Sexuality | Living Arrangements | Employment Status |
|---|---|---|---|---|---|---|---|---|
| AH | 22 | Trans Woman | She/Her | Hormones (2 years; private) | White British | Bisexual | Student with Roommates | Student |
| AJ | 24 | Male | He/Him | Pre-medical intervention/ On NHS waitlist/Socially transitioned | White British | Gay Man | Co-habiting/Living Together | Full-Time Student/Part-Time Employee |
| Alex | 26 | Trans Woman | She/Her | Hormones (2 months; Private) | Mixed Race (White/Asian) | Pansexual | Living with Parents | Employed |
| Arlo | 23 | Non-Binary | They/She | Socially Transitioning | White British | Lesbian | Living with a partner | Student/Part-Time Work |
| Ash | 18 | Non-Binary | They/Them | Early Social Transition | British | Questioning | Living with Mum | Unemployed |
| Cameron | 23 | Non-Binary Trans Masculine | They/He | Hormones (1 month; NHS), post top surgery (Private). | White British | Bisexual | Renting a Room | Employed Full-Time |
| Charlie | 26 | Trans Man | He/Him | Hormones (1 year; private) | White | Heterosexual | Living with Wife | Full-Time Employed |
| Dave | 20 | Trans Male | He/Him | Hormones (private; 2 years), awaiting surgery | White British | Bisexual | Shared House | Student with Job. |
| Eddie | 25 | Trans Man | He/Him/His | Hormones (private access); NHS 1st & 2nd Appointment | White British | Gay Man | Live with Family | Full-Time Employed |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Felix | 26 | Non-Binary | She/He/ They | Social Transition (4 years) – not currently seeking medical intervention | White British | Bisexual | Housed with Housemates | Full-Time Employed |
| Isaac | 23 | Genderfluid/ Genderqueer Trans Man | He/Him/His<br>Ze/Zem/Zir | Hormones (5 years - private), awaiting hysterectomy on NHS | White British | Bisexual | Single Tenant | Full-Time |
| J | 24 | Trans Female | She/Her | 2 months into private/DIY hormones. | White British | Pansexual | Living with Parents | Unemployed |
| Lucky | 22 | Gender Queer Trans Man | He/Him/ Ze/Zir | Hormones (4 years; private & NHS) and top-surgery (private). | White British | Queer | Student Flat. | Full-Time Student |
| M | 21 | Non-Binary | They/Them | Socially Transitioning | White British | Gay | Supported Accommodation | Unemployed |
| Ray | 25 | Non-Binary | They/Them | Social Transition (3 years) – not currently seeking medical intervention | White British | Queer | Living with Parents | Self-Employed |
| Sam | 25 | Trans Man | He/Him | Hormones (6 years; private & NHS) post top-surgery (NHS) | White British | Queer | Living with Parents | Part-Time Work |
| Sammy | 24 | Non-Binary | He/They | Hormones (private & NHS; 5 years) and top-surgery (NHS). | White | Queer | Living Independently | Employed |
| T | 24 | Trans Man | He/Him | Hormones (5 years), post top-surgery (NHS). | White British | Gay | Living with partner | Unemployed |
| Tress | 23 | Trans Woman | She/Her | Hormones (2 months, NHS). | White British | Pansexual | House Share | Part-Time Employment |
| Vesper | 22 | Non-Binary Femme | She/They | Early Social Transition/Closeted | White British | Bisexual | Living with Partner | Student/Part-Time Employment |

**Table 6.2.**

*Socio-demographic information for TGD health, social and voluntary care professionals.*

| Pseudonym | Age | Gender Identity | Pronouns | Ethnicity | Sexuality | Job Title |
|---|---|---|---|---|---|---|
| Bea | 40 | Female (Cis) | She/They | White British | Straight | General Practitioner (GP) |
| Cee | 37 | Gender Queer | She/They | White Welsh | Pansexual | Young Persons Support Worker |
| E.M. | 23 | Female (Cis) | She/They | White British | Bisexual | Youth Empowerment Director |
| Jasy | 24 | Female | She/Her | Black | Heterosexual | Counsellor |
| Lula | 43 | Cis | She/They | White British | Straight | Project Manager |
| Minim | 59 | Trans Woman | She/Her | White | Bisexual | Gender Specialist |
| Minty | 29 | Male | He/Him | African American | Heterosexual | Clinical Social Worker |
| Sonny | 34 | Male | He/Him | Caucasian | Straight | Clinical Psychologist |

*Note.* A full description of participants' job titles can be found in Appendix 12.

#### 6.3.3.2. Open-Ended Survey

An open-ended survey was completed by eight health, social and voluntary care professionals who work with TGDYP across England, hosted on Gorilla Experiment Builder. Survey questions (see osf.io/xqp9h for survey questions) centred around participants' perceptions of social engagement among TGDYP ("*What challenges related to community connectedness do TGDYP experience?*), and consideration of how the inclusion of social support as part of TGD healthcare could enhance the social lives of these groups and improve their health outcomes (e.g., "*How do you think SP could benefit TGDYP*"). Open-ended survey responses were compiled into respective documents for each participant, and uploaded to NVivo14 for analysis.

### *6.3.4. Data Analysis*

Data were analysed using Reflexive Thematic Analysis (RTA; Braun & Clarke, 2022a; 2022b), chosen for its flexibility in generating practice-relevant insights (Braun & Clarke, 2021; Leeman & Sandelowski, 2012). RTA was complemented by the Qualitative Triangulation Framework (QTF; Staras et al., 2025); an analysis tool developed by the PhD candidate and designed for triangulating qualitative data and highlighting agreement and disagreement between samples. The QTF was appropriate for two reasons: 1) in light of intragroup discrimination which may alter experiences of social support among TGDYP (Verbeek et al., 2020); and 2) for balancing competing perspectives between TGDYP and professionals (Jackson et al., 2023; Scheim et al., 2024).

First, the PhD Candidate familiarised themselves with the data through transcription and repeated readings. Following, data was coded beginning with TGDYP interviews and then coding professional survey responses. Coding was both inductive (to capture participant meanings) and deductive through applying the SIAH to facilitate data interpretation. Codes were revisited iteratively to incorporate later generated codes into earlier coded transcripts and refine meaning across both data sets. Best practice guidance for TA with TGD populations guided this process (Braun & Clarke, 2022b).

To systematically triangulate the two samples prior to theme development, we used the QTF (Staras et al., 2025). The QTF enabled us to map areas of convergence divergence, and silence between groups. For example, while some TGDYP were often optimistic about maintaining familial ties, other TGDYP and professionals emphasised the transformative value and reliable nature of ties with other TGDYP. This revealed divergence in how sources of support were prioritised. Similarly, community-based professionals described peer groups as safe and affirming spaces, whereas medical professionals tended to understate their psychosocial benefits; another instance of divergence. Further, both groups agreed on the scarcity of reliable transition-related information, but differed in their assessment of peer-to-peer knowledge sharing; TGDYP valued its reassurance, while professionals raised concerns about accuracy. These points of comparison shaped theme development and interpretation as demonstrated in Table 6.3.

The final organisation, refinement and naming of themes aimed to reflect nuances identified through application of the QTF while highlighting SIAH processes. For instance, ‘Sense of Belonging’ became ‘A Novel sense of Belonging and Understanding’ to reflect the shift from superficial to identity-relevant ties, often for the first time. Likewise, ‘Spaces to Explore Identity’ became ‘Feeling Safe to be Authentic’, highlighting that groups are protective when they allow authenticity, not just presence. Relevant extracts were chosen to support themes.

**Table 6.3.**

*How the QTF Informed Final Theme Development.*

| Final Theme | Triangulation Insights | How This Shaped the Theme |
|---|---|---|
| The Ambivalent Nature of Transition-Related Identity Loss | Category A: Both TGDYP and professionals consistently discussed the challenges of transition-related relationships. Category C: Accounts were mixed: some TGDYP valued continuity in family ties, others described them as harmful; many were ambivalent within their own accounts. | Led to framing the theme explicitly around *ambivalence*. Instead of treating identity loss solely as risk (SIMIC), the theme highlights how fragile or inauthentic ties meant that "loss" was often less psychologically damaging, and sometimes even beneficial. |
| The Psychological Benefits of Authentic, Meaningful Group Engagement | Category A: Both groups agreed TGD peer support was valuable. Felt Understanding (B): Expressed most strongly by TGDYP.<br>Safety & Authenticity (A): Emphasised equally across groups.<br>Knowledge Sharing (A & B): Both groups acknowledged its role, but TGDYP stressed that ingroup knowledge was emotionally reassuring in a way professional advice was not. | Triangulation justified breaking this theme into three subthemes. TGDYP's stronger emphasis on *felt understanding* shaped 2.1; convergence on *safety/authenticity* shaped 2.2; and divergence in how *knowledge-sharing* was valued reshaped 2.3 from being purely "practical" to showing its role as *emotional reassurance*. |
| The Negative Impact of Intragroup Dynamics on TGD Social Support | Category C: Non-binary exclusion raised by some TGDYP and some professionals, but not universally.<br>Category C: Online/offline differences raised by some participants, not all. | Even though these issues were not common across the whole dataset, triangulation highlighted them as *critical processes* for certain subgroups (e.g., non-binary youth). This influenced the decision to elevate them into subthemes, ensuring the analysis captured risks of the "social curse" alongside the "social cure." |

#### 6.3.4.4. Reflexivity

It is necessary here to examine my positionality as the PhD Candidate to demonstrate how this contributed to knowledge production (Hill & Dao, 2020; Trainor & Bundon, 2020). My own identity and lived experience made it possible to connect closely with the data, enabling active theme generation and richer interpretation (see Beasley et al., 2021). This positionality shaped the design, recruitment, data collection, and analysis.

In terms of design, I was mindful of the burden often placed on TGD people to be the sole educators while simultaneously often having their voices overlooked (Jackson et al., 2023). Responsively, I adopted an emancipatory approach, generating co-produced knowledge between TGDYP and professionals to reduce the pressure on TGDYP (Pettican et al., 2022). Balancing these perspectives using the QTF also ensured TGDYP views were not marginalised, ensuring equitable research participation and outcomes.

Recruitment also reflected my insider knowledge. Advertising the research within small online safe spaces where I was already a member signalled that the project was intended for the community's benefit, not to exploit it, and helped build trust from the outset.

In data collection, this sense of safety translated into interviews. I shared my own identity and transition story before inviting participants to share theirs, creating an atmosphere of unspoken shared norms and values. This reciprocity deepened rapport and allowed participants to articulate their experiences more openly. It also helped ease participants into the interview, offering felt understanding and trust that supported more in-depth disclosure.

Finally, in analysis, my positionality shaped interpretation in ways that remained grounded in participants' accounts, consistent with Reflexive Thematic Analysis (Braun & Clarke, 2022). Rather than inferring meaning where none was given, my insider perspective enabled me to recognise the salience of what participants did say. For example, I could identify how apparently "small" moments of peer connection carried disproportionate emotional weight, reflecting their rarity and importance. Likewise, when participants described family in brief or cautious ways, I could sensitively follow up during interviews on issues of nondisclosure and distance. This distinction, eliciting richer accounts in collection, and situating them in context during analysis, helped ensure a nuanced and credible representation of TGDYP's experiences.

## 6.4. Results & Discussion

Reflexive TA and triangulation led to the development of three themes, each with respective subthemes (Table 6.4). Convergent and divergent perspectives are discussed throughout each theme.

**Table 6.4.**

*An Overview of Themes and Subthemes.*

| Themes | Subthemes | | Triangulation Category |
|---|---|---|---|
| 1. The Ambivalent Nature of Transition-Related Identity Loss | | | A & C |
| 2. The Psychological Benefits of Authentic, Meaningful Group Engagement with TGD Others | 2.1. | A Novel Sense of Belonging & Felt Understanding | B |
| | 2.2. | Feeling Safe to be Authentic | A |
| | 2.3. | Ingroup Knowledge Sharing as Emotional Reassurance | A & B |
| 3. The Negative Impact of Intragroup Dynamics on TGD Social Support | 3.1. | Non-Binary Exclusion: Perceived Violation of Binary Ingroup Norms | C |
| | 3.2. | Differences in Identity Content Between Online and Offline Spaces | C |

*Notes*. The coding categories for triangulation were as follows:

A) *Consistent within and present across groups* (i.e., most young people and most professionals discuss this Main Code/Sub-Code).

B) *Consistent within and not present across groups* (i.e., most young people discuss this Main Code/Sub-Code, but it is not discussed by professionals, or vice versa).

C) *Inconsistent within and present across groups* (i.e., some young people and some professionals discuss this Main Code/Sub-Code, but this is not discussed consistently within either group).

D) *Rarely mentioned in either group* (i.e., only one/a few individuals from either group discuss this Main Code/Sub-Code).

### 6.4.1. Theme 1: The Ambivalent Nature of Transition-Related Identity Loss

Gender transition is often framed as a journey toward authenticity. However, this process also brings profound social and psychological shifts. Transition can disrupt existing relationships, heighten vulnerability, and unsettle one’s sense of identity. Yet for many participants, these social losses were not as psychologically damaging as one might anticipate, since pre-transition ties were often fragile, conditional, or lacked the authenticity needed to provide meaningful support.

This tension was especially visible in the early stages of transition, which participants described as emotionally and socially precarious. Many participants feared that disclosing their identity would jeopardise valued ties. As Eddie recalled:

> *"You may well have people who feel like nobody feels the same way as them. Or that if they did come out, they'd lose all their friends, they'd lose their job, their status at work, their family [...] I remember that"* (Eddie, Trans Man).

Eddie highlights the isolating anticipation of rejection: the fear that authenticity might mean losing everything. From a social identity perspective, such fears are unsurprising. This is because transition (whether that be medical, social, or both) can alter the way TGDYP relate to, and are perceived by others, in addition to the way they experience the world (Lewis et al., 2023). Thus, transition reshapes not only self-identity but also group memberships and with them the security those ties provide (Jetten et al., 2014). Such relational shifts inevitably heighten sensitivity to how others might respond to TGDYP's authentic identities. As recounted by Charlie, who described how anticipated rejection undermined the joy of transition-related changes:

> "*Any kind of excitement I've had about any change that has happened has almost been tempered by the thought that it's going to be awkward if someone reacts to this badly*" (Charlie, Trans Man).

In these accounts, identity authenticity and rejection are held in constant tension. This perceived rejection often coincides with periods where identity is in transition and thus feels most fragile (Jetten et al., 2014). Without secure ingroup ties to buffer this, rejection sensitivity is amplified, leaving TGDYP vulnerable precisely when affirmation is most needed (Wells et al., 2020). In line with SIAH theorising, this vulnerability stems not only from the absence of supportive groups, but from what this absence means for self-definition. When social connections are weak or uncertain, the very sense of self they anchor also becomes unstable (Haslam et al, 2018). For some TGDYP, the weight of these fears led to doubts about whether they could authentically embrace their gender identity at all:

> "*It was really scary, and it felt really intimidating to have to commit to a lifestyle like that and I so I was like ohh I I'm so scared that it's clearly not what I am. I'm so I feel so apprehensive and so worried about this, that that can't possibly be what I am*" (Eddie, Trans Man).

These fears echo SIMIC's prediction that identity change becomes precarious when the continuity of valued groups is at risk (Jetten et al., 2014). Without secure ingroup ties to buffer rejection, participants faced the paradox of embracing authenticity while anticipating social loss. In this way, actual and anticipated social rejection reverberate inward, threatening both social ties and self-identity.

At the same time, many reflected that the ties they feared losing were not truly protective (also see Pulice-Farrow et al., 2020). Feelings of disconnection often predated coming out: Eddie (Trans Man) recalled "*an underlying feeling of being really different to everybody else*," while others described belonging as conditional, dependent on concealment or conformity. As Isaac described when reflecting on the cost of concealing his true identity to avoid rejection:

> *"If you're going stealth* […] *You end up hiding so much of yourself […] then I'm not authentic*" (Issac, Genderfluid/Genderqueer Trans Man).

Issac illustrates how belonging is not only about being included, but about whether inclusion allows for authenticity. His words capture the fragility of pre-transition bonds: they offered surface-level inclusion but required suppression of identity, leaving them unable to provide the resources needed for resilience. From a SIAH perspective, such ties fail to function as *social cures*, because they cannot provide authentic recognition or meaningful belonging (Haslam et al., 2018; 2024).

Family relationships highlighted this ambivalence most clearly, with some participants describing them as an anchor for continuity ("*My parents are very supportive […] I am able to live comfortably because of their support*": AH, Trans Woman), while others experienced them as a primary source of harm. As captured by Cee:

> "*I am also powerless to stop their parents from treating them poorly […] young people that are not accepted, affirmed, or treated kindly by their parents […] describe participating in our groups as a lifeline as they get to meet other young people like them*" (Cee, Young Persons Support Worker).

Cee's description makes the contrast explicit. Where family ties often failed to provide affirmation, peer groups were positioned as a "*lifeline*". This metaphor underscores that peer connections offered more than social contact: they represented survival when existing bonds were conditional, fragile, or rejecting. In line with SIMIC, this illustrates the protective value of multiple group memberships. When continuity through family was weak or harmful, identity stability was maintained through alternative ties. For TGDYP, groups of other TGD peers carried this lifeline function, providing the recognition and validation needed to hold identity steady in moments when other ties faltered.

Taken together, these accounts demonstrate the ambivalence of transition-related identity loss. On one hand, anticipated rejection and severed ties left TGDYP vulnerable, undermining confidence and stability in identity. On the other, many of these pre-transition bonds were already weak or conditional, and thus less psychologically costly to lose than more protective group memberships observed in other populations (e.g., from veteran to civilian: Wakefield et al., 2023). This resonates with research emphasising that not all social support confers the same health benefits (Chi, 2023; Rimmer et al., 2022). For TGDYP, the bonds most at risk during transition were often those least capable of sustaining them: a dynamic that helps explain why new, affirming groups became so significant, as explored in Theme 2.

### *6.4.2. Theme 2: The Psychological Benefits of Authentic, Meaningful Group Engagement with TGD Others*

As described in Theme 1, transition often involves the loss of pre-existing ties. Yet these losses were not always as psychologically damaging as might be expected since many pre-transition bonds were fragile, conditional, or reliant on concealment. What participants consistently emphasised was that belonging only became meaningful when it was rooted in authenticity, defined as relationships that allowed them to be recognised and affirmed as their true selves. For most, this was far more attainable in groups with other TGD people than with cis peers or family, whose support was often experienced as inconsistent or invalidating. Theme 2 develops this point further by examining *why* these relationships were considered so valuable, showing how TGD-specific ties offered not just affirmation but the psychological resources needed to turn vulnerability into resilience.

#### 6.4.2.1. Sub-theme 2.1: A Novel Sense of Belonging & Felt Understanding

For many TGDYP, changing social identity that accompanied transition initially felt like a loss. Yet this same process also opened up the possibility of greater authenticity and, crucially, the discovery of others with similar experiences (Wilson et al., 2024). For the first time, participants described finding a social identity that felt more meaningful and relevant than those previously available to them. This ‘lightbulb moment’ is described by J:

> "*Accepting myself […] I've had a hard time […] It's [social groups with other TGDYP] been my only saving grace really, a place I can kind of really be myself […] It was like, one of the best moments ever. Like, just kind of realizing like, oh, God, other people feel like this before. I was just like, oh, I thought it was just me. I mean when I was reading all this stuff and like oh my God, I've never read anything so relatable in my life, just like oh God, I thought I was the only one. But yeah, it's nice. It's nice to have that. Like, just like figuring out you're not alone. Other people know how it feels*" (J, Trans Female).

J sentimentally captures the transformative impact that discovering other TGDYP who shared similar experiences was for her. She describes a profound sense of validation and recognition. She is "*not alone*" anymore. Instead, her loneliness was dispelled and replaced by a comforting sense of connection and felt understanding with others. Here, recognition not only eased loneliness but validated identity. This moved J from a place of self-doubt and confusion, attributable to a lack of social identity and belonging (Jetten et al., 2018) to a position of identity affirmation and confidence.

As such, whilst TGDYP may lose some former social identities during transition, either because they feel incompatible with their new sense of self or because earlier ties lacked depth (Fernandez-Rouco et al., 2019; Garcia et al., 2019; Hajek et al., 2023), they often gained more meaningful and authentic connections with other TGDYP. These bonds were likened to familial relationships, highlighting how community connectedness took on particular significance given the complexities of relationships with families of origin and cisgender peers (Bhattacharya et al., 2021; also see Levin et al., 2020 on chosen family). Livingstone (2023) suggests that such dynamics can be explained by the limits of outgroup understanding. When people feel misunderstood by outgroups, they turn more strongly toward ingroups where felt understanding is possible. This was illustrated by Alex:

> *"It's lovely to meet people who get it, like who understand your experiences or have had experiences very similar to your experiences or, you know, just people who understand the space you're in, or the place you're coming from. I have lots and lots of cis friends but like they don't necessarily always understand what you're like or where you might be coming from so like meeting people who do is so nice and like refreshing […] the infrastructure is there, the groundwork"* (Alex, Trans Woman).

Alex highlights how recognition in TGD friendships felt positively distinct. The "*infrastructure*" she describes points to a foundation of support that gave these relationships a depth she did not find with cis peers. This depth of understanding is made possible because TGD others are more likely to share a similar social status, making support feel genuine rather than condescending (Livingstone, 2023). This parity enables perspective taking, where experiences are recognised and validated from the inside, further strengthening shared social identity and receptivity to ingroup support (Haslam et al., 2018; Livingstone, 2023).

Taken together, these accounts show that what made TGD friendships distinctive was not just inclusion, but the dependable recognition and parity they offered. This consistent, mutual validation explains *why* such ties felt more meaningful than those with cisgender peers.

#### 6.4.2.2. Sub-theme 2.2: Feeling Safe to be Authentic

As described in Sub-theme 2.1, social connections with other TGDYP were valued because they offered belonging rooted in felt understanding. Sub-theme 2.2 develops this by examining what this belonging makes possible: the chance to live more authentically. Particularly in light of exclusion and hostility TGDYP experience in wider society, relationships with cisgender peers rarely provided the safety required for authentic expression (Kuper et al., 2022). In contrast, connections with other TGDYP created spaces where they could experiment with identity and expression without fear of judgement. This sense of safety not only affirmed who they already were but also encouraged exploration of who they might become. As captured by Felix:

> *"I've seen genuine growth in people [...] you see people becoming more confident [...] It lets you also see many different versions of how you could be, and that just opens the door of like how you can be yourself and I really like that and encourages you to experiment, and you also have a safe place to try things like UM Ohh, I don't usually present like this, but I know this is a place that I can try things"* (Felix, Non-Binary).

Felix captures two important dynamics. First, safety is not only protective but generative: it "*opens the door*" for experimentation with names, pronouns, and gender expression, giving TGDYP permission to inhabit their identity more confidently. Second, seeing multiple different versions of TGD lives normalised difference, showing there are multiple valid ways to live authentically. These processes illustrate why TGD-specific ties are not simply supportive but uniquely valuable: they offer possibilities for selfhood that other relationships cannot.

Professionals working in community organisations echoed this, but from a different vantage point. Whereas Felix described personal experiences of growth within safe spaces, E.M., highlights how such environments also restored agency and power more broadly:

> "*[Young people] get to connect with their local community, be a part of more person-focused support, meet their peers in a calmer environment, be able to express themselves safely without fear of not being understood […] have a safe space to express themselves […] self-expression can be achieved, reclaiming their lives*" (E.M., Youth Empowerment Director).

Here, E.M. moves beyond immediate affirmation to describe safe spaces as a platform for empowerment. By reclaiming their ability to live authentically, TGDYP can rebuild a sense of agency often undermined in other settings (e.g., family, school, healthcare; Austin & Craig, 2015), showing that authenticity could be lived openly and sustained, even when denied elsewhere. These findings show that it is not belonging alone, but the safety it affords, that allows authenticity to flourish.

#### 6.4.2.3. Sub-theme 2.3: Ingroup Knowledge Sharing as Emotional Reassurance

Alongside providing safety and validation, connections with other TGDYP also offered something more practical: shared knowledge to help navigate the transition process. Particularly for TGDYP in the early stages, this knowledge was not just practical but vital, often compensating for the lack of reliable information from formal sources (e.g., healthcare settings, family; Scheim et al., 2024). As explained by Alex:

> *"I think people who are really early on in their transition are in a very vulnerable place usually. I know I was like community and support and knowledge like access to shared knowledge is was valuable for like invaluable for me as like a budding trans person and like I definitely I would say I probably wouldn't be where I am right now if I had not talked to actual trans people like early on in my transition because like there's no the, the information is just not out there. Like if you if you need information like talking to actual people who know the information is just it's just the most valuable thing in the world. And so like, yeah, I definitely say, like, people in earliest stage of transition they, you know, it's it. They need so much help, like and they and they and like it's it would be good to like have something for that"* (Alex, Trans Woman).

Alex highlights how those at vulnerable points of transition often turn to other TGDYP to fill gaps left by professionals. While practitioners recognised their own limitations ("*I can face* *challenges in […] providing accurate and up-to-date information*”; Minty, Clinical Social Worker), TGDYP stressed that these ingroup exchanges were not just stopgaps. What mattered was not only *what* was shared, but *who* it came from. Tress illustrated this clearly:

> *“It [TGD social support] lets you, it lets you like, raise your concerns or your problems, or any like any problems you're having with other people. And it lets, people with more experience are able to tell you. They tell you stuff like ohh well, this is how I found it or this is what happened to me. So, it kind of like gives you information and it's like so you know kind of what to expect. It makes things a lot less nerve wracking, I guess. And then people with less experience while they're able to learn from that and it's kinda, people were just passing down knowledge and it's very nice. It's, you just you're able to learn a lot more when you're not going through it on your own […] you'll only ever get the best information from people who've been through it”* (Tress, Trans Woman).

Tress shows how this knowledge sharing was accumulative and intergenerational, with those further along in their transition “passing down” wisdom to those just beginning. Yet beyond easing uncertainty, the very act of receiving advice from other TGD people was emotionally reassuring. Because it came from trusted ingroup members, the information carried more weight and credibility than guidance from outgroup professionals (Haslam et al., 2018). This credibility was particularly important given many TGDYP’s mistrust of NHS services, where referrals are often delayed or lost, and where staff lack adequate training (Wright et al., 2021). Against this backdrop, peer knowledge became not just helpful, but essential. Thus, transition, which could otherwise feel isolating or confusing, was reframed as a shared journey, sustained by collective knowledge.

Overall, Theme 2 shows *why* connections with other TGDYP were uniquely valuable. They offered belonging rooted in felt understanding, the safety to live authentically, and the shared knowledge needed to navigate transition. These ties were not just compensatory but transformative, providing recognition that cisgender peers and families often could not. Ultimately, these connections with other TGDYP were both practical and identity affirming, reassuring TGDYP that they were not alone, that others had faced similar challenges, and that a viable future was possible. In this way, TGD-specific ties transformed isolation into connection, and uncertainty into collective resilience, demonstrating why they became the most sustaining relationships during transition.

### *6.4.3. Theme 3: The Negative Impact of Intragroup Dynamics on TGD Social Support*

Themes 1 and 2 highlighted how TGD-specific friendships can buffer rejection, foster authenticity, and provide practical tools for navigating transition. Yet these benefits were not universal. Not all TGDYP were able to access TGD groups, and even when they did, support was not always experienced as affirming. Instead, intragroup tensions and the dynamics of different spaces could, at times, undermine identity rather than sustain it. In this sense, social ties that might otherwise enable Social Cure processes also carried the potential for Social Curse effects (Kellezi & Reicher, 2012), where exclusion or unhelpful norms weakened rather than strengthened identity-based support. This theme explores these ambivalent dynamics: how boundaries within TGD communities could at times narrow, rather than expand, possibilities for belonging.

#### 6.4.3.1. Sub-theme 3.1: Non-Binary Exclusion: Perceived Violation of Binary Ingroup Norms

One barrier to accessing psychological resources of ingroup support was intragroup discrimination, particularly the marginalisation of non-binary identities within TGD spaces. As Arlo explained:

> "*You can be in a queer space, but then the people there might not like trans people or like or like might be OK with trans, like binary trans people, but not OK with non-binary people* […] *There's like people who hate us because they don't understand or like have been driven by the right, tough rhetoric that just create the gender binary […] there's people like in the community who don't want us to exist either […] a trans woman said I'm just a girl adding 'they' to my pronouns to be trendy* " (Arlo, Non-Binary).

Arlo's account illustrates a painful paradox: the very communities that promise safety and solidarity can replicate the same exclusions found in wider society. Here, non-binary identities are positioned as illegitimate, a violation of implicit ingroup norms that still privilege binary gender. What might otherwise be a space of refuge instead communicates that belonging is conditional; available only to those whose identities can be read as recognisably binary. Such dynamics reflect the influence of internalised transphobia, where broader cisnormative expectations of "real" masculinity or femininity are absorbed and re-enacted within TGD communities themselves (Bockting et al., 2020; Garrison et al., 2018; Scandurra et al., 2018). This means that even within ostensibly supportive spaces, TGDYP may encounter pressures to conform with binary expressions of gender, rather than being celebrated for the diversity of their transness.

Professionals in our sample echoed this concern, noting how TGDYP often felt pressured to “pass” as cis within TGD spaces, with deviation from binary gender norms discouraged rather than affirmed:

> “*Our trans young people are constantly telling us that within the gender diverse community, their peers put pressure on them to 'pass' as cis[gender] and not to divert away from, or merge, the gender binary at all. They say that the goal seems to be to seem cis[gender], instead of celebrating the joy of transness*” (E.M., Youth Empowerment Director).

From a social identity perspective, this kind of intragroup policing is identity-undermining rather than identity-affirming (Kellezi & Reicher, 2012). It not only withholds validation, but actively communicates that some identities are less legitimate than others, stripping away the psychological resources identity-relevant group membership should confer. In this way, the potential for TGD communities to act as a Social Cure is compromised. Exclusion and invalidation transform them into a Social Curse, reproducing stigma and leaving non-binary young people without the very support that could otherwise buffer minority stress and improve wellbeing (Vincent, 2021).

#### 6.4.3.2. Sub-theme 3.2: Differences in Identity Content Between Online and Offline Spaces

Alongside experiences of exclusion, participants also described how the *content* of group interactions shaped whether TGD spaces felt supportive or harmful. Online communities are often the first point of contact for information and connection, and have been identified as vital in extant literature for TGDYP wellbeing (e.g., Cronesberry & Ward, 2024; Eickers, 2024; Herrmann et al., 2023). However, some participants found that these spaces fostered narrow or negative narratives about TGD lives. As AH explained:

> *“Online spaces. They can all become a bit echo chambering [...] and they're very chronically online, and they're very kind of. Yeah, they don't. They don't live in the moment as much [...] they don't tend to exist much. The reason that they are like that is more because they haven't had proper LGBT socialization in like real life, yeah. And I think this kind of thing could definitely really help with that, because I think it's really important for younger queer people to learn, especially from elders within the*

> *community that […] not everything has, your life isn't going to be as drastically different as you possibly think it will be"* (AH, Trans Woman).

AH highlights how online spaces can become "echo chambers" disconnected from lived experience. Previous research has already documented hostility that TGDYP encounter in digital contexts (Hughto et al., 2021; McInroy & Criag, 2015; McInroy et al., 2024). Yet, AH's account suggests that hostility is not the only problem: these spaces can also narrow the scope of TGDYP's lives, collapsing their diversity into repetitive, often negative or alarmist narratives. Thus, rather than easing uncertainty, this insularity can amplify it, leaving young people disconnected from everyday contexts of belonging.

Professionals voiced similar concerns, emphasising that online connection does not necessarily translate into meaningful support:

> "*I worry that young people are considered to be better connected socially due to technology however this means they can often access misinformation, which contributes further to their own distress*" (Sonny, Clinical Psychologist).

Sonny's account reinforces the ambivalence of online spaces. Far from guaranteeing support, they risk compounding distress by circulating misinformation and overstating the depth of connection. Taken together, these accounts suggest that while online platforms can be accessible and vital in moments of isolation, they cannot always provide the quality of affirmation or breadth of perspectives needed to sustain positive social identities. By contrast, and as highlighted in Theme 2, face-to-face spaces were described as more grounding, providing access to diverse experiences and interactions that normalised difference and validated multiple authentic TGD identities (see Charles et al., 2023 for similar processes in different communities). In this way, offline encounters may be better placed to facilitate Social Cure processes, precisely because they reconnect TGDYP's identities to lived, everyday contexts.

Overall, Theme 3 shows that TGD-specific spaces, while often supportive, can also reproduce exclusion. Non-binary identities were sometimes marginalised within TGD community spaces, while online groups risked amplifying negativity and misinformation. These dynamics reveal that social support is not automatically protective. When belonging is conditional, its benefits can be undermined, illustrating how Social Cure and Social Curse can work in tandem.

## 6.5. General Discussion

Previous literature has emphasised the buffering role of social support between experiences of gender minority stress (e.g., discrimination) and health outcomes (e.g., Diamond & Alley, 2022; Wilson & Liss, 2023). However, existing theoretical frameworks (i.e., GMST) had not considered stressors specific to TGD populations, for example, *transitioning identity stress* (DuBois et al., 2017), that may impact the function of social support between minority stress and health outcomes. In addition, a theoretical framework that allows us to understand the psychological processes through which social support is protective for health has not yet been consistently applied (Austin & Goodman, 2016; Dowers et al., 2020; Rimmer et al., 2022). While recent work by Jones and colleagues (2024) has begun to address this gap by applying the SIAH to examine the role of identity-affirming familial relationships for trans people, this focus has largely been confined to family contexts. Building on this work, the present study applied the SIAH to a triangulated data set drawn from two populations: 1) TGDYP in England (aged 18 - 26) and 2) Health, Social, and Voluntary care professionals working with this population. The aim was to understand 1) how TGDYP experience social support in response to their changing social identities (i.e., how this is protective in the face of transitioning identity stress); and 2) the psychological benefits that group memberships provide for TGDYP.

### *6.5.1. Social Support in the Context of Changing Social Identities*

Concerning our first research question, and consistent with the SIMIC (Haslam et al., 2008b; Jetten et al., 2014), identity change was experienced as a critical juncture for TGDYP. Yet, in contrast to SIMIC's assumption that the continuity of existing groups provides stability, our data revealed three challenges that complicate identity maintenance for TGDYP. First, gender transition often precipitates relational change because TGDYP cannot be authentic, making the continuation of pre-transition groups difficult (also see Doyle et al., 2023). Second, even where continuity was achieved (i.e., with family), the quality of support often declined because of limited felt understanding, reducing the psychological resources these groups provide during and post-transition. Third, many TGDYP reported limited social resources prior to transition due to loneliness, discrimination, and identity concealment, aligning with observations in extant literature (Fernandez-Rouco et al., 2019; Garcia et al., 2019; Hajek et al., 2023).

Instead, wellbeing benefits were often achieved via *identity gain*. Connecting with other TGDYP allowed participants to feel understood and to experience authentic belonging often for the first time. While SIMIC frames identity change as a potential threat to health, our findings highlight its paradoxical potential to enhance wellbeing when previous group memberships were unsupportive or inauthentic. In this sense, transition can function as a pathway into richer, more affirming social worlds. Nonetheless, the fragility of this process was evident. Some participants lost old connections without securing new ones, underlining the precariousness of social support in this context.

### *6.5.2. Social Support, Social Cure, and Social Curse Processes*

Turning to our second research question, our findings demonstrate that TGD group memberships gained throughout transition are perceived as more meaningful than relationships with family or cisgender peers because they provide felt understanding and shared identity. This echoes wider social identity research on the health benefits of belonging (Haslam et al., 2024). Specifically, TGD community belonging offered safety to live authentically, practical guidance, and emotional reassurance; resources that empowered TGDYP to pursue their authentic selves.

However, consistent with previous research, not all groups were protective (Garrison, 2018; Sutherland, 2023). In some spaces, belonging was policed through binary-based identity criteria. That is, the idea that only those TGDYP who align with cisnormative expectations of gender count as *authentically* TGD. Such criteria positioned non-binary young people as less legitimate, since their identities often fell outside cisnormative pathways. These dynamics may, in part, reflect wider narratives of validity embedded in medical systems, where access to care frequently hinges on meeting these definitions of legitimacy (also termed *medically-based identity membership*; Sutherland, 2023). Previous research has highlighted how such boundaries on group membership are often used as a strategy to legitimise TGD identities (Sutherland, 2023). However, these boundaries simultaneously delegitimise others. From a SIAH perspective, this reproduces Social Curse processes, eroding identity security and sense of belonging for non-binary young people.

A second challenge lay in group content. Online spaces, though accessible, were often saturated with negative or alarmist narratives about TGD lives, creating echo chambers that narrowed perspectives and amplified distress. While hostility has long been identified as a feature of digital climates (Haimson et al., 2020), our data suggest that the reduction of diverse, positive representations is equally problematic. This resonates with findings from other stigmatised communities, where negative ingroup norms foster maladaptive coping (McNamara & Parsons, 2016). For TGDYP, this underscores the importance of groups that offer not only safety, but also positive identity content.

### *6.5.3. Implications*

#### 6.5.3.1. Theoretical Implications

These findings refine existing understandings of the SIMIC (Jetten et al., 2014). While SIMIC emphasises the value of maintaining prior group ties, for many TGDYP these ties were superficial or conditional from the outset. In this context, gaining new, affirming memberships was more protective than maintaining old ones. This nuance suggests SIMIC requires adaptations for contexts where identity change is not simply a disruption of valued memberships but a gateway to authentic ones. Furthermore, our findings complicate SIMIC's linear framing of a singular transition point. For TGDYP, identity development is iterative, with repeated disclosures, redefinitions, and renegotiations of belonging (Fiani & Han, 2020; Taube & Mussap, 2022). Adaptations to SIMIC that reflect non-linear and pluralistic identity journeys, particularly for minoritised identities where expressed identities can be dynamic and context dependent, would be valuable.

These findings also extend recent SIAH-informed work by Jones and colleagues (2024), who highlighted the ambivalent role of parental relationships for trans people. In their work, family ties were often maintained following disclosure, yet limited felt understanding and conditional acceptance constrained their capacity to function as reliable sources of Social Cure. The present study suggests that this ambivalence is not unique to familial relationships but also characterises support from cisgender peers. While relationships with cis peers were sometimes retained during transition, they did not consistently provide the identity affirmation, shared understanding, or psychological safety required to buffer transitioning identity stress. From a SIAH perspective, this indicates that the protective value of social support depends not on relational proximity alone, but on the degree to which group memberships enable authentic identity expression and felt understanding. Theoretically, this underscores the importance of moving beyond binary distinctions between 'supportive' and 'unsupportive' relationships and instead conceptualising social support as a continuum shaped by identity alignment.

#### 6.5.3.2. Practical Implications

Practically, these findings underline the central role of meaningful group memberships in shaping TGDYP wellbeing. Rather than being peripheral, relationships with peers emerged as the primary source of belonging, authenticity, and emotional reassurance. Existing youth groups for TGDYP should therefore be supported to prioritise inclusivity and resist pressures to define authenticity in binary or medical terms (Sutherland, 2023). Facilitators play a crucial role here, not only in countering intragroup stigma but also in cultivating diverse, positive narratives of trans lives. Offline spaces are particularly valuable, providing safe opportunities for identity exploration and validation in ways that digital environments cannot consistently replicate as illustrated in our data.

Healthcare services must also recognise that identity support is not an optional extra but a core component of care. In contrast to countries that have begun adopting more holistic approaches to care (Toze, 2019; Wall et al., 2023), gender-affirming care in England has been largely medically oriented. The limits of a clinical model are especially stark for TGDYP not pursuing medical transition, where support needs risk being overlooked and medical framing can perpetuate restricted narratives of what counts as an ‘authentic’ TGD identity (Adams et al., 2017; Pitts et al., 2009; Sonja et al., 2015; Sutherland, 2023). Professionals therefore need training to understand social elements as equally important as medical aspects of transition, and to signpost TGDYP to affirming community spaces.

### *6.5.4. Strengths and Limitations and Future Directions*

To the authors’ knowledge, this is the first exploration of TGDYP social experiences that utilises the SIAH to explain how social connectedness can improve the health and wellbeing of TGDYP. This theoretical basis highlighted the psychological processes, such as felt understanding, authenticity, and identity affirmation, through which groups improve wellbeing and buffer against minority stress. The QTF also proved useful in emphasising the role of intragroup discrimination, showing how exclusion undermined the health benefits of social support for some identities, particularly non-binary youth.

Nonetheless, this study has limitations. Despite prior research showing that minority stress and access to social support is unevenly distributed across these groups (Verbeek et al., 2020), we did not differentiate systematically between TGD identities (e.g., trans men, trans women, non-binary etc.). This limits our ability to fully interrogate the nature of some exclusionary dynamics observed in the data and raises important questions about the analytic treatment of TGDYP as a single social group. For example, while experiences of non-binary exclusion were initially interpreted as intragroup discrimination, it is also possible that such dynamics reflect intergroup processes operating within a broader TGD umbrella. From a social identity perspective, this depends on the extent to which non-binary and binary trans young people experience a shared sense of group identification, common fate, and mutual recognition as ingroup members. Where these elements are weak or contested, exclusionary dynamics may function less as intragroup marginalisation and more as boundary maintenance between partially distinct identity groups. This distinction has important implications for the SIAH, as the health-protective value of group membership depends on shared identity and felt belonging. Treating TGDYP as a homogenous group may therefore obscure meaningful variation in identification and risk overstating the availability of collective social resources for some identities. Future work would benefit from examining how degrees of shared identification within and across TGD identities shape whether group memberships function as sources of Social Cure or Social Curse.

Our findings also raise questions about the balance between identity gain and identity maintenance. This research has largely identified the benefits of *identity gain* during transition. However, with growing acceptance of TGDYP by families (Horton, 2022b; 2022c), the maintenance of existing ties may also become an important pathway to wellbeing. Future research should consider how identity maintenance interacts with identity gain, and whether it provides additive or distinct benefits.

Finally, while our findings underlie the health-enhancing benefits of social support, questions remain regarding how access to positive (i.e., Social Cure) social support can be facilitated and integrating into gender-affirming care. For example, at what point in transition, and by whom, should social support be offered? How directly would social support help to mitigate against the challenges that TGDYP are experiencing within TGD healthcare? And to what degree is standardised access to social support feasible?

## 6.6. Conclusion

Our results demonstrate that while social group membership loss is common as individuals transition, the social connections they are able to make with other TGDYP as they become their authentic self outweighs this loss. They provide them with a sense of felt understanding, safety, and emotional reassurance. This provides TGDYP the psychological and practical tools they need to navigate the transition process more smoothly. Whilst intragroup discrimination and rigid boundaries of ‘authentic’ TGD identities can undermine these benefits, we outline potential ways of overcoming these barriers. Future research would benefit from exploring how social support can be integrated into TGD healthcare pathways to provide rounded care for TGDYP. The next chapter (chapter 7) explores this further.

# Chapter 7 (Study 2, Part 2)

## "I believe Social Prescribing would be the base of the trans-healthcare pyramid": Exploring the Feasibility of a PsychoSocialBio Model of Trans and Gender Diverse Healthcare.

**Availability of Data and Materials**

In accordance with Open Science Framework (OSF) guidelines and NTU's IRep depository, pseudonymised transcripts will be made available on request for two purposes: 1) for the purposes of individual scrutiny, and 2) for the purposes of reproduction and/or research in a direction consistent with this research (i.e., to be of benefit to TGD communities in ways that affirm their identities). Permission to access will be on a case-by-case basis. Supplementary documents, including interview schedules, have been made available on the OSF and can be accessed at: osf.io/xqp9h

The findings from Chapter 7 (Study 2, Part 2) have been presented at the following academic conferences:

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, September). *Exploring the Feasibility of Social Prescribing for Trans and Gender Diverse People.* European Professional Association of Transgender Health (EPATH) Sixth Conference. Hamburg, Germany. *Oral Presentation.*

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, July). Improving Healthcare for Trans and Gender Diverse People: Exploring the Utility of Social Prescribing Pathways. An invited presentation for Nottingham Young People's Gender Service CPD training session.

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, May). *Improving Healthcare for Trans and Gender Diverse people: Exploring the Feasibility of Social Prescribing Pathways.* An invited presentation for the University of Exeter. *Oral Presentation.*

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, May). "*I believe Social Prescribing would be the base of the trans-healthcare pyramid": Exploring the Feasibility of a PsychoSocialBio Model of Trans and Gender Diverse Healthcare.* INQYR: Advancing LGBTQ+ Health, Well-being & Resilience. Birmingham, UK. *Oral Presentation.*

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2024, November). *Improving Healthcare for Trans and Gender Diverse People: Adapting and Testing the Effectiveness of Social Prescribing Initiatives.* An invited presentation for the British Association of Gender Identity Specialists, Nottingham, UK. *Oral Presentation.*

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2023, August 22nd). *Improving Healthcare for Trans and Gender Diverse People: Adapting and Testing the Effectiveness of Social Prescribing Initiatives.* An invited presentation for the University of Toronto, ON. *Oral Presentation.*

## 7.1. Abstract

**Background:** Social support is critical for the health and wellbeing of transgender and gender-diverse young people (TGDYP). The NHS has recommended incorporating psycho-social support as part of gender-affirming care, but this has yet to be fully implemented. In response, this study explores the potential of Social Prescribing (SP) to address challenges faced by TGYP and enhance their wellbeing, particularly in light of recent changes to UK gender-affirming care pathways.

**Methods:** The study interviewed 20 TGDYP (aged 18 – 26) in England, and obtained open-ended survey responses from eight health, social, and voluntary care professionals working with this population. Interview and survey questions focused on the current challenges of accessing gender-affirming care, the desire for SP and how this might help TGDYP manage these challenges, and the practicalities of implementing SP.

**Results:** Findings revealed that TGDYP face novel challenges due to recent changes in English healthcare, including uncertainty in navigating care and unpredictable waiting periods. These challenges are perceived as more distressing than initial wait times or discrimination because they make living as one’s authentic identity feel constantly out of reach. However, SP emerged as a promising approach to enhance support and self-efficacy, fostering social transition and helping individuals maintain a stable social identity throughout their transition.

**Conclusion:** Despite outstanding challenges related to resource availability for implementation, this study provides a preliminary framework for integrating psychosocial support through SP within TGD healthcare to improve the health and wellbeing of TGDYP.

**Key Words:** Social Support; Trans and Gender Diverse; Gender Identity Clinics; Social Prescribing; Wellbeing.

## 7.2. Introduction

Trans and gender diverse (TGD) individuals face disproportionately high rates of poor mental and physical health compared to their cisgender counterparts (Hajek et al., 2023; White et al., 2023). Experiences of loneliness and minority stress contribute to these disparities (Hendricks & Testa, 2012; Elmer et al., 2024), leading to calls for holistic approaches to TGD healthcare in England to address these psychosocial determinants of health (Marshall et al., 2019; NHS, 2019). However, despite the recognized need for addressing psychosocial determinants of health, and plans for multidisciplinary and integrated care systems to achieve this (NHS, 2023a; 2023b), TGD healthcare remains highly medicalised. Ongoing development of new child and adolescent gender identity services intend to provision increased psychosocial support in comparison to previous TGD healthcare models (Cass, 2024a). However, this largely centres on psychological care. Thus, healthcare services in England often fail to address the social determinants of TGD health (White et al., 2023).

Despite limited development in healthcare services, research in this field shows promising advancements. Extant research has demonstrated the utility of social support for TGD wellbeing (e.g., Dowers et al., 2020; Jones et al., 2021; Wilson & Liss, 2023). The Social Identity Approach to Health (SIAH) (Haslam et al., 2024; Jetten et al., 2017) explains why social support is effective (see Chapters 2 and 6). The SIAH posits that meaningful group memberships provide psychological resources such as social connection, shared meaning, and collective efficacy (Jetten et al., 2017). These identity-based mechanisms improve emotional resilience and help TGD individuals navigate stressful encounters (e.g., difficulties accessing gender-affirming care; Charles et al., 2023; Gorman et al., 2020; Haslam et al., 2024; also see Chapter 6). Meaningful social support can also improve physical health outcomes. Whilst not explored among TGD communities, social identification-building interventions (i.e., interventions based on SIAH principles) have demonstrated improvements in mental wellbeing, immune functioning and cardiovascular health, alongside reduced mortality risk (Gleibs et al., 2011; Haslam et al., 2019; Knight et al., 2010; Steffens et al., 2019). These insights suggest that socially-focused health interventions promoting SIAH mechanisms may offer parallel benefits for TGD populations.

### *7.2.1. Social Prescribing*

One way healthcare providers in England have integrated social support into healthcare services is through Social Prescribing (SP; NHS, 2019). SP is a non-clinical healthcare initiative whereby healthcare providers connect clients to community programmes (i.e., gardening workshops, sports groups) with the intention of increasing their access to health-enhancing psychological resources that meaningful groups provide (Haslam et al., 2024; Hayes et al., 2023; also see Chapter 3). This can range from community-level initiatives (e.g., libraries and community gardens; also termed *incidental SP*; Haslam et al., 2024) through to person-centred interventions (also termed *purposive SP*; Haslam et al., 2024). In the latter, link workers (individuals who aim to holistically understand client needs) refer service users to suitable social prescriptions and facilitate their introduction to, and continued membership of, groups and activities (Haslam et al., 2024; Sharman et al., 2022). Similar to broader social identification-building interventions, SP has demonstrated positive health and wellbeing outcomes (e.g., reduced loneliness, enhanced social connectedness and quality of life) among minoritised populations (e.g., Carnes et al., 2017; Gleibs et al., 2011; Morton et al.., 2015). Research has indicated that these health-related benefits of SP are the outcomes of SIAH process (i.e., that SP is most effective when it provides access to *meaningful* groups, which unlocks SIAH social cure mechanisms; Haslam et al., 2024; Staras et al., 2024; Stevenson et al., 2019). Thus, SP can be seen as a valuable pathway for developing socially-focused health interventions that promote SIAH mechanisms. Not only could SP improve health outcomes for TGD communities, but since SP is already an established healthcare pathway in England, leveraging SP rather than building new interventions from the ground up is a more resource-efficient approach.

### *7.2.2. Challenges for Social Prescribing Implementation*

Despite the potential benefits of SP for TGD populations, several outstanding challenges exist that limit our understandings of the best way to design, implement, and evaluate these initiatives (Evers et al., 2024; Staras et al., 2024). These challenges include: 1) variability in the health-related benefits of group memberships; 2) uncertainty about whether TGD people want NHS-facilitated social support and 3) challenges integrating SP within existing healthcare pathways. Each of these will now be considered in turn.

First, research has demonstrated that the benefits of group membership are not universal (McCarty & Burt, 2024; Puckett et al., 2023; Rimmer, 2022). The SIAH explains this, delineating that access to group-based support is dependent on the degree to which one identifies with the group in question (Jetten et al., 2017). However, for TGD people, identification with TGD groups can increase exposure to discrimination, negating the health benefits of meaningful group identification (Kellezi & Reicher, 2012; Puckett et al., 2023; Sonderlund et al., 2017). In addition, intragroup discrimination such as the exclusion of non-binary individuals within TGD spaces can restrict access to the health-enhancing benefits that groups can provide (Kellezi & Reicher, 2012; McCarty & Burt, 2024; Sutherland, 2023; also see Chapter 6) Thus, it is important for research to understand how SP can be developed to harness health-related benefits for all TGD identities.

Second, while extant literature has demonstrated the health-enhancing role of social support for TGD communities (e.g., Dowers et al., 2020; Jones et al., 2021; Wilson & Liss, 2023; also see Chapter 6), research is yet to establish TGD people's desire for this to be accessed through NHS routes. This knowledge is key, particularly given TGD people's significant mistrust in healthcare providers (Carlile, 2019; Eisenberg et al., 2020; Gridley et al., 2016; Herlitz et al., 2024; Turban et al., 2017; Wright et al., 2021). This scepticism is not misplaced. Healthcare providers are often ill-equipped for managing TGD healthcare needs, both gender-related and gender-unrelated (Eisenberg et al., 2020; Turban et al., 2017). Disputes over whether the individual is 'trans enough', refusal of care, and discrimination are also commonplace (Carlile, 2019; Clark et al., 2020; Corliss et al., 2007; Gridley et al., 2016). In addition, recurrent legislative and structural changes, including closure of the young people's Tavistock and Portman's Gender Identity Development service (GIDS; a GIC specifically for individuals under 17), the Cass Review, which concluded there is a lack of evidence that medical interventions should be prescribed to trans and gender diverse young people (TGDYP; Cass, 2024), and a resultant ban on puberty blockers (Department of Health and Social Care, 2024), can leave TGD people feeling uncertain about their transition journey, further limiting their trust in healthcare providers (White et al., 2023). Thus, it is essential that research uncovers both a need and want for NHS-facilitated social support as opposed to self-directed community engagement.

Third, and relating to structural elements of SP pathways (i.e., service delivery, care coordination, and referral pathways), concerns arise pertaining to the best way to integrate SP within existing Gender Identity Clinics (GICs). Whilst SP is often delivered within a primary care practice, with the intention of creating holistic and complementary healthcare systems, at current, these are only tangentially-related services (Westlake et al., 2023). This is because healthcare providers are often unaware of how SP is distinct from existing healthcare services and therefore the capacity needed to implement these initiatives (Westlake et al., 2023). This can limit the effectiveness of SP initiatives as they become detached from the service users' medical needs, providing fragmented rather than holistic care (Evers et al., 2024; Westlake et al., 2023).

Specifically, for TGDYP within England, the novel integration of SP into existing services is increasingly difficult given extensive changes to the function and delivery of GICs. For example, the current shift from national to regional GICs (Cass, 2024a) leads researchers to question how healthcare providers can implement SP that offers equal opportunities and access to group programmes when these resources will largely differ by region. While regional GICs do permit development of more locally available SP opportunities, continual changes within GICs in England means SP needs to be responsive to this while still providing a consistent service. To achieve this, it is crucial to consider SP from a structural perspective, exploring how it can be effectively integrated into healthcare pathways at multiple levels, including referral systems, service coordination and workforce training. This approach enables standardisation of SP interventions so they can be scaled nationally whilst remaining adaptable to local needs. Without this approach, SP risks becoming another fragmented service that does not fully address psychosocial needs of TGDYP (e.g., Evers et al., 2024).

Finally, in order to determine how SP can best complement existing GIC services to provide holistic, rather than fragmented, care, we need to understand the key challenges that TGDYP face navigating these services. Whilst a significant body of work has outlined these challenges (e.g., Carlile, 2019; Corliss et al., 2007; Eisenberg et al., 2020; Gridley et al., 2016; Turban et al., 2017), the recent changes to GIC provision in England raises the question of whether these obstacles remain the same or differ. Indeed, simply changing healthcare provision itself can increase minority stress, negatively impacting one's mental health, because it leaves them feeling uncertain (White et al., 2023). Subsequently, understanding these key challenges as well as thinking about the ways in which SP can help mitigate their associated stressors is vital.

### *7.2.3. This Study*

Based on evidence indicating the health-enhancing role of social support for TGD people, and the potential to leverage SP as a pathway for facilitating equal access to meaningful social support, the present research aimed to understand how SP can be best implemented within GICs[14]. Specifically, this research explores the perceived value of SP among TGDYP (aged 18 – 29).

While the rationale for focusing on TGDYP has been introduced in earlier chapters (see Chapters 1 and 4), it is important to further emphasise why this age-specific focus is essential

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[14] We focused on GICs, as these clinics represent the primary point of access for gender-affirming care for TGD individuals.

in the context of this empirical analysis. This is because the experiences of TGD individuals vary across the lifespan, necessitating age-specific approaches to SP interventions (Breder & Bockting, 2023; Li et al., 2021). Compared to older TGD individuals, young people often experience greater social vulnerability and instability, with fewer established support networks to rely on (Breder & Bockting, 2023). This period of emerging adulthood is characterized by identity exploration, shifting social structures, and ongoing psychosocial development (Arnett et al., 2014), meaning SP interventions for younger individuals must be more flexible to accommodate these evolving needs. Unlike older TGD populations, who may benefit from reinforcing existing social ties, younger people may require interventions that actively facilitate new support networks and identity-affirming connections (Breder & Bockting, 2023). Thus, a focused TGD age cohort was necessary to ensure SP meets the psychosocial needs of specific groups, with TGDYP identified as the most vulnerable subpopulation in need of tailored social support (e.g., SP; Burgwal et al., 2020; Jackman et al., 2018). By centring this study on the 18–29 age group, we aim to explore how SP interventions can be tailored to mitigate the long-term psychosocial consequences of systemic barriers and provide meaningful, developmentally appropriate support.

In addition to TGDYP, data was also obtained from health, social, and voluntary care professionals working with this population. Their perspectives were included to capture service-level constraints and resource considerations that TGDYP themselves may not have full visibility of, but which are critical for the development and delivery of SP. The following research questions were explored:

1) What are the key challenges experienced by TGDYP when navigating TGD healthcare in England, and how can Social Prescribing mitigate against these challenges?
2) How do TGD professionals and TGDYP perceive the integration of Social Prescribing into existing GIC services, and what challenges arise from this?

## 7.3. Methods

The methods and data outlined in this section are derived from the broader research project described in Chapter 6, which explored the environments in which social group memberships are helpful and or/unhelpful for health. With Chapter 6 identifying which types of social support are likely to encourage positive health outcomes, Chapter 7 shifts the focus to the development and implementation of SP to facilitate access to social support identified as health enhancing. For transparency, our initial pre-registered research plan proposed analysing the data in Chapters 6 and 7 as part of a single study (see osf.io/xqp9h). However, due to the unique challenges of integrating SP into existing healthcare pathways, a more focused analysis was required to thoroughly examine SP's feasibility and implementation. As such, the design, participant recruitment, data collection and analysis methods remain consistent, but with different emphasis for theme generation and subsequent conclusions.

### *7.3.1. Design*

Data from interviews with TGDYP, and open-ended survey responses from health, social, and voluntary care professionals working with these populations were collected. This qualitative approach was deemed appropriate for the present chapters' research questions given the adaptation of SP for TGDYP is novel. Thus, several pertinent questions exist relating to TGDYP's desire for NHS-facilitated social support and, if suitable, how SP could complement existing GIC services. Rich qualitative data allows researchers to explore these questions prior to adapting and testing the effectiveness of SP with TGDYP to ensure appropriate design and implementation of SP for these groups. This is important because ill-fitting SP can result in worsened health outcomes as a result of provisioning unmeaningful social support (Haslam et al., 2024).

### *7.3.2. Participants and Recruitment*

Twenty TGDYP (aged 18 – 26[15]), and eight health, social, and voluntary care professionals working with these populations, recruited through opportunity and snowball sampling (see Hughes et al., 2021; Mikulak et al., 2021; Owen-Smith et al., 2016 for similar methods with these populations; see Table 6.1 and Table 6.2 in Chapter 6 for participants demographic information):). Including both stakeholder groups was important to understand young TGDYP's desire for SP, how they envision 'good' SP to look, and how professionals believe that this could be practically achieved within the confines of GIC resources.

### *7.3.3. Data Collection*

Semi-structured interviews with TGDYP were conducted, and open-ended survey responses from professionals were obtained. However, this portion of the interviews (for young people) and survey questions (for professionals) focused on perceived benefits of SP (e.g., "*how do you think social prescribing could be beneficial for TGDYP*"), preferred structure and format of SP (e.g., "*what would be the ideal circumstances for these social groups*"), and the practicalities of SP implementation (e.g., "*what resources are currently available, if any, to*

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[15] Although our intended age range was 18–29 as previously justified, the upper limit of 26 reflects the age of the oldest participant recruited.

*facilitate implementation of social prescribing*; see osf.io/xqp9h for the interview schedule and survey questions). Immediately following interviews, the first author made notes in relation to the research questions to reflect on during analysis. Interviews were transcribed verbatim, facilitated by Microsoft Word, and uploaded to NVivo14 for analysis. Open-ended survey responses were downloaded from Gorilla, compiled into respective documents for each participant, and uploaded to NVivo14 for analysis.

### *7.3.4. Data Analysis*

Reflexive Thematic Analysis (RTA) facilitated by the Qualitative Triangulation Framework (QTF) was conducted. However, in this study, the focus of the analysis shifted from identifying when and how social support was health enhancing (Chapter 6), to considering how this meaningful social support can be leveraged to develop SP interventions for TGDYP.

RTA was appropriate given it allows themes to be developed that have clear implications for practice (Braun & Clarke, 2021; 2022a). This was key as the present research aimed to translate research findings into guidelines for practical health-enhancing interventions (i.e., SP) for TGDYP. Tantamount to Chapter 6, the present study adopted a pragmatic approach to RTA, where the usefulness of codes and themes are determined by their practical applications (Morgan, 2014). In this context, while the analysis was deductive in nature, guided by the SIAH framework to understand what makes SP effective (e.g., Haslam et al., 2024), it also incorporated inductive elements to explore alternate perspectives raised by participants. This combination of deductive and inductive approaches was crucial because resource limitations (McKechnie et al., 2023) and challenging political climates (Moon, 2024) within TGD healthcare may constrain the flexibility of SP development. By embracing both approaches, this pragmatic, pluralistic methodology allowed the research to consider diverse ways in which SP could be effectively implemented for TGDYP, given the current social and political context.

The QTF was also pertinent given 1) there are within-group differences among TGDYP's experiences (e.g., increased challenges experiences by non-binary individuals; see Chapter 6; Verbeek et al., 2020); and 2) there are differences between TGDYP and professionals regarding perceptions of what healthcare polices, and group memberships are (and are not) health-enhancing (Jackson et al., 2023; Scheim et al., 2024; see Chapter 6). Thus, the QTF enabled analysis to identify how SP could be developed to consider differing needs among TGDYP, and how this might contradict or challenge professionals' perspectives on what is helpful and achievable within GICs.

For example, although bureaucracy was widely identified as a barrier to GAC, professionals described it as inefficiency in the system, while TGDYP emphasised its emotional and recurrent toll. This revealed divergence in how bureaucracy was experienced. Further, broad agreement was observed on the value of SP pre-medical transition, but a small sub-set stressed the importance of continued support post-medical care. Highlighting this divergence was key to ensure analyses reflected experiences across transition, particularly where the majority of participants were pre-transition and thus largely did not consider their post-medical care needs. Differences were also evident in the way SP was valued. Some TGDYP described it as central to wellbeing, where others explained how physical dysphoria would be a barrier. In addition, professionals often framed all peer support delivered through SP as universally beneficial, whereas TGDYP highlighted shifting social support needs across transition. Taken together, the QTF demonstrated that while commonalities existed, careful attention to divergence and intragroup variation was critical in developing themes that captured the complexity of TGDYP's needs (see Table 7.1).

**Table 7.1.**
*How the QTF Informed Final Theme Development*

| Final Theme | Triangulation Insights | How This Shaped the Theme |
|---|---|---|
| Bureaucracy of TGD Healthcare | Category A: Both groups identified bureaucracy as central. Category B: Professionals framed it as systemic inefficiency; TGDYP described the ongoing psychological toll of recurrent barriers. | Led to framing bureaucracy as both structural and embodied, highlighting how system design and lived experience intersect to reproduce harm. |
| Navigating Beyond Bureaucracy: The Role of Social Prescribing Across Transition | Category A: Broad agreement on the importance of social support for transition. Category C: While most stressed its pre-medical value, a smaller subset emphasised continued relevance post-medical transition. | Ensured the theme spanned the whole transition spectrum, not just early stages, and positioned SP as both preparatory and sustaining. |
| Considerations for Social Prescribing Implementation | Category C: Intragroup differences among TGDYP, with some valuing social support while others felt physical dysphoria limited engagement. Category B: Professionals often saw peer support as universally beneficial; TGDYP stressed shifting needs across transition stages. | Highlighted the need for flexible, stage-sensitive, and cyclical models of SP provision, moving beyond one-size-fits-all approaches. |

#### 7.3.4.1. Reflexivity

Given these methods are consistent with Chapter 6, this section avoids redundancy by focussing on how the first author's positionality influenced analysis.

Our analysis centred on how SP could be developed to mitigate against existing challenges experienced within GICs by TGDYP. My own experience with these GIC services allowed me to explore this in more depth. For example, my understanding of the multi-stage approach to GIC access (which often is not communicated in broader knowledge bases; e.g., on GIC websites or extant literature) meant that I knew to ask about challenges at each stage of TGDYP's transition journeys to provide a nuanced understanding of young TGDYP's experiences beyond just the access challenges that are often reported in extant literature (e.g., long waitlists; White et al., 2023). Working collaboratively with GICs also allowed me to resonate with the challenges identified by professionals regarding SP implementation. This meant the results of the research could develop practical solutions that meet the needs of

TGDYP whilst adhering to potential restrictions (e.g., limited staffing). These are just a few examples; however, analysis demonstrates additional ways in which my positionality permitted a detailed understanding of the obstacles experienced by TGDYP, and how SP can mitigate some of these challenges.

## 7.4. Results and Discussion

RTA facilitated by the QTF led to the development of three themes, each with two subthemes (see Table 7.2). Convergent and divergent perspectives are discussed throughout each theme.

**Table 7.2.**

*Summary of Themes and Subthemes.*

| Themes | Subthemes | | Triangulation Category |
|---|---|---|---|
| 1. Bureaucracy of TGD Healthcare | 1.1. | Systemic Inefficiencies | A & B |
| | 1.2. | The Psychological Impact of Recurrent Bureaucratic Barriers | A & B |
| 2. Navigating Beyond Bureaucracy: The Role of Social Prescribing in Supporting Social Transition | 2.1. | Creating Stability: Social Prescribing for Social Transition Pre-Medical Transition | A |
| | 2.2. | Social Prescribing Post-Medical Transition: Navigating New Social Realities | C |
| 3. Considerations for Social Prescribing Implementation | 3.1. | Navigating the Interplay of Physical and Social Dysphoria | C |
| | 3.2. | Limited Infrastructure for Diversity in Group Provision | B |

### *7.4.1. Theme 1: Bureaucracy of TGD Healthcare*

Bureaucracy was experienced by both professionals and TGDYP as the defining feature of GAC. However, divergence illuminated by the QTF highlighted how this was conceptualised in markedly different ways. For professionals, bureaucracy appeared as a structural inefficiency, where lack of clarity, poor training, and limited services hindered effective care. For TGDYP, the impact was more visceral. Bureaucracy was lived as a constant and exhausting stressor that destabilised identity and threatened hope. This theme examines both dimensions, showing how bureaucratic systems reproduce minority stress within healthcare itself.

#### 7.4.1.1. Sub-Theme 1.1: Systemic Inefficiencies

Professionals consistently described GAC as fragmented and illogical. Minim, a Gender Specialist, reflected on the absence of clear or timely routes:

> "*What GIC services? Right now. If you are 16. There is no clear path. There is no timely option. This in and of itself is an irreversible path. Transfer to adult services is clunky*" (Minim, Gender Specialist)

Here, bureaucracy manifests as a void: complicated services that leave TGDYP stranded between services. This is not only an obstacle, but derails progression altogether. The "*irreversible*" nature of these delays highlights their permanence and continued impact. Thus, bureaucracy is not simply delay as captured in extant literature (Mikulak et al., 2021), but a structural flaw: services are configured in ways that prevent logical or timely progression.

Other professionals built on this point, describing how poor service configuration extended beyond pathways to professionals themselves. Just as service navigation and referral processes lacked coherence, so too did staff training and resourcing, leaving even motivated professionals unable to mitigate system failures:

> "*I am unable to provide our 12–17-year-olds with any real hope […] I am also powerless to stop their parents from treating them poorly […] staff in these areas are also seriously lacking in training around gender*" (Cee, Young Persons Support Worker).

Cee's words illustrate how systemic gaps translate into everyday professional inaptitude. Without adequate training, resources, or referral pathways, staff are unable to meet even basic needs. This reveals bureaucracy not as a neutral structure, but as one that actively strips away the capacity of professionals to offer meaningful care. In this way, inefficiency multiples, blocking TGDYP from progressing through GAC services while simultaneously preventing staff from intervening effectively.

#### 7.4.1.2. Sub-Theme 1.2: The Psychological Impact of Recurrent Bureaucratic Barriers

While professionals described bureaucracy as fragmented and illogical, TGDYP emphasised how these same flaws were felt in their everyday lives. What appeared to professionals as inefficiency or lack of training became an ongoing stressor. Bureaucratic barriers were not discrete hurdles that could be overcome with patience, but recurrent obstacles that shaped TGDYP's emotional landscape. This included updating documents, tracking referrals, rehearsing for assessments, and facing opaque communication from services (see Table 7.3 for exemplar quotes). In this sense, bureaucracy was not external to their lives but embedded within them, destabilising their sense of security and ability to plan a future as their true selves. Charlie, who was on a GIC waitlist, captured this sense of despair and futility:

> *"So, it kind of feels like you're put on a waiting list until you do actually, to be blunt, kill yourself and then you're not on the waitlist anymore and that's what you get to, and I'll be honest that you get no information about what's going on and kind of ignored"* (Charlie, Trans Man).

**Table 7.3.**

*Summary of Bureaucratic Challenges and Exemplar Quotes.*

| **Bureaucratic Challenge** | **Exemplar Quote** |
|---|---|
| Rumination Over GIC Process | *"I spend a few hours a week like rehearsing what I'm going to say to GIC doctor"* (Issac, Gender Fluid Trans Man). |
| Updating Identity Documents | "*I had to update my passport and my driving license [...] I had to legally change my name*" (A.H., Trans Woman). |
| Overseeing Own Referral Timeline | "C*ertain documentation was missing from my transfer stuff and if I hadn't been the one that caught that, I would have had to wait another couple of years to be seen by them*" (A.H., Trans Woman). |
| Managing Unrelated Healthcare Needs | "*They relate everything or any possible issue that I have back to ohh well, you've told us that you're trans [...] how is me being asthmatic and having a chest infection, anything to do with being trans?*" (Charlie, Trans Man). |

Charlie's account highlights how poor communication from GICs produced more than frustration: it created existential uncertainty. With no clear information about what would happen or when, waiting became synonymous with abandonment. Rather than functioning as a neutral pause before accessing care, waitlists for GAC were lived as indefinite suspension ("*there was no light at the end of the tunnel*": T, Trans Man). In this way, bureaucracy reproduced minority stress by amplifying existing feelings of neglect (Garcia et al., 2019).

Assuming TGDYP are able to navigate long waitlists, barriers did not disappear but shifted form. GIC assessments brought their own bureaucratic demands around strict, binary gender presentation and mental capacity. Issac reflects on the psychological toll of preparing for these obstacles:

> *"I spend a few hours a week like rehearsing what I'm going to say to GIC doctor [..] how can I convince them that I'm simultaneously mentally ill enough to deserve care but not mentally ill enough to be unable to consent to care, despite they made me more mentally ill because they kept me waiting for so long you know, that's how I fill my hours when I could be doing literally anything else"* (Issac, Gender Fluid Trans Man).

Issac laments the time he spends preparing for GIC interactions. Rather than enabling open disclosure, care is accessed by performing a version of oneself that aligns with restrictive clinical expectations (Chew et al., 2020; Wren, 2019; Wright et al., 2021). Thus, while adolescence and emerging adulthood are often periods of identity exploration, GIC protocols instead demand certainty, compounding distress (Anderson et al., 2020; Horton et al., 2024; Sansfaçon et al., 2020). Such expectations can push TGDYP toward inauthentic gender presentations, undermining identity authenticity and stability (Neville et al., 2021).

Despite these challenges, TGDYP worked to meet GIC expectations in the hope that diagnosis would secure care and enable authentic living. However, this expectation was rarely realised. Instead, new frustrations emerged in the ongoing management of care, where delays, miscommunication, and shifting expectations continued to erode trust. Cameron, who was further along in their transition than Charlie and Issac, described how these obstacles accumulated rather than diminished:

> *"To be honest, like the whole wait from like complete start to complete finish, it's probably about what I was expecting, so it's not actually the wait time that I found so difficult, it's literally like the expectations of things being like this will happen soon. This will happen within a couple of weeks and it not being that's the case at all and*

*also the like the lack of communication and the inability to actually like get any answers about it"* (Cameron, Non-Binary Trans Masculine).

Cameron highlights how access to GIC care is like opening Pandora's box. Far from offering resolution, each stage of the GIC process generated new delays and opaque rules, making the pathway feel endless. What emerges here is not just frustration but the sense that care itself is unreliable. This unpredictability made it impossible to envision a clear trajectory through transition, leaving identity work suspended in a cycle of uncertainty. Here, the very structure of care became destabilising: by offering expectations that could not be met, GICs fostered a sense of perpetual suspension, where TGDYP's efforts to secure stability were continually undermined by the system meant to provide it.

Overall, Theme 1 demonstrates how bureaucracy was experienced not merely as an administrative inconvenience, but a structure that restricted access, eroded trust, and produced psychological strain. For professionals, it appeared as inefficiency; for TGDYP, it was lived as abandonment and endless suspension. Ultimately, bureaucracy shaped experience not through isolated delays, but by embedding uncertainty and mistrust into every stage of GAC.

### *7.4.2. Theme 2: Navigating Beyond Bureaucracy: The Role of Social Prescribing in Supporting Social Transition*

Theme 1 highlighted how bureaucracy defined experiences of GAC. Against this backdrop of systemic and psychological strain, SP emerged as a critical source of support across multiple stages of transition. Subtheme 2.1. examines the benefits of SP in supporting social transition *before* individuals begin accessing medically-focused care. Subtheme 2.2. shifts the focus to the period *after* accessing medically-focused care, exploring how social support gained through SP could help TGDYP adjust to social life in their transitioned gender.

#### 7.4.2.1. Sub-Theme 2.1: Creating Stability: Social Prescribing for Social Transition Pre-Medical Transition

In the absence of timely medical care, social transition (defined as social changes one undertakes to live socially as a gender different from their sex assigned at birth e.g., name change, clothing, pronouns, haircuts etc.; Turban et al., 2021) became a crucial step for TGDYP. Social transition can foster self-acceptance and connection, but it is difficult to navigate without supportive structures (Doyle, 2022). SP could provide these structures by linking TGDYP to groups that affirm their identities, creating a stable foundation for wellbeing

(Bosse et al., 2023). Cameron reflects on how vital these supportive group structures were for their wellbeing before medical care became accessible:

> *"I think that socially transitioning was the most important thing that I needed to do like for myself. I don't think I would have, um, been able to survive a life where I had to just pretend to be a woman for my whole life. Like, you know, like gender affirming healthcare in terms of top surgery and testosterone is one thing and that is something that, you know for me is really, really important but I think even more so being able to socially transition and being able to have people in my life who, like, know that I am nonbinary like a non-binary […] and respect my pronouns and my name"* (Cameron, Non-Binary Trans Masculine).

For Cameron, social transition was not supplementary but foundational: it was the step that made life liveable. While medical interventions were important, authentic social ties provided a meaningful social identity, anchoring self-identity and buffering distress (Haslam et al., 2018). This illustrates why SP has potential to be transformative: it could provide consistent opportunities for identity recognition, particularly for those without affirming family or peer networks (Doyle et al., 2023; Gonzalez-Mendiondo et al., 2024; Chapter 6).

Where Cameron highlights *why* social transition matters, Tress explains *when* such support would be most valuable:

> "*It [Social Prescribing]'s going to help you feel a lot better about yourself generally and kind of just give you that experience where you are free. You can make it that time where you're able to socially transition* [in reference to the time being on a waitlist] *and make that part easier. If you make that bit easier then when you get to the medical bit you know what you want to do. It's not any different to how you feel and you're just kind of living the same life, you're just maybe taking medicine or you're getting surgeries*". (Tress, Trans Woman).

Tress reframes waiting not as wasted time but as a crucial period for developing authenticity. With SP, this liminal stage could become a foundation for continuity, allowing TGDYP to live authentically while preparing for medical transition; a notion further reflected by professionals ("*Engagement with this helps with the 'readiness' part of the assessment*": Sonny, Clinical Psychologist). This reflects the SIMIC model which highlights the health benefits of identity continuity: when new identities (e.g., as one's affirmed gender) can be carried forward across life transitions, they buffer disruption and sustain wellbeing (Jetten et al., 2017). In this way, socially transitioning during the waitlist period means later medical changes can be integrated into an already stable identity, rather than experienced as a destabilising rupture.

Taken together, these accounts illustrate how SP could create stability for TGDYP during the uncertainty of awaiting medical care. By facilitating identity development and recognition, SP has the potential to buffer the dislocation caused by bureaucratic delays. Rather than leaving TGDYP suspended in uncertainty, structured access to affirming social ties could anchor identity, foster resilience, and provide a foundation from which medical transition can be navigated with greater confidence.

#### 7.4.2.2. Sub-Theme 2.2: Social Prescribing Post-Medical Transition: Navigating New Social Realities

While much focus is placed on pre-medical transition support (i.e., supporting TGDYP on long waitlists and facilitating GIC readiness), participants emphasised the value of SP extending beyond this point. As Sonny explained:

> "*I believe it [Social Prescribing] could work well and could be appropriate throughout the care pathway i.e. pre- and post- diagnosis dependent on person-needs*" (Sonny, Clinical Psychologist).

This emphasis on adaptability to individual needs highlights how SP's value is not confined to preparing TGDYP for medical intervention but remains relevant in navigating the challenges that persist beyond it (Branje et al., 2021). Lucky's account illustrates *why* social support matters post-medical transition:

> "*What I'm infinitely aware of is that I didn't grow up learning how to intimidate people with my presence or how to protect myself. I grew up being quiet or being made to feel weird for being masculine or for being boisterous or any of these things. These weren't traits I was supposed to have, so I don't have them [researcher: yeah]. And it's odd navigating a world with an experience as a woman while not living as a woman"* (Lucky, Gender Queer Trans Man).

Lucky highlights the limitations of current models of care. Medical interventions could reduce bodily incongruence, but they did not erase the effects of being socialised into a gender role that constrained authentic expression. This leaves TGDYP without the social palette to navigate life as their transitioned gender, particularly in contexts governed by rigid gender norms. In this way, social invalidation can persist despite satisfaction with medical transition as TGDYP do not feel they identify or meaningfully belong to gendered groups. Without affirmation from others, the sense of security gained through medical transition risks being undermined (Cahill et al., 2025). SP was seen as a way to address this gap, as described by Vesper:

> "*You do face the fear of I am not a cis woman or a cis man so will I be accepted in that?* […] so *it [Social Prescribing] is absolutely essential alongside medical stuff […] having non-medical related stuff. Yeah. God yeah, it's needed […] I just need to be accepted*" (Vesper, Non-Binary Femme).

Together, these accounts highlight how medical interventions cannot guarantee smooth entry into gendered spaces. Conversely, SP was viewed as a valuable tool for provisioning stable social worlds that affirm diverse TGDYP identities, reducing the risk of rejection. In this sense, SP is not simply adjunct to medical care, but a response to the social dimensions of gender that current models of transition overlook. This reframes transition from a solely medical process to recognising social identity validation as a core component of TGDYP's quality of life.

Overall, Theme 2 demonstrated that SP was viewed by both professionals and TGDYP as valuable across the transition journey. Its potential lies in provisioning meaningful social ties that validate identity and provide continuity; resources that medical interventions alone cannot guarantee. Before medical care, SP can anchor identity through affirming relationships, easing entry into GIC assessments. After medical care, it can sustain belonging and help young people navigate shifting social expectations. By embedding recognition, stability, and authenticity within transition pathways, SP offers not just social enrichment but a means of withstanding the uncertainty and strain produced by bureaucratic systems.

### *7.4.3. Theme 3: Considerations for Social Prescribing Implementation*

While SP holds promise for addressing the psychosocial challenges experienced by TGDYP, participants also identified barriers to its effective implementation. These challenges were not simply practical but conceptual, reflecting tensions between different forms of dysphoria, diverse preferences for social support, and the non-linear nature of transition (Doyle, 2022; Sansfaçon et al., 2020). Subtheme 3.1. examines different preferences for support, while subtheme 3.2. considers how SP delivery must be structured to accommodate this diversity.

#### 7.4.3.1. Sub-Theme 3.1: Navigating the Interplay of Physical and Social Dysphoria

A key consideration for SP is that TGDYP do not enter transition with identical priorities. For some, the most urgent concern was physical dysphoria, where distress stems from incongruence between the body and gender identity. For others, it was social dysphoria; the misrecognition or invalidation of their identity by others. These experiences often overlapped, shaping both the perceived value of SP and the conditions under which it could be effective. As described by Alex:

> "*A lot of my dysphoria it came from like physical, physical dysphoria. So, like looking in the mirror and just being very unhappy. […] I completely understand those who like need to socially transition and need to like get it out there so that people can start using the correct pronouns for them and stuff like that, but that's less of a factor for me I think*" (Alex, Trans Woman)

Alex acknowledged the importance of social recognition for others, but highlights that SP cannot directly resolve the embodied distress of physical dysphoria. This reveals an important tension; while SP can provide affirmation and belonging, these benefits may remain inaccessible if TGDYP feel overwhelmed by their bodies. Thus, even where SP opportunities exist, engagement may be constrained unless medical and social needs are addressed together.

Professionals echoed this point, emphasising that physical dysphoria often prevents TGDYP from participating in the very activities designed to support them:

> "*Our young people are reporting fear of leaving their homes in outfits that feel gender affirming to them*" (E.M., Youth Empowerment Director)

E.M. highlights how physical and social dysphoria converge. Fear of visibility prevents TGDYP from accessing affirming spaces, foreclosing the benefits of social support before they can be realised. This underscores that SP cannot be treated as a standalone intervention: for some TGDYP, medical transition is a necessary precondition for social engagement.

This perspective was reinforced by professionals who stressed the interdependence of social and medical care:

> *"Community is often the key to wellness. However, transgender young people still ultimately need access to suitable healthcare for Social Prescribing to be truly meaningful"* (Cee, Young Persons' Support Worker).

Cee’s words capture a central insight: SP is best understood as complementary rather than alternative. It can buffer the instability of social dysphoria by embedding TGDYP in affirming communities, but its effectiveness depends on parallel access to medical care, particularly for those whose distress is rooted in bodily incongruence. This suggests that SP must remain flexible. For some TGDYP, SP’s role will be central in sustaining identity recognition, especially where body-gender congruence is not an aspiration for all (e.g., Anderson et al., 2020; Cahill et al., 2025; Galupo et al., 2021). For others, it will be secondary until physical needs are met.

#### 7.4.3.2. Sub-Theme 3.2: Limited Infrastructure for Diversity in Group Provision

A further challenge for SP is not whether it should be provided, but *how*. Participants highlighted that the types of groups most useful varied not only between individuals but across different stages of transition. Compared to professionals who often saw peer support as equal, TGDYP emphasised that support needs were dynamic rather than fixed, with early stages often requiring structured support and later stages calling for activity-based spaces. As Issac explained:

> “*You’ve got the questioning stage […] you get really excited, and you’ve just discovered this brand-new part of yourself, but also you’ve discovered all of the social oppression that goes with it […] so I think those [socially-prescribed] groups, really valuable for people in their early stages of transition, especially if they’ve got positive role models from a range of backgrounds. And then as you go towards, you know, early social transitions where they’re getting the support [from socially-prescribed groups] to try out new names and just being themselves. But then as you get into like later transition stages […] [they might feel] ‘this is sorted now. I want to do [activity based rather than support based] things’*” (Issac, Genderfluid/Genderqueer Trans Man).

Issac’s account shows that what counts as meaningful support shifts with identity development. In early transition, vulnerability and isolation demand structured environments where names, pronouns, and identities can be safely tested. These spaces provide the first scaffolding for a meaningful social identity (Haslam et al., 2024). Yet as identity becomes more stable, participants sought spaces less about support, and more about participation: opportunities to live as themselves in everyday contexts:

> *“We don’t necessarily need support. We just need space to be trans*” (Lucky, Gender Queer Trans Man).

Lucky highlights a gap in current social support provision, with social spaces often designed for early-stage support. This gap undermines identity continuity as TGDYP cannot carry a stable sense of belonging across transition stages if opportunities for participation fall away. The consequences of this absence were articulated further by Lucky in their calls for parity with cis peers:

> "*I think we need as much variety as cis kids have cause young cis people have free reign of all the sport groups […] Trans people have the barrier of 'is this a safe space for me?' So I want to see trans equestrian groups and like and swim clubs and brass bands, things that are explicitly queer and trans safe so that the trans theatre kid can go do something they wanna do without being worried if they're gonna be safe in that space or the trans sports kid is gonna be able to go play a sport they love without being worried about their safety or sacrificing presenting the way they want to, just so they can play sport. I will. I want trans kids to have as many options as cis kids have*" (Lucky, Gender Queer Trans Man).

These accounts underscore a central tension: SP has the potential to unlock identity-affirming participation, but only if infrastructure expands to provide diverse and safe opportunities. Without this, TGDYP remain constrained, unable to engage in the everyday pursuits that cement belonging.

At the same time, identity development was not always experienced as a linear progression from *support* to *activity*. Other participants described a more cyclical process:

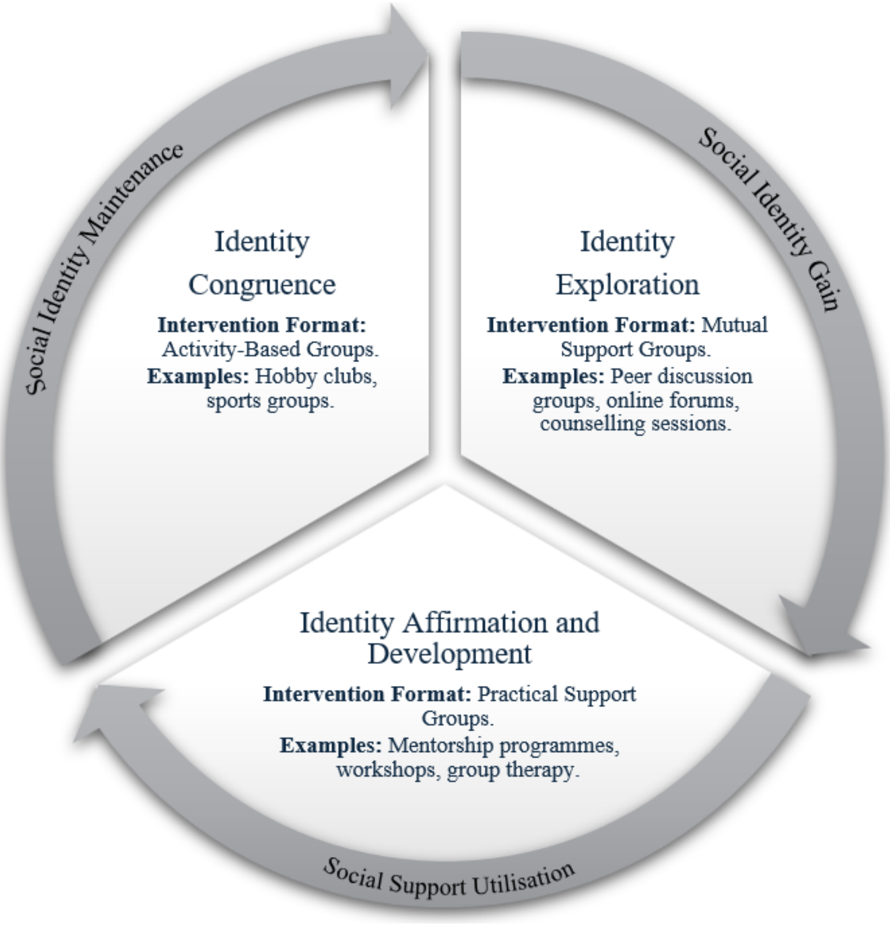
> "*I am one of the people who jokes about having been every letter of the LGBT because it's quite accurate […] I identified as a lesbian for a long time […] I find out about trans men […] thought at that point for a while that I was trans […] went back in the closet […] started getting these feelings about gender again […] trying to find an identity […] new understandings kept surfacing*" (Eddie, Trans Man).

Eddie's narrative illustrates that identity exploration can recur, not because of incorrectly recognising one's identity, but because gender is contextual and dynamic. This underscores the need for SP to be not only stage-sensitive but also cyclical and flexible. Support cannot be assumed to develop from questioning to resolution; it must accommodate retreat, re-emergence, and reconfiguration over time. This cyclical model is visually represented in Figure 7.1, which illustrates how individuals may move between stages of transition and require differing types of support at each stage.

Taken together, Theme 3 highlights that SP cannot be approached as a one-size-fits-all intervention. Instead, its success depends on responsiveness to the evolving, cyclical, and sometimes competing needs of TGDYP. Current infrastructure falls short. Without diverse SP provision, SP risks reproducing the very instability it seeks to buffer. To be effective, SP must provide both support-based and activity-based opportunities, while remaining flexible enough to accommodate the recursive nature of identity development. Only in this way can SP sustain the identity continuity and belonging that underpin long-term wellbeing (Jetten et al., 2014).

**Figure 7.1.**

*A Cyclical Model of Social Support for Gender Transition.*



*Note.* A cyclical model of social support, where individuals move between stages such as questioning, early transition, consolidation, and re-questioning. This reflects participants' experiences of transition as an ongoing process, highlighting the need for SP services that are flexible, continuous, and responsive across evolving gender journeys.

## 7.5. General Discussion

Extant literature has outlined the health-enhancing nature of social support (e.g., Haslam et al., 2024), particularly for TGD communities (Doyle, 2022; see Chapter 6). This has prompted NHS services to consider more holistic approaches to TGD healthcare (NHS, 2023a; 2023b). However, research and healthcare services have been unable to establish how to integrate social support into GIC provisions. Responsively, the present study collected qualitative data from TGDYP (aged 18 – 26) living in England, and from Health, Social, and Voluntary care professionals working with this population to explore how SP could complement existing GIC services. This research drew on the SIAH to understand how the benefits of meaningful social engagement (e.g., social support, a sense of meaning in life, belonging), that can be encouraged by SP (Haslam et al., 2024; Staras et al., 2024), may allow TGDYP to better navigate TGD healthcare, and thus how we can include SP as an integral part of TGD healthcare.

Concerning our first research question ("*What are the key challenges experienced by TGDYP when navigating TGD healthcare in England, and how can SP mitigate against these challenges?*"), we found that recent changes to GIC service delivery have intensified key challenges faced by TGDYP. In particular, many discussed uncertainties about their healthcare needs. While existing research highlights the negative impact of long waitlists and healthcare professionals' limited knowledge of TGD needs (e.g., Marshall et al., 2019; Shuster & Westbrook, 2022), our data offer a novel perspective. It identifies the lack of consistency and certainty within GIC processes as a more significant issue. This lack of clarity was psychologically more challenging because it left TGDYP feeling unprepared when navigating GIC appointments and planning their transition timelines. Moreover, the constant shifting of timelines regarding both appointments and receipt of gender-affirming medical interventions (e.g., hormones and surgery) made the possibility of living as their true selves seem like an unattainable goal. These uncertainties are compounded by the social consequences of delayed care, where many TGDYP may turn to online spaces with negative identity content (see Chapter 6) or adopt inauthentic presentations to align with restrictive GIC criteria (Zottola et al., 2023). While often seen as necessary, such strategies risk entrenching harmful narratives and undermining wellbeing (Haslam et al., 2024).

Given the uncertainty of future GIC provision (i.e., in terms of the availability and format of delivery; Horton et al., 2024) and the often-negative experiences of TGDYP, it is vital they receive resources to manage these challenges. Services should also support them in living authentically until medical interventions are accessible. Kearns and colleagues (2021) emphasise that alternative forms of identity validation, such as speech therapy, legal assistance, and social support, can be just as meaningful as medical transition. Our data reflect these findings, with some TGDYP highlighting that social transition was the most important aspect of their journey. This is because it gave them a sense of autonomy and control over their transition through creating spaces in which they were seen as their authentic selves, even without medical intervention. This is not to undermine the importance of medical transition, but to highlight that interventions that can support social transition may provide TGDYP with the self -efficacy needed to navigate healthcare challenges. SP was identified as a valuable pathway for supporting social transition at all stages of TGDYPs' journeys, from helping them solidify their gender identities in healthy ways through to preparing them for GIC assessments and navigating life following medical transition. Pivotally, SP would also provide structured resources for TGDYP who do not wish to medically transition, whose social and psychological needs are currently disregarded within medically-focused healthcare models (White et al., 2023).

Concerning our second research question ("*How do TGD professionals and young people perceive the integration of SP into existing GIC services, and what challenges arise from this?"*), our data highlight varied preferences. While both professionals and TGDYP expressed a desire for SP to be integrated within GICs, the type of social support thought to be meaningful varied by transition stage. Those earlier on in their transition (i.e., on GIC waitlists or pre-referral) communicated a need for support-focused spaces, whereas those later in their transition (i.e., those receiving medical care or discharged from GICs) articulated the need for activity-based spaces. Structurally, this indicates that SP may best function as a parallel service to GICs rather than an integrated healthcare pathway. This is because SP would need to be accessible to those receiving care from GICs but also: 1) people on waitlists and thus not yet in a GIC pathway, 2) individuals who have received medically-focused care and have been discharged from GICs back to primary care, and 3) TGDYP who do not wish to access medically-focused care, and as such may not pursue a GIC referral.

From a practical perspective, ensuring appropriate support is provided at each stage of transition is resource-intensive. However, this is necessary for SP to be effective. This is because providing social support opportunities early on in TGDYP's transition journeys (e.g., through support groups) without offering opportunities to maintain that support later, especially when preferences for social engagement have changed (e.g., a desire to connect with the same individuals, but within activity-based spaces), results in a lack of continuity of care. In short, without providing access to different types of SP groups (as detailed in Figure 7.1), TGDYP may find themselves unable to maintain the meaningful social relationships they are likely to acquire in support groups they may connect with at the start of their journey. Instead, they may outgrow these spaces without having new spaces for these relationships to develop. Given TGDYP in this sample already report uncertain and fragmented access to care, it is important that SP does not replicate or exacerbate these problems.

### *7.5.3. Implications*

Taken together, these findings point towards the need for more flexible and continuous models of support than is currently available. While this research has novelly highlighted that social transition is a continuous process occurring before, during, and after medical care, this contrasts with the current staged approach to care endorsed by the Cass Review (2024a), in which psychosocial support is primarily positioned as a prerequisite for medical intervention. Our findings challenge the implicit assumption that psychosocial support is only relevant prior to medical interventions. Instead, we show that such support remains essential throughout and beyond medical transition, particularly as new social challenges can arise following physical changes. This is crucial given that difficulties navigating social life post-transition have been identified as one factor contributing to detransition (Sansfaçon et al., 2023). This is because post-transition individuals may mourn the loss of social life attached to their pre-transitioned self if they are not provided with adequate opportunities to connect with meaningful others (Sansfaçon et al., 2023).

Therefore, while we agree with Cass that psychosocial support is important early in transition, our data indicate that this support should not be limited to that stage. We further demonstrate that not all individuals will need both psychosocial and medical interventions, nor will they access them in a fixed order. One form of care does not universally precede or outweigh the other; rather, effective support for TGDYP must be tailored to individual needs and be continuously available across all stages of transition.

This has important implications for implementation. Specifically, regarding how we can implement an appropriate SP model that provides psychosocial support across all stages of gender transition within the current staged approach to gender-affirming care. To align with these requirements, SP delivery for TGDYP may necessitate initial support (i.e., peer support sessions and group therapy) to be provided within GICs while individuals are on waitlists, with activity-based support positioned within the community sector for those who are further along in their transition journey. A flexible and ongoing SP model is therefore necessary to ensure psychosocial support does not fall away post-medical intervention, but rather evolves in line with the individual's transition journey.

### *7.5.4. Strengths, Limitations and Future Directions*

To the authors' knowledge, this is the first exploration of the role SP could play in improving the health and wellbeing of TGDYP. Beyond its novelty, utilising the QTF was methodologically advantageous. This is because it allowed the researchers to uncover differences between what TGDYP and professionals perceive to be the key challenges in TGD healthcare. This also allowed the research to explain why changes made by professionals are not always reflected in healthcare improvements among TGDYP (e.g., Scheim et al., 2024). Exploring convergence and divergence also allowed the research to understand that different formats of SP delivery are required due to varying needs among TGDYP, and within TGDYP as they progress through their transition journeys. Without these insights, changes to TGD healthcare, including SP delivery, may be ineffective. However, while SP was indicated to be helpful both for navigating healthcare challenges and for providing TGDYP with a route for creating these meaningful, good quality social connections, several challenges for implementing SP with TGDYP still stand.

For instance, while both TGDYP and professionals have highlighted a preference for SP to be integrated into existing GIC services, feelings of mistrust towards the NHS may still limit their engagement with this initiative. This may be particularly relevant for non-binary people, who have been increasingly underserved by GIC services in comparison to their binary-trans counterparts (Lykens et al., 2018). Similarly, even those who have had better experiences of GIC services may question the intentions of a socially-based service. For instance, it may be perceived as being a prerequisite for mandated medical intervention. Consequently, it is important that the integration of SP is predicated on trust and transparency. Indeed, the strong feelings amongst TGDYP in the present study regarding the idea that SP should be integral to GIC services may be in response to the dearth of social support that presently exists. Resultantly, future research would benefit from exploring whether social support delivered through NHS pathways is: 1) positively received and engaged with by TGDYP; and 2) allows them to develop meaningful, good-quality social connections that enable them to reap the benefits of group engagement (i.e., is this the best referral mechanism for good health and wellbeing outcomes?; see Evers et al., 2024 on the importance of referral format for successful SP delivery).

## 7.6. Conclusion

Our results demonstrate that TGDYP are experiencing novel challenges when accessing gender-affirming care in response to the recent policy changes within England. In particular, they feel uncertain about the process of navigating gender-affirming care, where extensive waits between, and miscommunication about, appointments mean access to medical care is perceived as a moving target. This is more psychologically challenging than initial wait times and discrimination from healthcare professionals because their ability to live as their authentic self feels out of reach. Positively, however, the proposed implementation of SP was suggested to be a beneficial route for providing TGDYP the support and self-efficacy they need to navigate these transition barriers. Specifically, SP would encourage social transition, increasing TGDYP's ability to live as their authentic self as much as possible until access to medical care is obtainable. Consequently, they would experience a smoother gender identity transition, where SP would provide them with access to social groups from an early stage in their transition. In turn, these groups would provide them with a meaningful social identity, imparting a sense of identity stability over the course of their transition. Whilst challenges around local communities accessing the resources required for SP implementation remain, the present study begins to provide a framework for the integration of psychosocial support within TGD healthcare to improve the health and wellbeing of TGDYP.

# Chapter 8 (Study 3)

At this stage in the project, we had planned to implement a SP pilot in collaboration with two GICs to test the proposed model in Chapter 7. However, following the publication of the Cass Review's interim findings and the subsequent policy response involving a review of adult GICs, a moratorium on service developments within gender-affirming care was introduced. This meant that trialling a new SP intervention was no longer feasible. In light of these constraints, we sought alternative ways to explore the potential value of social support within GIC settings without introducing new initiatives. We were aware of one GIC that was already informally engaging in signposting practices akin to SP that we were planning to adapt as part of the pilot study. This presented a valuable opportunity to examine how such approaches were being received and to consider how they might address ongoing concerns among TGDYP regarding NHS-facilitated support and broader mistrust in statutory services. Chapter 8 therefore takes a structural view, exploring whether SP might be best situated within GICs or the voluntary sector, by examining how NHS GIC-facilitated social support is currently engaged with and perceived by TGDYP.

# Symbolically Affirming, but Functionally Constrained: A Service Evaluation of Social Support Pathways within TGD Healthcare

## Availability of Data and Materials

In accordance with open science principles, and with consent from participants, pseudonymised transcripts have been uploaded to the UK Data Service (UKDS; Study Number: 857823). Access to the data may be subject to registration and standard conditions of use set by the UKDS, and has been deposited under safeguarded access. Researchers interested in using the dataset can apply through the UKDS platform. The results from Chapter 8 (Study 3) have also been provided to GIC 2 as an agreed service evaluation (see Appendix 13).

The findings from Chapter 8 (Study 3) have been presented at the following academic conference:

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, July). *Improving Healthcare for Trans and Gender Diverse People: Exploring the Utility of Social Prescribing Pathways.* An invited presentation for Nottingham Young People's Gender Service CPD training session.

**Staras, C.O.,** Wakefield, J., McDermott, D., & Jones, B. (2025, May). Improving Healthcare for Trans and Gender Diverse people: Exploring the Feasibility of Social Prescribing Pathways. An invited presentation for the University of Exeter. Oral Presentation.

## 8.1. Abstract

**Background:** Social Prescribing (SP) offers a promising route for integrating social support into Gender Identity Clinics (GICs) for TGDYP. Social support can help TGDYP navigate complex care pathways and improve health outcomes. However, concerns remain about whether NHS-facilitated SP within GICs enables meaningful social connection, a hallmark of effective SP, or risks being perceived as superficial, or 'friends on prescription'. Responsively, this study evaluates the first NHS GIC in England to embed social support into its care model to explore whether a model similar to SP is perceived by TGDYP as acceptable and beneficial.

**Methods:** The study collected open-ended survey data from 30 people using the aforementioned NHS GIC (10% of total users of this service). Questions explored the perceived value of social support, reasons for uptake and non-uptake, and ideas for future social support provision. Data were analysed using Framework Analysis (Gale et al., 2013).

**Results:** Participants valued the inclusion of social support as an acknowledgment of their holistic care needs. Trans-led delivery enhanced perceptions of authenticity and trust. However, many noted that support was offered too late in their transition journeys to be impactful. Access issues often mirrored difficulties in obtaining medical care, undermining the intended benefit of the support and contributing to perceptions of inauthenticity.

**Conclusion:** The findings underscore the importance of early, proactively offered social support as a core element of GIC care. Trans-led delivery enhances trust and engagement, but timing and structural barriers must be addressed to realise its full benefit. A sustainable model may involve outsourcing SP to established SP providers while ensuring clinical oversight by GICs and lived-experience experts. This model preserves the authenticity and accessibility of identity-led support, while embedding it within appropriate infrastructure for delivery. Ultimately, for SP to be effective for TGDYP, it must be more than symbolic; it must be timely, trans-led, and structurally supported.

**Key Words:** Social Prescribing; Gender Identity Clinics; Trans and Gender Diverse Young People; Psycho-social Support; Service Evaluation.

## 8.2. Introduction

Navigating Gender Identity Clinics (GICs) in England has long been characterised by complexity, delays, and gatekeeping (Boyd et al., 2022; Scheim et al., 2024). Recent structural changes, including the shift from the Gender Identity Development Service (GIDS) to the Children and Young People Gender Identity Service (CYPGIS), and the development of pilot adult GICs have aimed to improve services for trans and gender diverse young people (TGDYP). However, in practice, these changes have further fragmented care, making it increasingly difficult to access consistent support (Horton et al., 2024; see Chapter 7). In response to these systemic barriers, social support has emerged as a critical buffer, helping TGDYP navigate the emotional and logistical burdens of medical transition (Doyle et al., 2022; Jones et al., 2021; Wilson & Liss, 2023; also see Chapter 6 and 7). Given this value of social support for TGDYP health outcomes, coupled with the knowledge that many TGDYP struggle to make meaningful social connections through their own volition (Hajek et al., 2023; Lewis et al., 2022), it is reasonable to propose that embedding social-support pathways within GICs could be beneficial.

Accordingly, this thesis has begun to explore how Social Prescribing (SP) interventions underpinned by the Social Identity Approach to Health (SIAH), may help foster meaningful, identity-affirming social connection (see Chapters 6 and 7). However, while earlier findings suggest many TGDYP would welcome SP within GICs (see Chapter 7), less is known about whether NHS-commissioned pathways are *trusted* or perceived as *appropriate* for delivering such support. A growing tension exists between the desire for holistic care and deep-seated mistrust of the NHS (e.g., Herlitz et al., 2024; Horton et al., 2024; Wright et al., 2021). Thus, it remains unclear whether enthusiasm for integrated SP (see Chapter 7) reflects a genuine preference or simply a lack of alternatives. This ambiguity is especially pertinent given the Cass Review's (Cass, 2024a[16]) emphasis on psycho-social support as a necessary precursor to medical intervention. As a result, NHS-delivered SP pathways may be perceived not as an optional resource, but as a prerequisite and gatekeeping mechanism to accessing medical care. These factors risk undermining the perceived *genuineness* of SP pathways and subsequent uptake, not due to disinterest, but due to the contexts in which support is offered.

Crucially, the perceived genuineness of SP pathways matters. SIAH-based interventions, and by extension SP, depend on enabling meaningful group identification as their

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[16] Although the Cass Review (Cass, 2024a) focused on children and young people (under 18 years), its recommendation, particularly around increased psycho-social focus prior to pursuing medical intervention, has influenced emerging scrutiny of adult GICs, hence its relevance with the target population of this thesis.

active mechanism for improving health outcomes (Haslam et al., 2024; Staras et al., 2024). This means that both the *structure* of the pathway and the *nature* of the social support it connects TGDYP to must enable the formation of authentic, identity-affirming relationships. If SP is perceived as tokenistic, procedural, or obligatory, it risks reproducing the same shortcomings that have long undermined the SP evidence base (i.e., poorly theorised, disconnected interventions; Evers et al., 2024; Staras et al., 2024). At worst, poorly implemented SP interventions may do more harm than good (Haslam et al., 2024). By highlighting the presence of support while failing to foster genuine connection, they may intensify feelings of loneliness and alienation, reinforcing the belief that support will never be meaningful, even when it is available (Haslam et al., 2024). Therefore, understanding *how* SP is delivered, *who* delivers it, and *under what conditions* it is trusted and engaged with is key to ensuring that SP enhances rather than compromises TGDYP health.

Chapter 7 began to explore these questions, suggesting that the voluntary sector may offer a more accessible and trusted setting for SP in comparison to NHS-commissioned support, particularly for TGDYP outside of active GIC care (e.g., those on waitlists for GICs, discharged back to primary care following GIC treatment plans, or who do not wish to access medically-based care). While insightful, this prior work included few TGDYP currently engaged in GIC pathways (i.e., instead focused on those on wait lists or discharged back to primary care) and primarily captured views from individuals without direct experience of receiving structured social support alongside medical care. Consequently, these findings may reflect anticipated preferences rather than firsthand experiences, highlighting the need for research that explores how NHS-delivered support functions in practice within active clinical pathways.

### *8.2.1. This Study*

Based on outstanding questions related to the positioning of SP delivery to improve TGDYP health outcomes, the present study conducted a service evaluation of holistic care pathways within GIC 2 (GIC name and specific care pathway anonymised on request of GIC 2). GIC 2 is the first NHS GIC in England to include social support as part of their care pathway. Distinct from other GICs, GIC 2 refers service users to multiple forms of support (i.e., surgery, hormones, voice therapy, counselling, and social groups), offering a more holistic model of care. In addition, GIC 2 typically has shorter wait times than national GICs, reflecting its role as a regional service. This relative accessibility provided an important backdrop for evaluating how psycho-social support was received, as participants were less constrained by the extreme delays for first appointments and hormone access (although not surgical delays) that characterise most GIC pathways. While GIC 2's approach is closer to *signposting* than a fully embedded SP pathway (see Chapter 3 for this distinction between SP types), it provides a valuable opportunity to examine whether NHS-commissioned social support is perceived as meaningful and trusted by TGDYP, and whether they actually avail themselves of these services.

In focusing on the experiences of current service users, this study extends prior findings to explore both the value and positioning of social support in GAC. It explores not only how such support is experienced, but also *under what conditions* it may enable meaningful connection, thereby informing the future design and delivery of social support for TGDYP. The following research question guided this study:

1. How do TGDYP perceive social support delivered through GIC 2, and what factors shape its uptake and capacity to foster meaningful social connection?

## 8.3. Methods

### *8.3.1. Design*

This research adopted a qualitative design and was conducted as a service evaluation. Service evaluation is defined as the systematic assessment of an existing service to describe its implementation, acceptability, and areas for local improvement rather than to generate generalisable findings or test hypotheses (Health Research Authority, 2022). GIC 2 is the first GIC to integrate social support into their care pathway, and the purpose of this study was to capture service-user perspectives on this novel provision to inform service development. Accordingly, this study focused on experiences of care as delivered, rather than evaluating clinical effectiveness or introducing changes to standard practice.

Given the novelty of the pathway, a qualitative approach was appropriate to explore experiences and insights arising from routine service delivery. Data were collected via online, -ended surveys with TGDYP receiving care from GIC 2 at the time of data collection (January 4th, 2025 – March 18th, 2025). It was originally anticipated that TGDYP would take part via interviews. However, engagement fatigue and the increasingly challenging political climate meant uptake for interviews was not expressed (see Horton, 2024), despite using numerous recruitment channels (e.g., SMS messages, posters, and mentions of the study by clinicians within appointments). Thus, open-ended survey responses were deemed more appropriate.

### *8.3.2. Participants and Recruitment*

In total, 30 TGDYP (aged 18 – 27) were recruited using opportunity sampling (as common with TGD populations; Hughes et al., 2021), reflecting 10% of total service users within GIC 2. Of these participants: four (13.3 %) had accessed psycho-social support[17]; eight (26.6%), including one who had already received some form of psycho-social support, were awaiting access to psycho-social support; and 19 (63.3%) had chosen not to access psycho-social support.

Participant recruitment was facilitated by GIC 2 through three channels: 1) Posters on their website and in waiting rooms; 2) SMS messages; 3) Mentions of the study by clinicians in appointments. All participants had received a diagnosis of Gender Incongruence and were receiving care through GIC 2. All gender identities were recruited, and participants were required to be aged 18 – 29 (see Chapter 4 for sample justification). No other restrictions on participation were imposed. Table 8.1 provides the demographic information for all participants in this study.

### *8.3.3. Data Collection*

Open-ended survey responses were obtained from 30 TGDYP receiving care through GIC 2 from January 1st, 2025, through March 18th, 2025. The survey was hosted on Gorilla, and participants could respond to survey questions in typed or audio recorded format. This data collection method was most suited in light of research fatigue limiting engagement with interviews (e.g., Horton, 2024), allowing the researcher to collect qualitative responses while being mindful of participation challenges. The survey focused on participants experiences of GICs (e.g., "*could you describe your current experience of NHS gender services*"), how GIC 2 differed from other GICs (e.g., "*How do you think your experience at* [GIC 2] *differs from other gender identity clinics?*"), and their experiences of accessing (or not accessing) psycho-social support options available through GIC 2 (e.g., "*How did* [GIC 2] *facilitate access to these social groups*"; "*Can you share your thoughts on any reasons that might have influenced your decision to not use this social support*"; see https://osf.io/37hzg/files/ for all survey questions). Open-ended responses were downloaded from Gorilla, compiled into transcripts for each participant, and uploaded to NVivo 15 for analysis. For participants who submitted audio

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[17] Although the theoretical focus of this thesis is on social support and group-based connection, the term 'psycho-social support' is used hereafter throughout this chapter to reflect the broader scope of non-medical services offered by GIC 2, as discussed by participants. This includes both social and therapeutic support.

recordings as part of their responses (*n* = 3), audio recordings were transcribed verbatim prior to being included in the analysis.

**Table 8.1.**

*Socio-demographic information for GIC 2 service users.*

| Pseudonym | Age | Gender Identity | Pronouns | Transition Stage | Ethnicity | Sexuality | Living Arrangements | Employment Status | Psycho-Social Support |
|---|---|---|---|---|---|---|---|---|---|
| A | 20 | Male | He/Him | Hormones (5 months; NHS). | Venezuelan | Bisexual | Living Independently | Student | No. |
| Apollo | 22 | Trans Man | He/Him | Hormones (1 year) and top surgery referral (NHS). | White British | Gay | Living with Parent | Full-Time Student | No. |
| Aster | 19 | Male | He/Him | Hormones (8 months; NHS). | White | Queer | University Accommodation | Unemployed | No. |
| Bug | 28 | Genderfluid | They/She/It | Hormones (NHS). | White British | Pansexual | Living with Friend | Unemployed | Partly. |
| Cait | 22 | Trans Woman | She/Her | Hormones (NHS). | White | Lesbian | Flat Share | Student | No. |
| Cosmo | 24 | Male | He/Him | 4 years post-top surgery (private). Awaiting voice training with GIC 2. | Ashkenazi Jewish | Unknown | Living with Parents | Employed | No. |
| Dexter | 20 | Trans Man | He/Him | Hormones (3 years, NHS), top surgery (private). Awaiting lower surgery with GIC 2. | White British | Bisexual | Living with Partner | Unemployed | No. |
| Fredrick | 18 | Male | He/Him | Hormones (3 months). | White | Pansexual | University Accommodation | Unemployed | No. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Haz | 23 | Male | He/Him | Hormones (5 years) and surgery privately. Organising lower surgery through GIC 2. | White | Straight | Living with Parents | Full-Time Employment | No. |
| Jakey | 20 | Male | He/Him | Hormones (6 months; NHS). | White British | Bisexual | Living with Friends | Unemployed | Awaiting Access. |
| Jane | 19 | Trans Woman | She/Her | Hormones (NHS; 1 month). | White British | Bisexual | Living with Parents | Unemployed | No. |
| John | 19 | Trans Man | He/Him | Hormones (NHS). | White British | Gay | With Mother | Unemployed | No. |
| Josh | 18 | Non-Binary | They/Them | Hormones (NHS). | White | Lesbian | Living with Parents | Student | Partly. |
| L | 21 | Trans Feminine | She/Her | Hormones (NHS). | White British | Bisexual | University Accommodation | Full-Time Student | Awaiting Access. |
| Loncett | 20 | Female | She/Her | Assessment. | White British | Asexual | With Family | Unemployed | No. |
| Morgan | 25 | Woman | She/Her | Assessment. | White British | Bisexual | No Fixed Abode | Unemployed | Awaiting Access. |
| Nova | 28 | Trans Female | She/Her | Hormones and laser treatment (NHS). | White British | Heterosexual | Private Apartment | Unemployed | Awaiting Access. |
| Ol | 27 | Woman | She/Her | Hormones (3 years; NHS). Awaiting lower surgery referral and voice training with GIC 2. | White | Lesbian | With Partner and Housemates | Part-Time Employed and Postgrad Student | Awaiting Access. |
| Oliver | 19 | Trans Man | He/Him | Assessment. | White | Pansexual | With Parent | Unemployed | No. |
| Pyro | 20 | Trans Male | He/Him | Hormones (8 months; NHS). | White British | Gay | With Parents | Unemployed | No. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Re | 22 | Non-Binary/Trans Feminine | They/She | Hormones (5 months) and laser treatment (NHS). | White and Asian | Bisexual | Flat Share | Student | Yes & Awaiting Access for Further Support. |
| Rei | 23 | Female | She/Her | Hormones and surgery (NHS). | Mixed | Bisexual | Living with Parents | Student | No. |
| Ria | 19 | Trans Woman | She/Her | Hormones (1 year). | White British | Lesbian | University Accommodation | Employed | Awaiting Access. |
| Roo | 25 | Gender Queer | They/He/It | Assessment and psychological therapy. | White British | Queer | Living with Partner | Unemployed | No. |
| Sheep | 19 | Agender | They/Them | Hormones (NHS; 7 months). | White British | Lesbian | University Accommodation | Unemployed | No. |
| Skylar | 27 | Trans Woman | She/Her | Hormones (NHS). | White British | Unsure | Living with Friend | Unemployed | Yes. |
| Terra | 22 | Non-Binary | They/Them | Prescribed hormones, awaiting prescription (NHS). | White British | Queer | Independent | Freelance | Awaiting Access. |
| Theo | 25 | Male | He/Him | Hormones (NHS) and surgery (private). | White British | Heterosexual | Homeless/Couchsurfing | Self-Employed | No. |
| Willow | 18 | Trans Woman | She/Her | Hormones (NHS). | White British | Bisexual | Living with Parents | Unemployed | No. |
| Zari | 20 | Trans Feminine | She/It | Hormones (NHS). | White British | Demisexual | Alone | Unemployed | No. |

*Note*. Details regarding length of hormonal intervention and time post-surgery was not provided by all participants. Only where details have been provided by participants have they been stated in the table.

### *8.3.4. Data Analysis*

Data were analysed using Framework Analysis (FA) as outlined by Gale and colleagues (2013). FA is a versatile method widely used in qualitative health research, particularly within applied contexts like service evaluations which have specific, pre-specified outcomes (e.g., Heath et al., 2012). Its methodological flexibility, stemming from its lack of attachment to any single epistemological perspective, allows it to accommodate diverse data types and research designs (Goldsmiths, 2021). Thus, FA was appropriate in this context given 1) the present research was a service evaluation with structured aims; 2) the dual format of survey responses (i.e., written and spoken) which requires a method flexible to different levels of detail in responses; and 3) the auditable and transparent nature of FA which is ideal for enhancing credibility of findings and the ability to develop actionable recommendations for clinical practice (Goldsmiths, 2021).

In line with the steps set out by Gale and colleagues (2013), participants' transcripts were uploaded to NVivo, with each transcript reflecting the responses for one participant. All 30 transcripts were read and re-read by the first author to ensure familiarity with the data, and notes relating to the research question were made. Based on this understanding, a coding framework was developed that aligned with developing insights from the transcripts and the aims of the service evaluation (i.e., to understand whether TGDYP are up taking psycho-social support and why/why not). This coding framework was discussed with the research team and GIC 2 and refined in light of these discussions (see Table 8.2 for the final coding framework). This refinement included adding the coding construct "Improving Psycho-Social Support" to differentiate future areas of improvement from current experiences. This process ensured that the coding framework would capture information pertinent to the research aims *and* clinical priorities GIC 2.

The coding framework was applied to each transcript using NVivo 15 in an index-type fashion. Once all relevant data had been indexed into the coding framework by the PhD Candidate, a randomly-selected subset (20%) of transcripts were second coded by another member of the research team (JW) to assess inter-coder reliability. Cohen's Kappa was calculated to determine consistent applicability of the coding framework, which indicated substantial agreement ($k$ = .91). Given consistency between coders, data were charted and summarised into a framework matrix. This matrix comprised one row per participant and one column per code from the coding framework (see Appendix 14). Data charting was facilitated by the *Coding Matrices* function in NVivo 15 and finalised by the PhD Candidate. Summaries in the matrix largely drew on verbatim words to ensure these summaries were grounded in the data. Following data charting, themes were developed by making connections between participants and coding categories. Relevant extracts were chosen to support themes.

#### 8.3.4.1 Reflexivity

Synonymous with Chapters 6 and 7, my own identity and knowledge of GICs in England shaped research design, participant recruitment, data collection, and analysis (i.e., through adopting methods that increase participation comfort for TGDYP). This reflexivity section therefore focuses not on method, but on how my positionality influenced interpretation and meaning-making throughout the analysis.

As someone with lived experience of navigating GICs in England, I brought an insider perspective to this work, particularly in interpreting how participants made sense of the structure, timing, and emotional tone of social support. This allowed me to remain attuned to subtle emotional cues that might otherwise have been overlooked, such as the tension between the promise of holistic care and the reality of institutional overextension, and to interpret the perceived ephemerality of social support as more than just a structural flaw, but also as something that undermines emotional trust and subsequent willingness to engage.

However, it is important to note that I have not been a service user of GIC 2 specifically, nor have I accessed social support through GICs. My relationship with GIC 2 was therefore professional in nature, placing me in a partial insider-outsider position: familiar with the broader system but not directly embedded in this service context. This shaped the assumptions that I brought to the data. For example, based on empirical understandings surrounding the value of social support identified earlier in this thesis (i.e., Chapters 6 & 7), I initially assumed that the offer of social support would be widely accessed and positively received. However, participants' non-engagement with social support offered by GIC 2 challenged this assumption and required me to reflect critically on how emotional, practical, and symbolic accessibility operate in practice. It became clear that availability alone does not guarantee uptake. Support must also feel timely, meaningful, and emotionally resonant. This encouraged deeper analytical engagement with how social support is framed, delivered, and temporally situated within GICs. This reflexive positioning ultimately enriched the analysis, helping to reveal the complex and sometimes contradictory ways in which support is perceived and utilised by TGDYP within NHS GIC contexts.

**Table 8.2.**

*Coding Framework.*

| **Coding Constructs** | | **Definition** |
|---|---|---|
| **Availability of Support** | | How participant perceive the availability of holistic support and community services. |
| | General Awareness | The extent to which participants are aware that holistic and community support options are available through holistic care pathways. |
| | Access to Psycho-Social Support | The extent to which participants perceive that they can easily connect with psycho-social support services, such as community groups or peer support. |
| **Uptake of Psycho-Social Support** | | Whether participants actually engaged with the offered support and reasons for uptake or non-uptake. |
| | Utilised Support | Instances where participants actively engaged with the holistic support or community services offered. |
| | Did not Utilise Support | Instances where participants chose not to engage with the available holistic or community support services, despite wanting to. |
| | No Need for Support | Instances where participants did not take up support because they felt it was unnecessary or irrelevant to their needs. |
| **Perceived Impact** | | How the support (whether taken up or not) affected their wellbeing or sense of connection. |
| | Positive Change | Reported improvements in well-being, social connections, or feelings of support as a result of engaging with the services. |
| | Negative Change | Reported negative experiences or perceived deterioration in well-being or social connections after engaging with the services. |
| | No Impact | Instances where participants felt that engagement with the services made no significant difference to their well-being or social support. |
| **Barriers to Engagement** | | Specific challenges that prevented or discouraged uptake of support. |
| | Personal Barriers | Individual factors that limit engagement, such as social anxiety, lack of motivation, or personal preferences. |
| | Structural Barriers | External factors related to the service design or environment that make it difficult to engage, such as location, accessibility, or unclear information. |
| **Improving Psycho-Social Support** | | Factors identified by participants that would improve their engagement with, or experience of, psychosocial support. |

## 8.4. Results

FA led to the development of three themes (see Table 8.3). This section explores these themes, with specific consideration to what these mean for service provision; a common format for reporting FA results (see Gale et al., 2013; also see Heath et al., 2012; Ward, 2010 for examples).

**Table 8.3.**

*Summary of Themes and Relevant Coding Constructs.*

| **Theme** | **Description** | **Coding Constructs** |
|---|---|---|
| Availability as Access: The Power of Trans-Led Support | Emotional accessibility and value placed on simply knowing support exists. | General Awareness; Did not Utilise Support; No Need for Support; Access to Psycho-Social Support; Perceived Impact. |
| Reactive Rather than Proactive Support | Limited uptake does not reflect disinterest. Rather, support is offered too late, or after need has passed. | Did not Utilise Support; No Need for Support; Improving Psycho-Social Support; Personal Barriers. |
| A System of Echoes: When Support Replicates the Problem | Structural barriers to psycho-social support mirror issues in medical care around waitlists, clarity and resources. | Utilised Support; Did Not Utilise Support; Structural Barriers; Improving Psycho-Social Support; Access to Psycho-Social Support. |

### *8.4.1. Theme 1: Availability as Access: The Power of Trans-Led Support*

A striking pattern across participants' accounts was that the value of psycho-social support extended beyond its direct use. Although many participants did not take up psycho-social support directly (63.3% of the sample did not access support), its availability, particularly within a trans-led context, was experienced as meaningful, affirming, and far exceeding the level of support they had come to expect from GICs. Oliver describes how the presence of this support alone could be reassuring:

> "*The most meaningful support has been knowing that if I needed help with anything, I could ask. Just having the opportunity and support there is enough*" (Oliver, Trans Man).

Oliver's quote illustrates the emotional accessibility of GIC 2's support and suggests a broader sense of being cared for. For TGDYP who often experience healthcare as inaccessible, conditional, or hostile (Berrian et al., 2024), the presence of a safety net offered peace of mind; the comfort of knowing support is available without needed to constantly justify or fight for it.

Other participants elaborated on this sentiment, emphasising that the value of GIC 2's psycho-social support lay not only in its availability, but in *how* it was offered. Unlike many GICs, GIC 2's support was perceived as more expansive and better aligned with diverse experiences of gender (i.e., that it attends to medical, psychological, and social elements of transition), juxtaposing TGDYP's learned expectations of what GICs could provide:

> "*What the service [GIC 2] offered was far more expansive than my initial expectation*" (Re, Non-Binary/Trans Feminine).

The value of this support was further strengthened by GIC 2's trans-led model, which facilitated perceived accessibility of this support. As highlighted by Ria:

> "*[GIC 2] being so trans-run definitely helps me feel a lot more comfortable [...] I'm very glad to be getting care by people who clearly genuinely care about me*" (Ria, Trans Woman).

Ria's emphasis on comfort and genuine care underscores the importance of representation. A trans-led model countered the mistrust that many participants described in relation to mainstream healthcare, where providers often lacked understanding of TGDYP experiences. GIC 2's staffing structure thus did more than deliver services; it reassured participants of shared understanding and solidarity.

These features translated into a broader sense of trust in GIC 2. Participants felt not only able to be honest with staff, but also confident that support would be reliable:

> "*I have always felt so heard and able to be honest with then [...] they have a much better and more trusted reputation in the trans community*" (Sheep, Agender).

Such accounts show how GIC 2 fostered a rare sense of reliability in a system where TGDYP often expect to be disbelieved of dismissed (Horton, 2022). Trust was therefore not incidental, but integral to the model's success, reinforcing the emotional accessibility participants valued. Thus, several participants who did not access support directly still described the offer as positively received. As noted by L:

> *"The community groups they've suggested have played a role in making me feel I have the option to reach out"* (L, Trans Feminine).

While Apollo affirmed:

> "*[GIC 2] has made sure I get the right support and care*" (Apollo, Trans Man).

In this context, non-uptake did not equate to non-value. On the contrary, participants explicitly highlighted that the *"integration of social and medical support [was] very important*" (Cosmo, Male). Instead, then, participants acknowledged emotional accessibility, a trans-led ethos, and a clear commitment to holistic care as core components of meaningful psycho-social support pathways. These features enabled participants to feel acknowledged and authentically supported, even when they did not directly engage with psycho-social support.

### *8.4.2. Theme 2: Reactive Rather than Proactive Support*

While the availability of psycho-social support was valued in itself, many participants described a fundamental mismatch between *when* support was offered and when it was most needed. This, in part, contributed to limited uptake of psycho-social support, where it arrived too late to be meaningful. Many participants noted that by time support was offered, they had either already found alternative sources of help or were preoccupied with medical transition. Willow explains how developing a support system prior to GIC access reduced the need for service-provided psycho-social support:

> "*I have a pretty good support system, so I've never really seen the need to*" (Willow, Trans Woman).

This was echoed by Fredrick, who noted they were already attending social events by the time GIC 2 made psycho-social referrals. Together, these accounts suggest that, while TGDYP value social support, GIC 2's facilitation of this support often arrived after some participants had already met those needs independently, reducing the likelihood of uptake:

> "*I currently attend social events of the kind they [GIC 2] were referring*" (Fredrick, Male).

For others, the issue was not that support had already been accessed elsewhere, but that medical transition took precedence at the time support was offered. Many participants viewed medical transition as the primary and most urgent need. As Pyro explained:

> "*I just wanted to get my transition started […] starting testosterone*" (Pyro, Trans Male).

Here, social support was perceived as secondary, something to be considered only before or after medical goals had been achieved. Feeling overwhelmed by the process of medical transition itself left TGDYP with little energy to pursue additional psycho-social support which was often offered at the same time as medically-related transition options (i.e., hormones and surgery referrals; also see Lorusso et al., 2024 on exhaustion from medical navigation). As L (Trans Feminine) reflected, being "*overwhelmed with day-to-day life"* meant she had "*never gotten round to accessing this [psycho-social] support"*. Others described how access to hormones had already alleviated psycho-social challenges, reducing the perceived need for further support. As explained by A:

> "*I felt any struggles go away upon starting hormone therapy. I feel if I took a spot for social support, I'd be taking it from someone who actually needed it*" (A, Male).

This account evidences how some participants framed psycho-social support as a limited resource intended for those perceived to be in greater need, leading them to position their own support needs as less legitimate once medical transition had begun. Such framings may contribute to an implicit ordering of support priorities, in which medical intervention is foregrounded while psycho-social support is viewed as conditional or discretionary.

However, it is critical to emphasise that not all participants had this level of external support or alleviation of psychological distress following GIC access. While some had already developed coping strategies or secured social networks, for others, prolonged emotional challenges resulting from limited support in the early stages of their transition made the prospect of engaging with psycho-social support once they accessed GICs feel overwhelming. Loncett described how fear ultimately kept her from accessing available groups offered by GIC 2:

> "*I was offered the groups […] but I was too scared to use them and just pushed on alone*" (Loncett, Female).

This further underscores the need for earlier, support-building interventions, as delayed support can allow emotional barriers to deepen over time (a finding observed in other populations; see Dyregrov et al., 2018). Moreover, when support is offered in a way that feels disconnected from participants' lived realities (i.e., unresponsive to participants' ingrained social anxieties), it can risk seeming performative rather than personal (Evers et al., 2024). As Loncett noted, *"social groups felt artificial*", suggesting that this reactive timing not only reduced the potential impact of psycho-social support, but at times made it feel like a procedural formality, rather than an authentic gesture of care.

These accounts suggest that non-uptake should not be mistaken for non-need. Rather, it often reflected how support was framed and timed. Offering support too late, when loneliness is entrenched, or overshadowed by the urgency of medical navigation, risks missing the window where, and for whom, psycho-social support might have the most impact (i.e., "*social support groups for people who feel like they have no one to support them*": Haz, Male). This reactive approach to support appeared to diminish its impact, and for some, made it feel like a checkbox, not true care. Thus, non-uptake should not necessarily be misconstrued as disinterest, but, in some cases at least, as a legitimate response to a systemic failure to intervene early and to position psychosocial support as integral rather than supplementary to care.

### *8.4.3. Theme 3: A System of Echoes: When Support Replicates the Problem*

Despite GIC 2's affirming model, many participants found that the infrastructure surrounding psycho-social support mirrored the same systemic issues they encountered accessing medically-focused care. Unclear access routes, poor communication, and long wait lists re-emerged, undermining the emotional accessibility and trust highlighted in earlier themes. In this way, psycho-social support echoed the problems it was aiming to resolve.

A recurring notion was the illusion of access. What appeared accessible in theory (as emphasised in Theme 1 i.e., because support was emotionally attuned) became elusive in practice, with many participants struggling to understand how to engage with it or where to begin. As Nova shared:

> "*I would love to take part in some community groups, but I haven't received any information about them*" (Nova, Trans Female).

Nova's experience is mirrored by Jane:

> "*I have not been instructed on where to contact for these things [psycho-social support]"* (Jane, Trans Woman).

Others echoed this confusion, describing uncertainty about who to contact or even whether groups existed. These accounts suggest not only communication challenges but may also broader structural constraints such as limited resources, staff capacity, or competing priorities within the service (Silver et al., 2025). These gaps raise questions about whether psycho-social support is being resourced and prioritised at the level needed to make it truly accessible.

Rei (Female) reflected more directly on this challenge suggesting *"better organisation of resources may help with this*" with Josh (Non-Binary) also suggesting "*more open communication with the steps, concrete dates […] or an estimate"*. This points to the need not only for emotional accessibility (as highlighted in Theme 1) but operational clarity, reinforcing that the reason for the breakdown in psycho-social support accessibility was often related to poor infrastructure rather than poor intentions.

This lack of clarity upon entry to the service was often mirrored after referral. Even when participants were signposted to support, poor follow-up communication and slow system responses left TGDYP in prolonged uncertainty about the next steps or timelines. As Ria explained:

> "*I expressed interest in voice training but have heard nothing back*" (Ria, Trans Woman).

In other cases, participants pointed to extensive wait times that made psycho-social support feel unattainable. Participants often drew comparisons to their experiences of medical gatekeeping, where delays and deferrals eroded trust in GIC 2's ability to fulfil their promise of available psycho-social support:

> "*I'll probably have had like bottom surgery by the time I am able to access therapy through the GIC*" (Ol, Woman).

This experience of support offered in principle, but indefinitely deferred, led some participants to disengage entirely. As elaborated on by Ol:

> "*Whatever I try to access through a GIC is minimal as possible. I don't want to spend time there accessing support from them*" (Ol, Woman).

While these experiences suggest broad structural issues, it is important to note that some participants described smoother referral processes ("*[GIC 2] is really good at providing access to services*": John, Trans Man). However, even in these cases, wait times remained a persistent barrier across the sample, diluting the positive impact of any initially perceived accessibility.

These accounts raise important questions about *where* and *how* psycho-social support should be delivered. The above excerpts imply that psycho-social services located within clinical systems, even affirming ones, carried the baggage of bureaucracy. This invites consideration of whether non-clinical, voluntary-sector provision might offer a better model for delivering psycho-social support (as suggested in Chapter 7). Yet, as Cait pointed out, community provision is not always accessible or welcoming to TGDYP:

> "*[I would like] social [support] through clinics as I've found voluntary sectors to be somewhat closed off*" (Cait, Trans Woman).

This highlights a double bind, with medical pathways feeling too institutional, and community pathways not always perceived as inclusive or equipped. In this context, GIC 2's psycho-social offer risks becoming an empty signifier: symbolically affirming, but functionally constrained. These accounts demonstrate that in order for psycho-social support to be positively received and experienced, it *must* be matched by appropriate infrastructure to facilitate access. Without this, even well-intentioned care may replicate the systemic shortcomings it seeks to overcome.

Taken together, these themes show that while holistic care pathways hold meaningful potential for trans-affirming psycho-social support, its success ultimately depends on the timing, framing, and structural conditions in which that support is offered. Emotional accessibility must be matched by infrastructural integrity if such pathways are to be truly transformative for TGDYP.

## 8.5. Discussion

Recent literature has begun to suggest that integrating social support into GAC through SP is a useful tool for improving TGDYP health outcomes (see Chapter 6 and 7). However, research has been unable to establish whether accessing social support through NHS pathways (i.e., through SP embedded within GICs) would allow TGDYP to develop *meaningful* social connections (i.e., those where they have a shared identity with others and that facilitate a sense of belonging); a core component of effective SP initiatives (Haslam et al., 2024; Staras et al., 2024). Questions regarding actual (as opposed to hypothetical) uptake, and the benefits of GIC-integrated social support also remain. Responsively, the present study conducted a service evaluation of GIC 2, the first GIC to integrate social support as part of its holistic care pathways, to understand whether NHS-facilitated social support is utilised, to understand reasons for uptake vs. non-uptake, and ultimately understand the benefits experienced when social support is integrated into GICs for TGDYP.

Concerning our research question (*"How do TGDYP perceive social support delivered through GIC 2, and what factors shape its uptake and capacity to foster meaningful social connection"*), perceptions of social support were mixed. In the first instance, social support was perceived as overwhelmingly positive. Even without direct engagement, knowing that social support was present, and that this support was trans-led, contributed to the *authentic* feel of GIC 2's social support, positioning it as a genuine expression of care rather than an obligatory or procedural offering. This allowed TGDYP to feel holistically cared for, in contrast to the medically narrow focus of many other GICs (e.g., Coyne et al., 2023; White et al., 2023) and affirmed that their broader needs were being taken seriously. This echoes earlier findings in the thesis, which suggested that TGDYP are more likely to trust and value transition-related information when it comes from other TGDYP (see Chapter 6). In this context, GIC 2's trans-led model fosters emotional accessibility through a shared social identity (see Haslam et al., 2018 on the SIAH). This is because ingroup support promotes perspective-taking, trust, and perceived authenticity, as opposed to outgroup support which can be experienced as supercilious or misattuned (Livingstone, 2023). Thus, social support is perceived as genuine and meaningful when it is provided in a way that directly meets TGDYP needs (i.e., the need for holistic models of GAC; Coyne et al., 2023; White et al., 2023), and is championed by those with lived experiences.

However, these positive perceptions were undermined by the timing of support. Notably, while participants valued support in principle, the lateness of the offer made its purpose seem nebulous (also see Dyregrov et al., 2018 on poorly timed support). Specifically, participants struggled to understand why social support was not offered earlier when their social support needs were greater, and before their transition-related needs had shifted towards medical outcomes. As a result, in contrast to participants who perceived the offer of social support as genuine, other participants described it as feeling tangential or even burdensome. Thus, social support is perceived as inauthentic and less meaningful when the timing of delivery does not match TGDYP's needs or capacity for navigating this support (Dyregrov et al., 2018; Singer et al., 2021), ultimately reducing motivation to engage.

This sense of misalignment was compounded by limited clarity about *where* to access social support and *when* support would be received. This uncertainty echoed the wider opacity already present within medical GIC pathways; long waitlists (Scheim et al., 2024; Thibeault et al., 2025), unclear transition timelines (Boyd et al., 2022; Witney et al., 2025; Taylor et al., 2024), and attempting to navigate systems that often feel impenetrable (Scheim et al., 2024; Taylor et al., 2024). As such, rather than social support being viewed as supportive for navigating GIC challenges, it reinforced existing patterns of unmet needs. This led some TGDYP to disengage, not due to disinterest, but because social support became entangled in the same systemic inefficiencies that have long shaped GIC experiences (e.g., Witney et al., 2025; also see Chapter 7). In this sense, social support utilisation is not only contingent on *emotional accessibility* as highlighted prior, but also on the *practical timing and transparency* of the pathway. Overall, decisions around uptake were shaped not simply by whether support was available, but by how it was delivered, with perceived authenticity, timing, and transparency all playing critical roles in whether participants perceived social support as potentially beneficial, and thus whether they decide to engage with it.

### ***8.5.1. Practical Implications***

Practically, these findings reinforce arguments made in Chapters 6 and 7 regarding the importance of early social support provision for TGDYP. This study not only supports previous claims that early engagement facilitates authentic social connection (Chapters 6 & 7), but also highlights the consequences of delayed intervention. Specifically, postponing social support may result in missed opportunities for meaningful connection during critical periods of identity formation and vulnerability (also see Kirkbride et al., 2024). Over time, social challenges can become entrenched and normalised, further diminishing the perceived relevance and/or accessibility of social support (Kirkbride et al., 2024; Muhl et al., 2025). As such, integrating SP earlier in TGDYP's transition journeys is not merely beneficial; it is essential for interrupting trajectories of social disconnection and mitigating the long-term mental and physiological effects of loneliness (Muhl et al., 2025).

Early intervention is also crucial because, once TGDYP begin receiving medical care, clinical concerns tend to take precedence, leaving limited capacity, both for individuals and GAC providers, to prioritise social support (e.g., Lorusso et al., 2024). In this context, social support is experienced as an afterthought, framed as supplementary rather than core to care. As a result, it can feel ephemeral and tokenistic, rather than a meaningful opportunity for social connection. This may limit the effectiveness of SP programmes delivered in a similar manner to GIC 2's social support, because without *meaningful* social connection, SP benefits are inconsistent (Haslam et al., 2024; Staras et al., 2024).

However, this positioning is shaped not by intent but by structural limitations. GICs often do not have the infrastructure or staffing to provide timely and embedded social support, nor to provide this for individuals on waitlists (hence why these individuals are on waitlists and not in care pathways; Silver et al., 2025; Thibeault et al., 2025), thus pushing social support into the later stages of care (i.e., because even if such support is offered at first GIC appointment, waitlists for accessing it postpone access). Yet, this is precisely when it is least likely to be perceived as relevant or impactful. Thus, timing, resource scarcity, and the way support is presented interact to undermine both the perceived value and uptake of social interventions.

Collectively, these challenges raise questions regarding *where* and *how* social support interventions (i.e., SP) can be embedded early and through identity-affirming avenues, while simultaneously overcoming the logistical challenges present within GICs (i.e., limited resources to provision this support and subsequent delayed access). One potential avenue for early intervention would involve outsourcing SP to dedicated providers (e.g., NHS Property Services who provide SP hubs; NHS Property Services, 2025). This model would enable TGDYP to access better-resourced social support at an earlier stage, particularly if referrals to SP could be made concurrently with GIC referrals initiated in primary care. However, while this may enhance structural access, it is important to recognise that structural availability alone is insufficient. As highlighted in our findings, if support is experienced as emotionally inaccessible, whether due to fear, mistrust, or a lack of perceived authenticity, its potential for uptake and health impact is significantly diminished. This point aligns with observations made by Evers and colleagues (2024), who critique the broader SP literature for overlooking the importance of referral pathways and for assuming that the presence of support within clinical settings will automatically lead to uptake. While traditional SP models emphasise connecting individuals to resources to combat loneliness, they often neglect the relational quality and symbolic meaning of how and when it is offered (Evers et al., 2024). This underscores the significance of TGDYP concerns around the TGD non-affirming nature of community-based support, which can act as a barrier to engagement as found in the current study (also see Chapter 6 & 7).

In response, TGD-specific programmes could be developed within the infrastructure of specific SP providers, with facilitation and oversight by individuals with lived experience and/or Care Navigators (where capacity allows). This would help ensure SP for TGDYP is well resourced, while mitigating the risk of detachment from clinical relevance (a common issue with SP implementation; Westlake et al., 2023) and reinforcing the value of lived experience in shaping affirming, contextually appropriate support (as emphasised in social identity literature e.g., Haslam et al., 2024; Livingstone, 2023). In sum, ensuring timely, identity-affirming, and emotionally resonant social support for TGDYP requires both structural innovation and attentiveness to the relational dynamics of care. Without this dual focus, SP risks remaining underutilised and ineffectual.

### *8.5.2. Strengths, Limitations, and Future Directions*

To the authors' knowledge, this is the first evaluation of integrated social support pathways within GICs in England. This provides a refreshing angle on GIC evaluations, moving beyond a deficit-focus to considering solutions to the challenges experienced by TGDYP (Shuster & Westbrook, 2024). While we do highlight shortcomings of current social support provision within GICs, this marks a positive step towards considering the best avenues through which TGDYP's health and social care needs can be holistically met. However, despite our suggestions for how to implement SP in beneficial ways, there are a number of limitations that need to be considered that may alter this model.

First, while we suggest that SP referrals may be best timed simultaneously with GIC referrals from one's GP, this presumes that all TGDYP will pursue a GIC referral. However, research shows that not all TGDYP wish to access GICs, particularly if they perceive the central purpose of such clinics to be the provision of medically-based care (Cahill et al., 2025; Hall et al., 2021; Wright et al., 2021). Particularly for individuals who do not wish to medically transition, revealing their TGD identity to GPs can prompt discrimination and the assumption that all healthcare needs are rooted in trans-related challenges, potentially complicating their access to routine healthcare (Holti et al., 2024). Resultantly, some TGDYP who do not wish to access medical care will choose not to disclose their TGD identity, given it is not necessary if they are not pursuing GIC access (Kcomt et al., 2020; see Chapter 7). Thus, there is a need for SP pathways that do not require disclosure of one's TGD identity to a GP. Although SP could still be based within dedicated SP providers, future research should explore alternate access routes for SP (e.g., self-referral rather than GP referral) to ensure all TGDYP who wish to access social support can do so within safe and affirming environments.

Second, it is important to acknowledge that the participants in this study differed from those in Chapters 6 and 7, particularly in terms of their access to care. Many had comparatively quicker and more affirming access with GIC 2 compared to participants in Chapter's 6 and 7 who received care through other GICs beyond GIC 2, which may have influenced their perceptions of social support needs. This is because participants' more positive healthcare experiences may have reduced the salience of unmet support needs that are more prominent in other contexts (Goldenberg et al., 2020). In this sense, GIC 2's care model may inadvertently lower the perceived value of social support, not because social support is ineffective, but because it is less urgently needed in services that are affirming and well-resourced (e.g., Goldenberg et al., 2020). As such, participants' relative ambivalence toward SP within GICs should not be generalised to all TGDYP. For those navigating longer wait times, more bureaucratic systems, or less affirming care, social support may still play a crucial role in mitigating distress and promoting wellbeing during periods of uncertainty or isolation throughout all stages of transition, not just prior to medically-affirming care (Doyle et al., 2022).

Third, two thirds of our sample actively chose not to engage with GIC 2's social support. Initially, this was a concern as it limited the number of participants who could tell us about their motivation for and perceptions of actively engaging with social support. However, upon reflection and reviewing the data (particularly reasons for non-uptake), it was felt that this distribution of uptake vs. non-uptake may be reflective of the preferences of this group and thus an accurate representation of general responses to GIC-integrated social support. Nonetheless, future research may benefit from more targeted exploration of TGDYP who *have* engaged with NHS-facilitated social support to gain a more comprehensive understanding of these experiences.

Finally, as a service evaluation, this study relied on qualitative data to explore experiences of a novel care pathway. While qualitative methods were well suited to capturing depth, meaning, and early insights into acceptability, service evaluations often also incorporate descriptive quantitative indicators (e.g., service uptake, engagement, or routinely collected wellbeing measures). At the time of implementation, such quantitative data were not available in a form suitable for analysis, and the exploratory focus of this evaluation prioritised experiential accounts. As the service matures, future evaluations would benefit from integrating descriptive quantitative data alongside qualitative methods to support a more comprehensive mixed-methods assessment of service delivery and impact.

## 8.6. Conclusion

This study offers a novel and timely evaluation of NHS-integrated social support for TGDYP, providing critical insights into how such interventions are experienced within clinical pathways. While GIC 2 demonstrates promising potential for offering affirming and holistic care, the success of social support interventions depends heavily on their timing, framing, and emotional resonance. Participants valued the presence of support, especially within a trans-led model, yet uptake was limited by practical barriers, delayed delivery, and ambiguity around purpose. These findings suggest that for social support to meaningfully impact TGDYP health, it must be both structurally accessible and emotionally attuned to the identity and timing needs of those it aims to support. Future implementation efforts must prioritise these dual imperatives to ensure that social support functions not as symbolic affirmation alone, but as a substantive, trusted, and transformative component of GAC.

# Chapter 9

## General Discussion

### 9.1. Introduction

In this closing chapter, the findings across the thesis will be synthesised to address the overarching research questions. Earlier chapters examined theoretical explanations for how SP works and TGDYP's social support experiences to understand how best to design and implement SP for this population. This chapter draws these strands together to explore what the thesis contributes as a whole. It will identify theoretical contributions, highlight practical implications, and offer directions for future research.

### 9.2. Recap of the Thesis Aims

TGDYP in England face a healthcare landscape that is fragmented, clinically-focused, increasingly restrictive, and overall ill-equipped to address the broader social conditions shaping TGDYP health (Scheim et al., 2024; Thibeault et al., 2025; White et al., 2023; Witney et al., 2025). While access to gender-affirming care (GAC) is crucial, current services often prioritise clinical pathways (e.g., medical care or individualised psychological support) while overlooking social determinants of health, including loneliness, minority stress, and a lack of identity affirmation. Neglect of these social factors not only compromise wellbeing, but also undermines the ability of GAC to improve health outcomes (Hajek et al., 2023; Thomas et al., 2024; White et al., 2023). In response, there is a growing recognition that meaningful, holistic care for TGDYP must move beyond clinical interventions to support the broader social needs of TGDYP (NHS, 2019; White et al., 2023).

A consistent protective factor identified in the literature to mitigate social determinants of poor health is social support (e.g., Elmer et al., 2023; Puckett et al., 2023; Wilson & Liss, 2022), particularly support that is identity-affirming and grounded in shared experience (Haslam et al., 2018; Jones et al., 2021). Yet, formalised pathways for delivering social support within GAC have received limited attention. One promising model is SP: a non-clinical healthcare intervention that links individuals to community groups to promote health and wellbeing. However, SP has not yet been meaningfully evaluated with TGDYP, nor is it clear how such interventions could be tailored to meet the specific identity-based needs of this population. Critical gaps remain around how SP works, what mechanisms underlie benefits, and how it might be experienced by TGDYP.

This thesis responded to these questions by examining the potential of SP as a mechanism to support TGDYP and improve health outcomes. Drawing on the SIAH, a theoretical model explaining how group identity and belonging enhance health, this thesis explored the psychological underpinnings that make SP effective, and how this can be tailored for TGDYP. To achieve this, the following overarching research questions were explored:

1) How can the SIAH inform the effective implementation of Social Prescribing as a healthcare intervention?

2) How can the SIAH inform our understanding of the psychological processes through which social support enhances wellbeing for TGDYP?

3) In what ways can a SIAH-informed model of Social Prescribing be designed and implemented to improve health outcomes for TGDYP?

Through a systematic review, empirical qualitative studies, and an evaluation of a service model that incorporates social support, this thesis aimed to contribute both theoretically and practically. It advances conceptual understandings of SP through a SIAH lens, and it offers the first examination of how SP might be affirmingly and effectively adapted to support the health and wellbeing of TGDYP in England.

## 9.3. Summary of Each Study and Key Findings

This section summarises each of the key studies that comprise this thesis, restating their rationale, key findings, and how this refined the focus of subsequent studies.

### *9.3.1. Chapter 3 (Study 1): A systematic review of SP initiatives through a SIAH lens*

Study 1 responded to overarching RQ1 ("*How can the SIAH inform the effective implementation of Social Prescribing as a healthcare intervention?*") by systematically reviewing existing SP initiatives through the lens of the SIAH. This served as a theory-testing exercise which underpinned the remainder of the empirical research presented in this thesis.

The review was motivated by growing enthusiasm for SP as a public health intervention, and its potential to enhance access to social support for TGDYP, despite concerns that its evidence base remains premature and theoretically underdeveloped (Dayson et al., 2017; Husk et al., 2019). Applying a theoretical framework that allows researchers to understand *how* SP works, *for whom*, and in *what contexts* is key if researchers want to consistently harness health benefits (Bickerdike et al., 2017). The SIAH was identified as one such framework. This theoretical grounding was crucial in the context of the wider thesis, as our aim was not only to improve understandings of *how* SP works, but to use this understanding to *inform* the design of SP for TGDYP.

Study 1's findings support growing consensus that SP's effectiveness hinges not on the quantity, but on the quality of group memberships, defined as psychologically *meaningful* group memberships that instil a sense of shared identity (e.g., Haslam et al., 2024; Stevenson et al., 2019). Aligning with SIAH principles (Haslam et al., 2018), SP programmes that helped individuals feel they belonged, through common experiences, structured support from link workers, and the development of self-efficacy, were more likely to facilitate Social Cure benefits.

However, the study also identified critical gaps. While many studies reported improvements in loneliness or wellbeing, few directly measured shared identity or other group-based processes related to the *quality* of these group memberships. Most relied on qualitative inference rather than quantitative operationalisation of SIAH constructs. Thus, although existing SP initiatives likely activate SIAH processes, the lack of explicit measurement hinders efforts to clarify for whom and under what conditions SP is effective. This points to the need for more theoretically grounded evaluations of SP, in which shared identity and other SIAH-relevant constructs that pertain to the *quality* of group memberships are explored. This would strengthen the evidence base and allow researchers to design and evaluate SP that actively promotes the mechanisms most likely to lead to sustained wellbeing benefits.

This chapter therefore concluded that the SIAH could inform the effective development, implementation, and evaluation of SP through centring the role of shared identity and meaningful group identification as key psychological mechanisms that underpin the effectiveness of SP in producing health benefits. By demonstrating that SP's benefits are contingent on meaningful group identification, Study 2, Part 1 turned its focus to the specific group affiliations TGDYP find meaningful.

### *9.3.2. Chapter 6 (Study 2, Part 1): Exploring meaningful social connections among TGDYP*

Based on insights from Study 1 highlighting the importance of *meaningful* group memberships for effective SP, Study 2, Part 1 sought to understand what group memberships are experienced as meaningful by TGDYP. While theoretically, meaningful group memberships for TGDYP can be presumed as ties with other TGDYP due to their shared social identity, marginalisation and intra-group discrimination may shape *how* meaningful group memberships are formed (e.g., Chi, 2023). Specifically, research demonstrates that not all social support for TGDYP is health-promoting (e.g., Rimmer et al., 2022). However, extant research adopting a GMST lens limits ability to theorise *what* social support is meaningful and *how* it functions to improve health (Chi, 2023; Scheim et al., 2024). Thus, applying a theoretical lens that identifies the psychological mechanisms through which social support operates, and the conditions under which it is experienced as meaningful, enables the design of interventions that effectively harness and target these mechanisms for TGDYP.

Accordingly, and in addressing the thesis's RQ2 ("*How can the SIAH inform our understanding of the psychological processes through which social support enhances wellbeing for TGDYP?*"), we applied the SIAH to explore Social Cure, Social Curse, and social-identity change processes (i.e., SIMIC; Jetten et al., 2014). These SIAH frameworks examined which group memberships were perceived as helpful or unhelpful, and how these perceptions evolved throughout TGDYP's transitions; the later of key importance given gender transition can reshape social identities and thus the psychological support TGDYP can gain from group memberships (Doyle et al., 2023).

Study 2, Part 1's findings indicated that *meaningful* group memberships were most often formed with other TGDYP as anticipated. Through adoption of the SIAH as a theoretical framework, we identified that peer relationships were anchored in shared social identity, enabling authenticity and meaningful group engagement. Contrasting interactions with cisgender individuals, where participants often reported feeling misunderstood, rejected, or engaging in identity concealment, connections with other TGDYP facilitated the construction of a meaningful social identity, often for the first time. This meaningful connection shifted participants from a sense of identity confusion and disconnection to a place of authenticity and affirmation.

However, in line with Social Curse literature (e.g., Kellezi & Reicher, 2012) and previous research (e.g., Garrison, 2018; Sutherland, 2023), not all group memberships were experienced as health-enhancing. Non-binary individuals experienced exclusion from TGD-specific spaces under the pretence that they did not fit the normative social identity expected within those groups, where the perceived norm was conformity to binary conceptions of gender (Kellezi & Reicher, 2012; Sutherland, 2023; Vincent, 2021). Others described online social spaces as saturated with trauma narratives that reinforced negative self-perceptions and undermined the value of TGDYP group membership.

Overall Study 2, Part 1's findings suggest that while TGD-specific spaces can facilitate meaningful social connections, the extent of their benefit is contingent on the inclusivity of group boundaries and the degree to which these groups instil positive perceptions of one's TGD identity. In response to overarching RQ2 then, the SIAH was a useful lens for understanding *what* group memberships were meaningful, *how* they were meaningful, and the conditions that undermine the health benefits of these meaningful group memberships. Building on these insights, Study 2, Part 2 considered *how* these meaningful group spaces could be provisioned through SP.

### *9.3.3. Chapter 7 (Study 2, Part 2): Designing a TGD-Inclusive Social Prescribing Pathway*

Extending Study 2, Part 1, Study 2, Part 2 considered how this can be envisioned in practice, beginning to address overarching RQ3 ("*In what ways can a SIAH-informed model of SP be designed and implemented to improve health outcomes for TGDYP?*"). Specifically, we explored what social spaces (e.g., peer support groups, activity-based programmes) create conditions for meaningful identification to occur.

Yet, the viability of these spaces cannot be considered separate from TGDYP's broader experiences with GICs. For many TGDYP, NHS GIC involvement in social support may carry connotations of gatekeeping, creating concerns that SP could be viewed as a prerequisite for medical intervention (e.g., Herlitz et al., 2024). Thus, we needed to explore TGDYP's desire for NHS GIC facilitated SP.

Further, given the development of SP is predicated on addressing current challenges experienced by TGDYP, we sought to understand *what* novel challenges TGDYP face in light of recent developments in GAC and *how* SP could mitigate these challenges. By foregrounding these interrelated factors, Study 2, Part 2 addressed the practical challenges of designing SP interventions that actively promote meaningful group identification, while remaining responsive to the unique needs and structural constraints experienced by TGDYP.

Drawing on the same sample outlined in Study 2, Part 1, findings from Study 2, Part 2 reinforced mounting concerns that recent shifts in GAC have exacerbated existing barriers for TGDYP (e.g., Horton, 2024). In comparison to professionals who highlight long waitlists as a key barrier to GAC, TGDYP identified the lack of consistency and certainty within GIC processes as a more significant issue. This is because their shifting transition timelines made living authentically feel out of reach, underscoring the urgent need for structured, identity-affirming support like SP to counteract the psychosocial toll of unstable service provision.

Indeed, TGDYP and professionals alike expressed enthusiasm at the prospect of integrated SP within GICs, particularly in light of this increasingly challenging climate. Notably, social support accessed through SP was framed not as ancillary but as essential to social transition, enabling TGDYP to begin living in alignment with their gender identity even in the absence of medical intervention. In this sense, SP was deemed critical to resisting the indefinite deferral of authenticity that often accompanies delayed access to GAC (Dias et al., 2021; McKay et al., 2025).

However, although participants agreed TGD-specific spaces are vital, the *format* and *function* of meaningful social support varied across transition. Individuals earlier in their transition (e.g., on waitlists/pre-referral) favoured support groups, where group membership serves a formative function, supporting processes of self-definition and belonging. Conversely, those later in their transition (i.e., within GIC pathways or discharged back to primary care) often sought activity-based spaces that affirm their identity without requiring them to (re)negotiate or centre it. These findings reflect SIAH literature emphasising that the psychological benefits of group membership depend on where individuals are in their identity journey (Cruwys et al., 2014; Haslam et al., 2018). SP must therefore be flexible enough to support identity formation, affirmation, and congruence throughout transition.

Thus, in response to overarching RQ3, a SIAH-informed model of SP can be effectively designed through provisioning varied social support to ensure SP is responsive to TGDYP's evolving social identity needs over the course of their transitions. These findings raised important questions about whether NHS GICs could meaningfully deliver the kind of flexible, identity-sensitive support TGDYP need, or whether community-based models might be better placed to do so: questions that Study 3 explored by evaluating NHS-led implementation in practice.

### *9.3.4. Chapter 8 (Study 3): Service Evaluation of a GIC Social Support Model*

Study 3 completed the thesis' response to RQ3 by examining real-world implementation through a service evaluation of GIC 2; the first NHS GIC incorporating social support into its care model.

Despite enthusiasm for SP in Study 2, Part 2, concerns persisted around NHS involvement, particularly fears that support could be perceived as gatekeeping rather than genuine care (e.g., Herlitz et al., 2024), and not attuned to the diverse identity needs among TGDYP. This was important given that SIAH-informed interventions rely on perceived authenticity and identity alignment to foster meaningful group engagement (Evers et al., 2024; Haslam et al., 2024). To examine these issues in practice, in Study 3 we evaluated how TGDYP experienced GIC 2's social support pathway. While not a formal SP programme, it provided a naturalistic case to assess whether identity-based support embedded within NHS GICs could meet the needs of TGDYP.

Study 3's findings indicated that trans-led delivery was key to the perceived genuineness of support. The offer of social support was initially welcomed and interpreted as a sign of GIC 2's commitment to holistic care. However, this symbolic value was undermined by poor timing. TGDYP stressed the need for social support *earlier* in their transition journeys, prior to engagement with medically-based care. At the point when support was offered, many felt overwhelmed by medical processes to meaningfully engage, or resigned to navigating challenges alone.

This misalignment in timing was compounded by unclear referral processes and long wait times, which mirrored the very barriers that TGDYP were already encountering in medical care. Rather than feeling supported, participants described difficulties accessing social support echoing broader systemic failures.

Together, these findings illustrate that while GIC-integrated social support is symbolically affirming, poor timing and complex navigation undermine its effectiveness. Thus, concluding our answer to the thesis's RQ3, SIAH-informed SP can be effectively implemented when it is well timed to align with the social identity needs of TGDYP and is easily accessible in a way that does not replicate or exacerbate GAC challenges that TGDYP are already experiencing. However, this social support must also be emotionally resonant, delivered by those who understand the challenges experienced by TGDYP (i.e., other TGD people). In this sense, SIAH-informed SP for TGDYP must be emotionally accessible, well-timed, and transparent to navigate if it is to effectively improve health outcomes for TGDYP.

## 9.4. Contribution of Findings for Designing and Implementing SP to Improve TGDYP Health Outcomes

Collectively, this thesis offers a framework for understanding *how* to effectively design and implement SP for TGDYP. From establishing *why* and *how* SP works, through to understanding *what* group memberships are (and are not) health-enhancing for TGDYP, this thesis responds to calls by NHS England for holistic approaches to GAC that attend to psycho-social determinants of health (NHS, 2019).

A key thread across all findings is that structural factors, including timing, resource provision, and the positioning of support, are central to whether SP can be meaningfully accessed, trusted, and experienced as beneficial. Yet, structural factors are often overlooked in extant literature, particularly in the design, evaluation and implementation of SP (Evers et al., 2024; Westlake et al., 2023). This section therefore considers our findings in relation to existing literature, foregrounding how structural features of SP, including when support is offered, who delivers that support, and where that support is positioned can shape both engagement with, and outcomes of, SP for TGDYP.

### *9.4.1. Appropriate Timing of Support: Identity Relevance and Perceptions of Support Authenticity*

Across the empirical studies in this thesis, *timing* emerged as a crucial structural factor shaping whether social support was experienced as meaningful by TGDYP. While SP initiatives often assume support is intrinsically valuable (Westlake et al., 2023), our findings uniquely demonstrate that its effectiveness depends on *when* in a person's identity journey it is offered, and whether it aligns with their current social identity needs.

For instance, Study 2, Part 2 showed that TGDYP's support preferences change over the course of transition. Early on, identity-focussed groups may offer validation and belonging; later on, as gender identity exploration becomes less salient, the same groups may feel irrelevant or limiting (also see Bockting et al., 2016). Thus, contrasting our findings from Study 1 and broader SIAH literature (e.g., Haslam et al.., 2018; 2024) where *meaningful* group memberships are generally treated as a relatively stable construct (with the exception of Cruwys et al., 2014 and the SIMIC), findings in Study 2, Part 2 show that, for TGDYP, identity salience (and thus which groups are meaningful) is time-sensitive. While the SIMIC model (Jetten et al., 2014; 2018) does account for changes in meaningful group identity in response to identity change, it focuses on shifts between core social identities (i.e., from veteran to civilian; Wakefield et al., 2023). In contrast, TGDYP often remain anchored in the same core identity (i.e., as TGD), but experience shifts in which aspects of that identity are most salient over time. This distinction is critical: group memberships may move from affirming to irrelevant not because identity changes, but because identity *needs* change.

These findings provide new insights into why some prior research has found support groups to be unhelpful for TGDYP (e.g., Rimmer et al., 2022), particularly when support does not match identity salience or priorities. This notion was echoed in Study 2, Part 2 where participants reflected on the paucity of activity-based spaces relative to support-focused spaces, limiting opportunities for identity-relevant connection. These insights support Cruwys and colleagues' (2014) argument that *identity-congruent* group memberships (i.e., group memberships that are aligned with where someone is in their identity journey) are central to wellbeing, while novelly refining what identity-congruence means for TGDYP. Identity congruence is not static as posited by Cruwys et al. (2014). Rather, it is dynamic, meaning group membership can shift from affirming to irrelevant as identity salience changes.

Study 3 reinforced this need for identity-aligned support, where identity-incongruent social support was not only disregarded, but undermined trust in the provider. This is because support was perceived as inauthentic; inauthenticity that limits the possibility of *meaningful* group memberships being developed (also see Dyregrov et al., 2018; Singer et al., 2021 on the importance of well-timed psycho-social support). This highlights that timing carries both symbolic and functional weight, determining whether support feels like care or obligation.

This temporal positioning has significant implications for SP design. While general support literature has long emphasised the value of timing in psychosocial interventions (Kindt et al., 2019; Lam, 2024; Wanzer & Czapla, 2022), this insight has yet to be meaningfully incorporated into SP theory or practice. As a result, support within generic SP programmes is often offered at fixed points in care pathways without accounting for the identity development trajectories of the groups being targeted. Instead, then, our findings suggest that SP programmes must assess community-specific dynamics in order to determine not just *what* support to offer, but *when* it should be delivered. Timing, in this sense, is not just logistical: it is psychological and relational. If mistimed, even well-designed support may be disregarded or perceived as inauthentic.

Building on suggestions made in extant literature (e.g., Evers et al., 2024; Westlake et al., 2023), our findings advance current knowledge by demonstrating that the timing of support is not peripheral, but a core tenet shaping the effectiveness of SP programmes, especially when tailored to the identity-specific needs of TGDYP. Yet even when support is well-timed, its success also depends on *how* it is delivered and by *whom.* The next section explores this, highlighting the critical role of link workers as facilitators of identity-affirming, meaningful group connections.

### *9.4.2. Effective Resourcing of SP Programmes: The Importance of Link Workers*

To date, research has been unable to clearly establish the role of link workers in SP (Bickerdike et al., 2019). This has led to inconsistent SP design and delivery, where the utilisation of link workers has been largely dependent on resource availability rather than strategic planning (Sharman et al., 2022; Wilding et al., 2024). However, our findings question the notion that link workers merely signpost to support. Instead, Study 1 highlighted that link workers can support the development of *meaningful* group memberships through referring to identity-affirming groups and fostering self-efficacy for social engagement. Thus, this thesis extends our understandings of the link worker role, clarifying *how* and *why* link workers must act as more than administrative connectors. Rather, well-resourced link workers can actively scaffold Social Cure processes by facilitating tailored, affirming connections that support identity development and social integration.

Later studies in this thesis refine this understanding, illustrating that link workers' ability to promote Social Cure processes may be influenced by perceived identity alignment. For instance, across Study 2, Part 1 and Study 3, the relational aspects of support delivery emerged as critical. Support was more likely to be accepted, and experienced as meaningful, when it was offered by someone who understood TGDYP experiences. In Study 3, this was particularly evident in reflections of Care Navigators (akin to link workers). While all Care Navigators within the clinic evaluated in Study 3 had lived experience, and thus no direct comparison could be made to those without it, the data suggests that shared identity and perceived understanding were central to establishing trust and supporting engagement. This echoes extant literature on the increased receptiveness to, and value of, receiving support from those with shared identities (e.g., Haslam et al., 2018). These findings suggest that Link Workers must not only be attuned to the timing and nature of support, but must themselves be seen as identity-relevant and affirming if they are to enable TGDYP to access the benefits of social connection theorised by the SIAH.

These findings underscore a key insight: identity alignment is not a supplementary benefit, but a core mechanism. This challenges much existing SP literature, which tends to under-theorise the relational dynamics of link worker interactions (Evers et al., 2024; Westlake et al., 2023), and rarely accounts for the role of facilitators' identity in shaping social support outcomes. Given the paucity of research focused on link workers specifically, we looked to the broader group facilitation literature to contextualise these findings. While some work has acknowledged the importance of facilitator-participant relationships for group cohesion and safety (e.g., Coholic et al., 2019), facilitators are often framed as hierarchical actors (Curtin & Hitch, 2018). Our findings extend these understandings, illustrating that effective facilitator-participant relationships are those where the perceived identity of the facilitator matches the target group. This identity alignment is of increased importance for minoritised groups where outgroup support may be received as inauthentic (Livingstone, 2023). In this way, link worker identity alignment is not just a matter of comfort, but a precondition for activating the psychological mechanisms that underpin effective SP.

Collectively, these insights raise practical questions about who is best positioned to facilitate identity-relevant support for TGDYP. Particularly within the resource constraints of GICs, this prompts consideration of how such roles can be embedded in ways that are contextually appropriate and trusted by TGDYP (see 9.5.3. Practical Implications for further discussion). However, while timing and facilitation are critical, so too is the broader setting in which support is delivered. As explored next, the positioning of SP, whether embedded within NHS systems or delivered through the community sector, plays a pivotal role in determining whether support is perceived as accessible, trustworthy, and affirming by TGDYP.

### *9.4.3. Positioning of Support: NHS Vs. Community-Led Social Support Pathways*

Typically, SP is delivered as a partnership between primary care and the community sector. However, given many TGDYP approach GICs for care (despite GICs' shortcomings; Holti et al., 2024), this thesis sought to explore how SP could complement GIC pathways as opposed to extending primary care-led SP for TGDYP. Having said that, our findings offer a new perspective on how delivery setting is not just a practical consideration, but a key determinant of whether support is trusted, accepted, and experienced as identity-affirming.

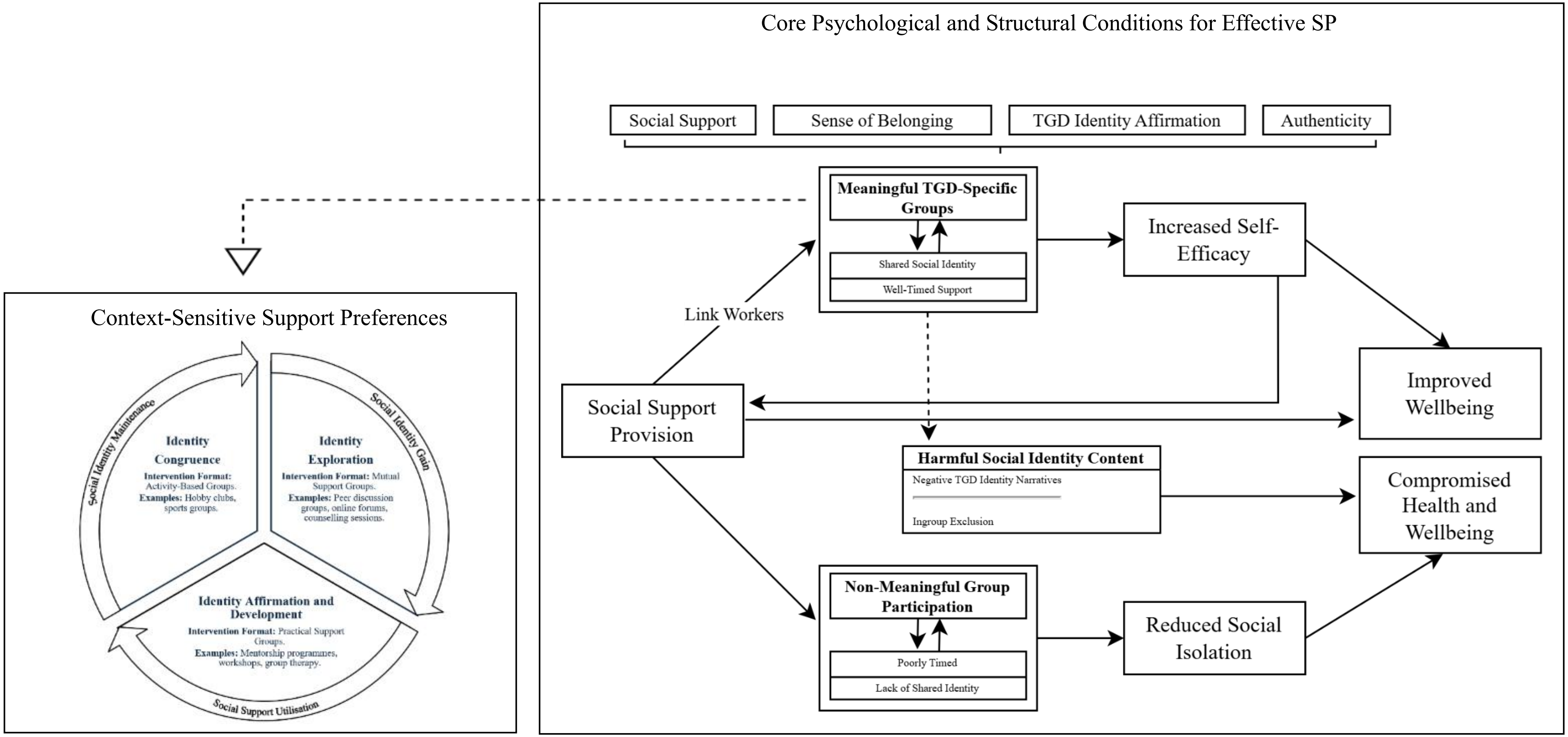
For instance, while Study 2 did not explicitly identify the community sector as a preferred provider, participants expressed a wide range of needs that could not be easily met within existing statutory services (i.e., GICs; Horton, 2024). Study 3 reinforced this, revealing an overstretched service that could not offer timely access to social support. Responsively, TGDYP reported heightened mistrust and an eagerness to disengage from medicalised services such as GICs, reflecting a desire for more accessible, everyday forms of care that are not tethered to medical transition. Similar calls have been made in the international literature to enhance TGDYP's access to social support (Coleman et al., 2022; Johson & Rogers, 2019; Mayfaire et al., 2021; and Zwickl et al., 2019). This is because community-led provisions can facilitate trust in support pathways as emphasised in Study 2, Part 1 and Study 3 (also see Haslam et al., 2018; Livingstone, 2023 on the value of in-group support), and can increase access to support through mainstreaming services (Zwickl et al., 2019).

At the same time, participants also expressed hesitation at engaging with community-led services, questioning whether these spaces would be consistently trans-affirming, particularly for non-binary individuals (see Study 2, Part 1). This reflects ongoing issues experienced by TGDYP when accessing community support (Cronin et al., 2023; Lewis et al., 2022). Thus, despite frustrations with GICs, many TGDYP often still expressed a preference for GIC-facilitated SP, but with the caveat that this support needs to be provisioned earlier in their care pathway. Since GICs currently lack the capacity to meet this expectation (Horton, 2024; also see Study 3), the desire for GIC-facilitated SP remains unfeasible. This reveals a structural paradox: the spaces perceived as most affirming are often the least accessible, while those seen as accessible are not always trusted.

Rather than advocating for a single delivery route, our findings support the need for a layered model of SP: one that combines the trans-affirming nature of GICs with the identity specificity and flexibility of community-led initiatives. This is particularly important in light of Study 2, Part 1's findings that identity-aligned support is not universally accessible within existing group structures (also see McAuliffe et al., 2022; Rimmer et al., 2022), and that exclusion (especially of non-binary individuals) can undermine the psychological benefits of social connection. A responsive SP model must therefore attend not only to identity congruence (Cruwys et al., 2014; also see Chapter's 7 and 8), but also to the structural conditions under which group memberships are experienced as authentic and supportive.

Bringing together these mechanisms and structural considerations discussed across this chapter, Figure 9.1 presents an adapted theoretical model of SP for TGDYP. Building on the earlier SIAH-informed model developed in Chapter 3, this revised version integrates empirical insights from across the thesis, illustrating the core enabling mechanisms for wellbeing and the features that may compromise outcomes when SP is not carefully attuned to the needs of TGDYP. In doing so, this thesis moves beyond existing models of SP delivery to offer a framework that is aligned with the identity needs of TGDYP. This model highlights how SP's effectiveness for TGDYP is shaped as much by *what* is offered as by *how* and *where* support is delivered: a point that holds significant implications for future design and implementation, explored in the following section.

**Figure 9.1.**
*SIAH-Informed Model of Social Prescribing for TGDYP: Key Conditions and Pathways for Effective Support*



## 9.5. Implications

The previous section integrated findings across the thesis to outline the key mechanisms, conditions, and structural considerations that underpin effective SP for TGDYP. This section now turns to the broader implications of these findings, highlighting their contribution to theory, methodology, and practical implementation.

### *9.5.1. Theoretical Implications*

This thesis makes several theoretical contributions that advance understanding across three domains: 1) Applying the SIAH to TGDYP; 2) Extending the SIAH; and 3) Advancing theoretical understandings of SP. This section explores each of these in turn.

#### 9.5.1.1. Applying the SIAH to TGDYP

By applying the SIAH to explore TGDYP's experiences, this thesis offers an alternative conceptual lens to GMST (Meyer et al., 2015) which primarily positions social support as a buffer against internalised minority stress. Instead, the SIAH (Haslam et al., 2018) allowed us to simultaneously view social support as actively health enhancing, elucidating the conditions that enhance (i.e., well-timed, inclusive groups positioned within trusted and accessible services) or undermine (i.e., poorly timed, exclusionary and identity misaligned groups) such support. In this way, our findings provide new insights to a previously neglected dimension of TGDYP's social support experiences: *when* and *why* social support is (or is not) effective (Chi, 2023; Rimmer et al., 2022).

Furthermore, a SIAH lens allowed our findings to shed light on identity-specific factors that shape the effectiveness of social support for TGDYP. While previous research had documented disparate outcomes between TGD individuals and their cisgender LGBQ peers in response to comparable levels of social support (Puckett et al., 2019), reasons for these outcomes have been largely unexplored. Dubois and colleagues (2017) suggest transitioning identity stress, defined as the stress associated with one's changing gender identity and others' perceptions of that change. However, they predominantly focus on physiological consequences rather than the underlying psychological processes that contribute to negative health outcomes. By applying the SIAH, we build on earlier findings by illustrating the mechanisms through which gender transition impacts health: not only by increasing exposure to minority stress (Dubois et al., 2017; Meyer et al., 2015), but by reshaping broader social identities and, in turn, access to health-protective group memberships (see Jetten et al., 2017 on the SIMIC).

The SIAH lens also enables us to identify how TGDYP's salient social identities shift across transition (see Jetten et al., 2017 on the SIMIC). This helps explain why TGD individuals benefit less from generic forms of social support than their cisgender LGBQ peers (e.g., Puckett et al., 2019): as identity salience changes, the types of support that are effective, namely, support that is identity aligned, must also shift. Taken together, these insights demonstrate the explanatory power of the SIAH in comparison to GMST in advancing theoretical understandings of TGDYP's social support experiences. By explaining how shifting identity salience impacts access to health-enhancing group memberships, this framework shows that support is not inherently beneficial, but contingent on social identity alignment. Such understanding is critical if interventions are to meaningfully harness the power of social support to improve TGDYP's health and wellbeing.

#### 9.5.1.2. Extending the SIAH

By applying the SIAH to TGDYP, this thesis both evidences the framework's theoretical utility and identifies important refinements. Our findings affirm the central claim of the SIAH: that meaningful group memberships underpin the health benefits of social support. However, they also show that what constitutes a *meaningful* group membership cannot be assumed, especially in contexts of minoritisation. For TGDYP, shared identity alone was not always sufficient for meaningful connection. Intragroup tensions, such as transnormativity[18] and non-binary exclusion, undermined belonging even in seemingly identity-matched spaces. This highlights the need to understand how power, exclusion, and legitimacy operate within minoritised communities, and to avoid essentialising identity similarity as inherently health-enhancing.

In doing so, we also highlight the importance of recognising how social identities shift across transition. While the SIMIC model (Jetten et al., 2017) typically presents identity change as a linear process from old to new, TGDYP described cyclical experiences, such as returning to earlier identity stages or navigating repeated "coming out" moments. This suggests a more dynamic, recursive identity process, calling for a re-conceptualisation of identity change within the SIAH for populations undergoing ongoing identity renegotiation.

Finally, our findings refine existing understandings of multiple group memberships. Prior work emphasises their value in supporting individuals' multiple co-existing identities (Charles et al., 2023). However, we show that for TGDYP, identity needs are not only multiple

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[18] Transnormativity refers to the societal privileging of TGD identities that conform to binary gender norms, medical transition, and cisnormative expectations, often marginalising more diverse TGD experiences (Lindley & Budge, 2023).

but also shifting. Thus, the benefit of multiple group memberships lies not solely in their simultaneity but in their sequencing, enabling flexible engagement with different groups as identities evolve. This introduces a crucial temporal dimension to the SIAH, with direct implications for how support is structured to meet changing identity needs over time (see 9.5.3. Practical Implications).

#### 9.5.1.3. Advancing Theoretical Understandings of SP

Finally, this thesis makes a novel theoretical contribution by applying the SIAH to SP: a connection explored in some literature (Haslam et al., 2024; Kellezi et al., 2019; Stevenson et al., 2019; Wakefield et al., 2020), but that had not yet been systematically explored across a large body of work. By grounding SP in the SIAH, this thesis provides a theory-based understanding of its effectiveness, clarifying that it is not merely the provision of support that matters, but whether that support facilitates identity-relevant group memberships.

These understandings have direct implications for SP implementation. Specifically, how SP can be designed and implemented to meet the identity-relevant needs of the groups it aims to serve. This is because the degree to which an individual identifies with a group (and can thus access psychological benefits of group membership) is dependent on whether one's salient social identity aligns with the group in question (Haslam et al., 2023; Tajfel & Turner, 1979). Thus, if the aligned social identity is not salient, individuals will not *identify* with the group, and therefore will not benefit from SP that provisions those group spaces. Particularly for TGDYP, and as mentioned prior, the likelihood of SP connecting individuals to these meaningful group spaces is also influenced by the timing and delivery of support. Thus, through identifying SIAH processes as central to SP effectiveness, future SP provision must shift away from referral models toward a more relational and identity-responsive approach if SP is to harness consistent benefits.

#### 9.5.1.4. Theoretical Implications: Summary

Together, these theoretical contributions expand our understandings of how social identity processes shape the health and wellbeing of TGDYP. By applying and extending the SIAH framework, this thesis highlights the context-dependent nature of social support, illustrating how, while *shared identity* and *meaningful* social relationships are core to health benefits, this is contingent upon identity alignment, inclusivity of group boundaries, and the ability of these social relationships to match shifting social identities. By grounding SP in these SIAH processes, this work offers a robust foundation for designing effective SP interventions for TGDYP. These theoretical advancements deepen conceptual understandings and also highlight the need for innovative methodological approaches to capture the dynamic and nuanced social identity processes experienced by TGDYP. The following section reflects on our use of a novel analytical framework used to do this, the QTF, and the methodological implications of this.

### *9.5.2. Methodological Implications*

This thesis introduced a novel methodological contribution: the Qualitative Triangulation Framework (QTF), developed to address the complex, and at times, conflicting experiences among TGDYP and key stakeholders (i.e., GIC clinicians, support workers). As detailed in Chapter 5, the QTF moves beyond traditional applications of triangulation as a tool for validating findings through convergence. Instead, the QTF explicitly captures discordant perspectives, enabling multifaceted experiences to emerge and foreground analytical conclusions. These insights were vital for understanding differences among TGDYP in how social support was received and experienced, and between TGDYP and professionals regarding the key issues negatively impacting TGDYP's healthcare experiences.

The implications of this are significant. In the context of TGD healthcare research and service development, a predominant focus on majority or 'typical' narratives has, at times, contributed to the implementation of services that align with institutional logic but not with the lived needs of the communities they serve (Horton, 2024). This has meant that 'improvements' in TGD healthcare have not consistently translated into improved health outcomes for TGDYP populations (see Study 2, Part 2 in Chapter 7).

By centring divergence, the QTF offers a method towards *epistemically-just* research practice where minoritised voices are not only included, but treated as essential to understanding the barriers to effective support (McIntosh & Wilder, 2022). While we demonstrated the value of these insights for research with TGD populations, the QTF also presents itself as a novel analytical tool for research with multiple populations who may be minoritised or in conflict. Ultimately, future research would benefit from adopting the QTF, particularly in areas such as SP, where intra- and inter-group variability impact the development of meaningful group memberships, but are often overlooked (Handayani et al., 2025).

### *9.5.3. Practical Implications*

The findings presented across this thesis have important implications for the future design and delivery of GAC in England. While current debates often focus on reducing long waiting times for GICs (e.g., Marshall et al., 2019; Shuster & Westbrook, 2022), our data suggests that delays are only one part of the problem. For TGDYP, the complexity, lack of clarity, and limited visibility of outcomes within existing pathways can be equally detrimental, impeding their ability to imagine a future as their true selves. These experiences become compounded by the increasingly hostile social and political climate for TGDYP globally, in which their identities are not recognised as legitimate or valuable in their own right, but are instead instrumentalised within political debates (Horton, 2024).

In this context, SP has the potential to serve as a vital adjunct to GAC by offering timely, identity-aligned social support during periods of waiting and uncertainty. However, the effectiveness of SP in this role will depend heavily on how it is positioned and delivered, particularly given TGDYP's shifting identity needs (see Study 3 in Chapter 8), longstanding mistrust with both community and NHS partners (see Studies 2 and 3 in Chapters 6 through 8), and the resource constraints of GICs (Silver et al., 2025; Thibeault et al., 2025). Thus, SP for TGDYP must be well-resourced to meet this variety of need *and* be delivered by trusted partners.

It is also important to recognise that even well-resourced, identity-aligned SP will not be equally accessible or beneficial for all TGDYP, and in some circumstances may inadvertently reproduce exclusion or distress if delivered in inflexible ways (e.g., Study 3 in Chapter 8). Some participants described discomfort with group-based social interaction, while others faced barriers related to neurodivergence, social anxiety, or communication differences that made conventional social activities difficult to access or sustain. For these individuals, models of social prescribing that rely heavily on unstructured group interaction or verbal engagement may be experienced as overwhelming, exclusionary, or even harmful (McAuliffe et al., (2023). Importantly, this does not indicate a lack of need for social support, but rather a mismatch between support format and individual preference or capacity (Featherstone, 2024).

These findings suggest that social prescribing pathways should not be conceptualised solely as facilitating social interaction, but instead as enabling access to a range of identity-affirming and psychologically supportive activities. For some TGDYP, this may involve activity-based or purpose-led groups that allow connection to develop indirectly (e.g., through shared tasks or interests), smaller-scale or one-to-one support, or settings that allow for parallel participation without pressure to engage socially. Safeguarding requirements, facilitation styles, and the availability of trained link workers are also likely to shape accessibility for TGDYP with complex needs (Featherstone, 2024). Without such flexibility, social prescribing risks reproducing exclusion by privileging forms of sociability that are not universally accessible. A more inclusive approach would therefore involve offering multiple modes of engagement and recognising that meaningful social support does not always require, or result from, direct social interaction.

As discussed in Study 3 (Chapter 8), one potential strategy is for GICs to outsource SP delivery to existing providers, such as NHS Property Services, which already offer dedicated SP hubs, while retaining referral and care coordination within identity-relevant roles. Outsourcing in this manner offers strategic benefits: these providers already possess the necessary infrastructure, staffing models, and referral pathways to scale SP provision effectively. Crucially, positioning SP outside of GICs also increases accessibility for TGDYP who are on waiting lists for GICs, have been discharged back to primary care, or who are not seeking medically-based GAC. However, for this approach to succeed, it must be coupled with the development of trans-specific, trans-led programmes within these broader structures (see Study 2 in Chapter 6). Without this, SP risks replicating the same mismatches and exclusions found in other parts of the healthcare system (e.g., Scheim et al., 2024; Wilson & Liss, 2023).

To facilitate meaningful engagement, link workers, who serve as key facilitators of SP referrals and engagement (Staras et al., 2024), must be trained to assess where individuals are in their identity journeys and to connect them with support that aligns with their current identity needs. One promising route is the adaptation of existing Care Navigator roles within GICs. Many Care Navigators already bring lived experience and operate within affirming institutional settings, offering the potential for shared identity and relational trust: factors that have been shown to be critical for TGDYP engagement (see Studies 2 and 3 in Chapters 6 & 8). When appropriately resourced and positioned, Care Navigators could help reposition SP not as a gatekeeping mechanism or bureaucratic diversion, but as a credible and supportive offer in its own right.

## 9.6. Strengths and Limitations

### *9.6.1. Strengths*

This thesis makes several contributions to SIAH, SP, and GAC literature, enhancing our understandings of how to meaningfully design and implement SP initiatives to improve the health and well-being of TGDYP. This theoretically-grounded, data-driven approach enabled the thesis to respond to NHS calls for holistic approaches to GAC (NHS, 2019), providing a road map for how to effectively implement SP for TGDYP. This represents a key strength of the thesis: its ability to translate complex theoretical insights into practical, scalable strategies that directly address systemic shortcomings in the current provision of care for TGDYP.

We also offer novel theoretical understandings of the social support experiences of TGDYP. As mentioned prior, while research had established the health benefits of social support for TGDYP (e.g., Pucket et al., 2019; Wilson & Liss, 2023), this literature had been unable to account for disparate outcomes stemming from social support provision (Chi, 2023; Rimmer, 2022). Advantageously then, this thesis overcame these limitations present in prior literature by applying the SIAH to elucidate the psychological processes that enable meaningful, health enhancing social support, and the conditions that undermine these positive outcomes. Similarly, in Study 1, our application of the SIAH to SP programmes enabled us to identify the active mechanisms that underpin effective SP. Not only does this extend current literature, but it allows researchers to develop social support interventions that harness the power of meaningful group memberships to ensure intervention success.

These insights in Study 2 were facilitated by our novel methodological tool, the QTF, by enabling the systematic inclusion of divergent and often minoritised perspectives. By moving beyond convergence-driven approaches, and giving voice to multiple stakeholder groups, we demonstrate that actionable recommendations can still be drawn from divergent perspectives (e.g. Campbell et al., 2018). In doing so, the proposed SP pathway attends to multiple needs present within TGDYP communities while also being responsive to the systemic limitations highlighted by professionals.

This systematic approach to our data was present across all studies within this thesis, from our systematic review (see Chapter 3) through to our use of the QTF (see Chapters 5, 6 & 7) and Framework Analysis (Chapter 8), the route from raw data to thematic presentation is clear and grounded. While qualitative research is often criticised for its opaqueness and positioned as inferior to quantitative data (Masaryk & Rogers, 2024), we demonstrate that systematic and transparent engagement with qualitative data can produce insightful and impactful outcomes. This clarity was driven by our commitment to Open Research principles. We pre-registered[19] Study 1 on Prospero (registration number: CRD42023427377) and Study 2 on the OSF (https://osf.io/xqp9h), detailing research questions, methods, and analysis plans to ensure transparency and reproducibility. Additionally, we collected data from both TGDYP and professionals working with this population, demonstrating a commitment to emancipatory research without imposing a sole knowledge burden on minoritised communities. Reducing the knowledge burden on TGDYP was further facilitated by making our data partially open, with

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[19] Study 3 was not pre-registered because it was an internal service evaluation and as such reproducibility is not its primary goal.

data from Study 2 (parts 1 and 2) available on request, and data from Study 3 deposited under safeguarded access on the UK Data Service (Study Number: 857823). Ultimately, our emancipatory methodology allowed the proposed SP pathway to be shaped by TGDYP. Open data and materials make these methods and findings transparent to others, increasing trust and accessibility of research recommendations to influence positive change in GAC.

### *9.6.2. Limitations*

While this thesis offers important insights, it is not without limitations. First, although the findings identify a set of proposed mechanisms, such as identity-congruent support, authenticity, and timing, as central to effective SP for TGDYP, these mechanisms have been inferred from qualitative and cross-sectional data. While theoretically grounded, they remain hypothesised pathways and require further empirical testing to determine their generalisability and causal influence. Future work should evaluate these mechanisms in applied settings, particularly through intervention-based and implementation studies.

Second, although this research attends to identity salience and transition as evolving processes, the cross-sectional and retrospective nature of the data limited our ability to trace identity change as it unfolds over time. A longitudinal research design would be better suited to capturing how support preferences shift in relation to identity development, and how particular forms of support accrue or diminish in meaning over time.

Third, in Study 3, we collected open-ended survey data instead of conducting interviews in light of recruitment challenges. While this was a necessary pragmatic decision, it limited our ability to follow-up on participants reported experiences and capture the same level of nuance that emerged in earlier qualitative phases (i.e., Study 2). This difference in data quality further reinforced the rationale for adopting Framework Analysis in this study as its structured and pragmatic approach was better suited to data that prioritised breadth and applicability over depth (see Chapter 4). Nevertheless, future research should consider alternative methods for collecting rich qualitative data from TGDYP that account for the current hostile political climate, which may reduce participants' willingness or capacity to engage in research (Horton, 2024).

These limitations do not detract from the value of the findings, but rather highlight important areas for future investigation to ensure the robustness, applicability, and sustainability of SP models designed for TGDYP.

### *9.6.3. Reflexivity*

In addition to the methodological strengths and limitations outlined above, it is also important to reflect on positionality, and how this shaped the conduct and interpretation of the research that comprises this thesis. Over the course of this research, I have developed a more critical and theoretically grounded approach to intervention design, recognising the limitations of individual-level framings in addressing structural barriers to care. The introduction of the moratorium on new GAC developments marked a turning point in my thinking, illustrating the challenges of generating recommendations within politically and institutionally constrained environments. This prompted a deeper engagement with the systemic conditions that shape both the feasibility and impact of interventions. I also refined my use of open research practices, not as a neutral ideal, but as a means of enhancing rigour and transparency in research shaped by personal investment. These developments have strengthened my capacity to navigate the ethical and methodological demands of working at the intersection of minoritised experience, policy, and service provision.

## 9.7. Future Research

### *9.7.1. Operationalisation of SIAH Pathways*

While this thesis has drawn on qualitative insights to establish the conditions under which meaningful SP can be designed and implemented (see Figure 9.1), the pathways proposed remain theoretically grounded and have not yet been quantitatively tested. Given the preference of healthcare systems for quantitative evidence in the adoption of new interventions (Guetterman, 2019), future research would benefit from quantitatively validating this model (see Figure 9.1).

A particular priority for future research is the use of longitudinal designs. SIAH research (Dingle et al., 2024) and our empirical findings alike highlight that the benefits of social connection are unlikely to emerge immediately, but rather develop over time. Capturing these temporal dynamics is essential to understanding the longer-term impact of social support. Longitudinal data would also allow researchers to track how TGDYP's social identities shift over time and shape what *meaningful* social support looks like, addressing a key limitation of the current thesis' reliance on cross-sectional and retrospective accounts.

### *9.7.2. Implementing SP for TGDYP*

Although this thesis has laid the groundwork for designing and implementing SP for TGDYP, ongoing reforms within GAC limited our ability to trial an SP programme in line with the suggestions made within this thesis. Further, outstanding challenges remain about how trusted relationships can be built between established SP providers and GICs in order to implement and test the model proposed in this thesis. Responsively, future research would benefit from exploring 1) established SP providers capacity to deliver trans-specific programmes; 2) GICs willingness to outsource support to these providers; 3) the capacity of Care Navigators to oversee these support pathways; and 4) TGDYP's trust in, and readiness to engage with, SP delivered in this manner. In addition, future work should consider how TGDYP who do not disclose their trans status to GPs, often because they are not pursuing medically based care and for whom social affirmation is therefore increasingly important (see Study 2, Part 1), can still be made aware of, and access, SP delivered through the model proposed in this thesis. Clarifying these pending questions would strengthen current understandings of how to effectively design SP for TGDYP, and prepare researchers and key stakeholders for delivering SP that enhances, rather than undermines TGDYP's health.

## 9.8. Conclusion

This thesis has explored how SP can be effectively designed and implemented for TGDYP. Drawing on the SIAH, meaningful social identities, defined as those in which individuals experience a sense of shared identity with others, are central to effective SP. However, the development of such connections are suggested to be shaped by structural factors including timing, resource availability, and the positioning of support. Intra-group dynamics, namely in-group discrimination and negative identity narratives, also undermine the protective effects of social support.

In light of these factors, this thesis proposes an SP model for TGDYP that builds on the structural strengths of existing SP infrastructure (i.e., increased resources and flexibility over timing of support) while retaining the affirming and identity-relevant practices TGDYP experience within GICs, particularly those led by practitioners with lived experience. Central to this model is identity alignment, ensuring support is not only available but resonates with TGDYP's evolving social identity needs. Ultimately, effective SP for TGDYP requires not only access, but identity attunement: support that meets people *where they are*, not where systems assume them to be. While important questions remain for future research, particularly around how to build effective partnerships between GICs and SP providers, this thesis presents the first dedicated model of SP for TGDYP. In doing so, we offer a tangible route toward holistic care that recognises social identity as central to wellbeing, not incidental, aligning with NHS priorities to address the social determinants of health in TGDYP healthcare.

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# Appendices

## Appendix 1: Systematic Review Consort-SPI (2018) Quality Appraisal

| **Section** | **Checklist Item** | **Articles Included** | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Greaves & Farbus (2006). | Giebel et al. (2020). | Foster et al. (2021). | Venter & Buller (2015). | Roberts & Windle (2019). | Thomson et al. (2020). | Simpson et al. (2020). | Todd et al. (2017). | Kellezi et al. (2019). | Wakefield et al. (2020). | Redmond et al. (2018). | Woodall et al. (2018). | Cheshire et al. (2022). | Vogelpoel & Jarrold. (2014). | Hassan et al. (2020). | Moore & Thew (2022). | Orellana et al. (2020). | Finn et al., 2023. | Porter et al., 2023. |
| **Title and Abstract** | Item 1a.<br>Identification of the study as randomised. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Item 1b.<br>Structured summary of trial design, methods, results, and conclusions. | 1 | 1 | 1 | 1 | ½ | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| **Introduction** | Item 2a.<br>Scientific background and explanation of rationale/s. | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | Item 2b.<br>Specific objectives or hypotheses. If pre-specified, how the intervention was hypothesised to work. | ½ | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | ½ | 1 | 1 |
| | Item 3a. | ½ | 0 | ½ | 1 | ½ | ½ | ½ | ½ | ½ | ½ | ½ | ½ | ½ | ½ | ½ | ½ | ½ | ½ | ½ |

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| **Methods: Trial Design** | Description of trial design, including allocation ratio/s. | | | | | | | | | | | | | | | | | | | |
| | Item 3b.<br>Important changes to methods after trial commencement with reasons. | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| **Methods: Participants** | Item 4a.<br>Eligibility criteria for participant/s. When applicable, eligibility criteria for settings and those delivering the interventions. | 1 | 1 | 1 | 1 | 1 | 1 | 1 | ½ | 1 | 1 | 1 | 1 | 1 | 1 | ½ | ½ | 1 | 1 | 1 |
| | Item 4b.<br>Settings and locations where the data were collected. | 1 | ½ | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | ½ | ½ | 1 | 1 | 1 | 1 |
| **Methods: Intervention** | Item 5.<br>The interventions for each group with sufficient details to allow replication, including how and when they were actually administered. | 1 | 1 | 1 | 1/2 | 1 | 1 | ½ | 1 | ½ | 1 | ½ | ½ | 1 | ½ | 1 | ½ | 1 | 1 | ½ |
| | Item 5a.<br>Extent to which interventions were actually delivered by providers and taken up by participants as planned. | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | ½ | 1 | 0 | ½ | 0 | 0 | 0 | 0 | ½ | 0 | 0 |
| | Item 5b. | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | ½ | 0 | 0 | 0 | 1 | 0 | ½ | 0 | 0 | 1 | ½ |

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| | Where other information materials about delivering the intervention can be accessed. | | | | | | | | | | | | | | | | | | | |
| | Item 5c.<br>When applicable, how intervention providers were assigned to each group. | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 0 |
| **Methods: Outcomes** | Item 6a.<br>Completely defined pre-specified outcomes, including how and when they were assessed. | 1 | 1 | ½ | 1 | 1 | 1 | ½ | 1 | 1 | 1 | ½ | 1 | 1 | 1 | 1 | ½ | 1 | 1 | 1 |
| | Item 6b.<br>Any changes to trial outcomes after the trial commenced, with reasons. | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| **Methods: Sample** | Item 7a.<br>How sample size was determined. | ½ | ½ | ½ | ½ | ½ | 0 | 1 | 1 | 1 | ½ | ½ | 0 | ½ | 0 | 0 | 0 | 1 | 1 | 0 |
| | Item 7b.<br>When applicable, explanation of interim analyses and stopping guidelines. | 0 | 0 | 0 | 0 | 0 | ½ | 0 | 1 | 1 | ½ | 0 | 0 | 0 | 0 | 0 | 0 | 0 | ½ | 0 |
| **Methods: Randomisation:** | Item 8a. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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| **Sequence Generation** | Method used to generate the random allocation sequence. | | | | | | | | | | | | | | | | | | | |
| | Item 8b.<br>Type of randomisation; details of any restriction. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Methods: Randomisation: Allocation Concealment Mechanism** | Item 9.<br>Mechanism used to implement the random allocation sequence, describing any steps taken to conceal the sequence until the interventions were assigned. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Methods: Randomisation: Implementation** | Item 10.<br>Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Methods: Awareness of Assignment** | Item 11a.<br>Who was aware of intervention assignment after allocation, and how any masking was done. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Item 11b.<br>If relevant, description of the similarity of interventions. | 0 | 0 | 0 | ½ | 0 | 0 | 0 | ½ | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | ½ |
| **Methods: Analytical Methods** | Item 12a.<br>Statistical methods used to compare group | 1 | n/a | 1 | 1 | 1 | 1 | n/a | n/a | ½ | 1 | n/a | ½ | n/a | n/a | n/a | n/a | 0 | ½ | n/a |

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| | outcomes. How missing data were handled with details of any imputation method. | | | | | | | | | | | | | | | | | | | |
| | Item 12b.<br>Methods for additional analyses, such as subgroup analyses, adjusted analyses, and process evaluations. | 1 | n/a | 1 | 1 | 1 | 0 | n/a | n/a | 1 | 1 | n/a | 1 | n/a | n/a | n/a | n/a | 0 | 1 | n/a |
| **Results: Participant Flow** | Item 13a.<br>For each group, the numbers randomly assigned, receiving the intended intervention, and analysed for the outcomes. Where possible, the number approached, screened, and eligible prior to random assignment, with reasons for non-enrolment. | ½ | ½ | 1 | ½ | 1 | 1 | 0 | ½ | ½ | 1 | 1 | 1 | 1 | ½ | ½ | ½ | ½ | 1 | ½ |
| | Item 13b.<br>For each group, losses, and exclusions after randomisation together with reasons. | ½ | ½ | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 1 | ½ | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| **Results: Recruitment** | Item 14a.<br>Dates defining the periods of recruitment and follow-up. | 1 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | ½ | 1 | 1 | 0 | 1 | ½ | 1 | 0 | 1 | 1 | 1 |
| | Item 14b.<br>Why the trial was ended or was stopped. | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | ½ | ½ | ½ | 0 | 0 | 0 | ½ | 0 |

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| **Results: Baseline Data** | Item 15.<br>A table showing baseline characteristics for each group. Include socioeconomic variables where applicable. | 1 | ½ | 1 | 1 | 1 | ½ | ½ | 1 | 1 | 1 | 0 | 1 | 1 | ½ | 0 | 1 | 1 | 1 | 0 |
| **Results: Numbers Analysed.** | Item 16.<br>For each group, number included in each analysis and whether the analysis was by original assigned groups. | 1 | 1 | 1 | ½ | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1/2 |
| **Results: Outcomes and Estimation** | Item 17a.<br>For each outcome, results for each group, and the estimated effect size and its precision. Indicate availability of trial data. | 1 | n/a | ½ | 1 | 1 | 1 | n/a | n/a | ½ | ½ | n/a | 1 | n/a | n/a | n/a | n/a | 0 | 1 | n/a |
| | Item 17b.<br>For binary outcomes, presentation of both absolute and relative effect sizes is recommended. | 1 | n/a | 1 | ½ | 1 | 1 | n/a | n/a | 1 | 1 | n/a | 1 | n/a | n/a | n/a | n/a | 0 | 1 | n/a |
| **Results: Ancillary Analyses** | Item 18.<br>Results of any other analyses performed, including subgroup analyses, adjusted analyses, and process evaluations, distinguishing pre-specified from exploratory. | 1 | n/a | 1 | 1 | 1 | 0 | n/a | n/a | 1 | 1 | n/a | 1 | n/a | n/a | n/a | n/a | 0 | 1 | n/a |
| **Results: Harms** | Item 19. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | ½ | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | ½ | 1 |

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| | All-important harms or unintended effects in each group. | | | | | | | | | | | | | | | | | | | |
| **Discussion: Limitations** | Item 20.<br>Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses. | 1 | 1 | 1 | ½ | 1 | 0 | 1 | 1 | 1 | 1 | ½ | 1 | ½ | 0 | ½ | ½ | 1 | 1 | 1 |
| | Item 21.<br>Generalisability of the trial findings. | 1 | ½ | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | ½ | 1 | 1 | 1 | 1 | 1 | 1 |
| **Discussion: Interpretation** | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence. | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| **Important Information: Registration** | Item 23.<br>Registration number and name of trial registry. | 0 | 0 | 0 | 0 | 0 | 0 | ½ | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Important Information: Protocol** | Item 24.<br>Where the full trial protocol can be accesses, if available. | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Important Information: Declaration of Interests** | Item 25.<br>Sources of funding and other support, role of funders. Declaration of any other potential interests. | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 |
| **Important Information:** | Item 26a. | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 1 |

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| **Stakeholder Involvement** | | | | | | | | | | | | | | | | | | | | |
| | Any involvement of the intervention developer in the design, conduct, analysis, and reporting of the trial. | | | | | | | | | | | | | | | | | | | |
| | Item 26b. | 1 | 1/2 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 1 |
| | Other stakeholder involvement in trial design, conduct, and/or analyses. | | | | | | | | | | | | | | | | | | | |
| | Item 26c. | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 |
| | Incentives offered as part of the trial. | | | | | | | | | | | | | | | | | | | |
| **Count** | | 24 ½ | 14 ½ | 22 | 24 ½ | 25 ½ | 20 ½ | 18 ½ | 18 | 26 ½ | 25 | 14 ½ | 19 | 18 ½ | 14 ½ | 14 ½ | 14 | 19 | 28 ½ | 17 |
| **Percentage*** | | 57% | 38% | 51% | 57% | 59% | 48% | 49% | 47% | 62% | 58% | 38% | 44% | 49% | 38% | 38% | 37% | 44% | 66% | 45% |

## Appendix 2: Study Two Information and Consent Form for Trans and Gender Diverse Young People

# Information sheet: Understanding how valuable group memberships can benefit sense of belongingness, health, and wellbeing of trans and gender diverse young people in England and Wales.

## What is the study about?

My name is Chase Staras, and I am a PhD candidate at Nottingham Trent University. This study aims to understand the current engagement of young trans and gender diverse populations with community and social groups. It also aims to explore what types of group activities may be beneficial, how these groups may be valuable, and potential challenges to engagement. I hope that this knowledge will help inform effective interventions aimed at reducing loneliness among trans and gender diverse people.

## What will I be asked to do?

You will be asked to take part in a one-hour interview, conducted on Microsoft Teams. The interview will include questions about your current engagement with social and community groups, barriers to accessing and participating in community groups, and what social groups you would prefer or would find beneficial. With your permission, the interview will be video-recorded (if you switch on your webcam), or audio-recorded (if you do not switch on your webcam).

We know that for many people, this might be a topic that brings up difficult memories. So, if at any time during the interview you would like to stop, or take a break, notify me and I will do so. You don’t need to tell me why. If you do decide to end the interview, I will discuss with you whether you want to keep the data you have already given me or if you would like this deleted. I will also discuss arranging an alternate time for interview if this is something you would prefer. I will also signpost you to support resources, which can also be found at the bottom of this information sheet.

## Why have I been asked to take part?

I am asking for trans, and gender-diverse people who are living in England and Wales aged 16 - 25 to take part in this research.

If you are living with a serious mental health condition, I advise you don’t take part in this research as you may find it upsetting.

## Do I have to take part?

No, it’s completely up to you.

If you decide to take part, you’ll need to give your consent, which means telling me that you understand the research and would like to take part.

If you do decide to take part, any care and support that you are receiving will not be affected.

## What if I change my mind about taking part?

During the interview, you can ask me to take a break, or you can end the interview at any point. You do not have to provide a reason for this. After the interview, if you would like to remove your data from the study, you can do so within 2 weeks of taking part. All you need to do is email me (contact details below). It won’t be possible to remove data after the 2-week period

## How will information about me be stored and shared?

The project has gone through the relevant NTU research ethics procedures and has been given a favourable ethics opinion by Nottingham Trent University's Schools of Business, Law and Social Sciences Research Ethics Committee. All information that is collected from you during the interview will be stored securely for 10 years at NTU, UK. Identifiable information will be collected from you (e.g., names, where you live), but will be redacted from any publications, so data collected cannot be traced back to you.

Anonymous data may be published in academic research journals and shared at conferences or research talks. This might mean that direct quotes are taken from the interviews. To protect your confidentiality, no names, places or organisations will be used in these quotes: you will only be referred to by a pseudonym (false name). Other researchers may also ask for permission to use the anonymous research data; access to which will be granted only if the data is to be used in ways beneficial and affirming to trans and gender diverse identities.

If you would like to hear about the findings of the research, please contact me (contact details below).

## I have some questions

**Researcher:** Chase Staras (Email: chase.staras2022@my.ntu.ac.uk); Address: Chaucer Room 433, Nottingham Trent University, Shakespeare Street, Nottingham, NG1 4FQ; School of Social Sciences, Department of Psychology).

**Director of Studies:** Dr. Beth Jones (Email: Beth.Jones@ntu.ac.uk, Phone: 0115 848 6632; Address: Chaucer Room 433, Nottingham Trent University, Shakespeare Street, Nottingham, NG1 4FQ, School of Social Sciences, Department of Psychology).
Please contact the Data Protection Officer at DPO@ntu.ac.uk if:

- You have a query about how your data is used by the University
- You would like to report a data security breach (e.g., if you think your personal data has been lost or disclosed inappropriately).
- 
- You would like to complain about how the University has used your personal data

If you want to speak with someone who is not directly involved in this research, or if you have questions about your rights as a research subject, please contact Lucy Betts (Director of Doctoral Programmes, Social Sciences) at Nottingham Trent University. You can contact them at tel: +44 115 84 85558 or send an e-mail to: lucy.betts@ntu.ac.uk.

## What support can I access?

You can access support from:

**Mermaids:** Freephone: 0808 801 0400, Web Chat: https://mermaidsuk.org.uk/contact-us/, Forum: https://mermaidsuk.org.uk/young-people/mermaids-youth-community-application/

**Gendered Intelligence:** Website https://genderedintelligence.co.uk/projects/supportline.html Phone: 0330 3559 678, Email: SUPPORTLINE@GENDEREDINTELLIGENCE.CO.UK, WhatsApp Chat: 07592 650 496

**In an emergency, please contact Samaritans**:
Call 116 123 (or use their email service jo@samaritans.org)

## Consent

Please confirm:

- I acknowledge my participation in this study is voluntary.

- I confirm I am aged 16 - 25 years of age.
- I understand that the interviews will be audio-/video-recorded
- I understand my right to withdraw and agree to the aims and objectives of the study.
- I provide fully informed consent to take part and for my data to be used in line with the above aims.

# Demographic Information

Please complete the following:
**Age:**
**Pronouns:**
**Gender Identity:**
**Ethnicity:**
**Sexuality:**
**Living arrangements:**
**Employment status:**
**Pseudonym*:**

*a pseudonym is a fictitious name that will be attached to your data to protect your identity.

## Appendix 3: Study Two Recruitment Poster for Trans and Gender Diverse Young People

Nottingham Trent University

# Better Together

## Call For Participants

We want to better understand how valuable group memberships can benefit sense of belongingness, health, and wellbeing of trans and gender diverse young people in England and Wales. If you meet the participant criteria below, we would love to hear from you.

***Are you:***

- 16 – 29
- Living in England or Wales
- Transgender, or gender diverse

***Taking part includes:***

- A 1-hour interview via Microsoft Teams
- You will be asked questions about your healthcare experiences, current social engagement and ways this can be enhanced
- All participants receive a £10 gift card

For more information, or to take part, contact Chase Staras at chase.staras2022@my.ntu.ac.uk

## Appendix 4: Study Two Information Sheet and Consent Form for Health, Social, and Voluntary Care Professionals

# Information sheet: Understanding how valuable group memberships can benefit sense of belongingness, health, and wellbeing of trans and gender diverse young people in England and Wales.

## What is the study about?

My name is Chase Staras and I am a PhD candidate at Nottingham Trent University. This study aims to understand the current engagement of young trans and gender diverse populations with community and social groups. It also aims to explore what types of group activities may be beneficial, how these groups may be valuable, and potential challenges of engagement. I hope that this knowledge will help inform effective interventions aimed at reducing loneliness among trans and gender diverse people.

## What will I be asked to do?

You will be asked to complete a survey that will take approximately 30 minutes. The survey will consist of questions asking about your current perceptions of social engagement among trans and gender diverse young people (ages 16 – 25), and how this can practically be enhanced. There will also be questions around social prescribing, a type of healthcare initiative that aims to enhance social connectedness, to consider how this may be implemented within a reformed gender identity care model.

We know that for many people, this might be a topic that brings up difficult memories. So, if at any time during the survey you would like to stop, or take a break, you can do so and come back to the survey at a later date using the same link you used to initially access it. If you decide you no longer want to take part in this research, you can close your browser. Any incomplete responses will be deleted prior to data analysis. If you feel you require extra support, these are provided at the bottom of this information sheet. Alternatively, you can contact me (contact details below) and I will signpost you to helpful support resources.

## Why have I been asked to take part?

I am asking for trans and gender diverse health, social and voluntary care professionals.
If you are living with a serious mental health condition, we advise you don't take part in this research as you may find it upsetting.

## Do I have to take part?

No, it's completely up to you.
If you decide to take part, you'll need to give your consent, which means telling us that you understand the research and would like to take part.

If you do decide to take part, your work within trans and gender diverse healthcare will not be affected.

## What if I change my mind about taking part?

If at any time during the survey you would like to stop, or take a break, you can do so and come back to the survey at a later date using the same link you used to initially access it. If you decide you no longer want to take part in this research, you can close your browser. Any incomplete responses will be deleted prior to data analysis. If you feel you require extra support, these are provided at the bottom of this information sheet. Alternatively, you can contact the researcher who will signpost you to helpful support resources. After completing the survey, if you would like to remove your data from the study, you can do so within 2 weeks of taking part. All you need to do is email me (contact details below). It won't be possible to remove data after the 2-week period.

## How will information about me be stored and shared?

The project has gone through the relevant NTU research ethics procedures and has been given a favourable ethics opinion by Nottingham Trent University's Schools of Business, Law and Social Sciences Research Ethics Committee. All information that is collected from you during the interview will be stored securely for 10 years at NTU, UK. Identifiable information will be collected from you (e.g., names, where you live), but will be anonymised so data collected cannot be traced back to you.

Anonymous data may be published in academic research journals and shared at conferences or research talks. This might mean that direct quotes are taken from your survey responses. To protect your confidentiality, no names, places or organisations will be used in these quotes. Other researchers may also ask for permission to use the anonymous research data; access to which will be granted only if the data is to be used in ways beneficial and affirming to trans and gender diverse identities.

If you would like to hear about the findings of the research, please contact someone from the research team (contact details below).

## I have some questions

**Researcher:** Chase Staras (Email: chase.staras2022@my.ntu.ac.uk); Address: Chaucer Room 433, Nottingham Trent University, Shakespeare Street, Nottingham, NG1 4FQ; School of Social Sciences, Department of Psychology).

**Director of Studies:** Dr. Beth Jones (Email: Beth.Jones@ntu.ac.uk, Phone: 0115 848 6632; Address: Chaucer Room 433, Nottingham Trent University, Shakespeare Street, Nottingham, NG1 4FQ, School of Social Sciences, Department of Psychology).
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- You would like to complain about how the University has used your personal data

If you want to speak with someone who is not directly involved in this research, or if you have questions about your rights as a research subject, please contact Lucy Betts (Director of Doctoral Programmes, Social Sciences) at Nottingham Trent University. You can contact them at tel: +44 115 84 85558 or send an e-mail to: lucy.betts@ntu.ac.uk.

## What support can I access?

You can access support from:

**Gendered Intelligence:** Website https://genderedintelligence.co.uk/projects/supportline.html Phone: 0330 3559 678, Email: SUPPORTLINE@GENDEREDINTELLIGENCE.CO.UK, WhatsApp Chat: 07592 650 496

**In an emergency, please contact Samaritans**:
Call 116 123 (or use their email service jo@samaritans.org)

## Consent

Please confirm:

- I acknowledge my participation in this study is voluntary.
- I confirm I am aged 18+ years of age.

- I understand my right to withdraw and agree to the aims and objectives of the study.
- I provide fully informed consent to take part and for my data to be used in line with the above aims.

# Demographic Information

Please complete the following:
**Age:**
**Pronouns:**
**Job Title:**
**Gender Identity:**
**Ethnicity:**
**Sexuality:**
**Pseudonym*:**

*a pseudonym is a fictitious name that will be attached to your data to protect your identity.

## Appendix 5: Study Two Recruitment Poster for Health, Social, and Voluntary Care Professionals

Nottingham Trent University

# Better Together

## Call For Participants

We want to better understand how valuable group memberships can benefit sense of belongingness, health, and wellbeing of trans and gender diverse (TGD) young people in England and Wales. If you meet the participant criteria below, we would love to hear from you.

***Are you:***

- An NHS health, social or voluntary care professional working with young trans and gender diverse people
- Living in England or Wales

***Taking part includes:***

- An open-ended survey lasting approx. 30 minutes.
- Questions around your perceptions of young TGD peoples' social engagement, and how we can expand current NHS gender services to provide more holistic care.

For more information, or to take part, contact Chase Staras at chase.staras2022@my.ntu.ac.uk, or scan the QR code.

QR Code

**Appendix 6: Study Three Information and Consent Form**

# Information sheet: A Service Evaluation of [Information redacted for privacy purposes]

## What is the study about?

My name is Chase Staras, and I am a PhD candidate at Nottingham Trent University. This study aims to understand the current experiences of young trans and gender diverse people receiving care through [GIC 2]. Specifically, it aims to understand whether referrals to social support as part of gender-affirming care are valuable for the health and wellbeing of young trans and gender diverse people. I hope that this knowledge will help inform effective interventions aimed at reducing loneliness among trans and gender diverse people.

## What will I be asked to do?

You will be asked to complete an online survey. This will take approximately 30 minutes to one hour. The survey will include questions about general experiences of gender-affirming care in England, your current experience of GIC 2, and your views on the helpfulness of social support being an integral part of this service. You can submit your responses to questions as written responses, audio, or video files.

We know that for many people, this might be a topic that brings up difficult memories. So, if at any time during you would like to stop, or take a break, you are welcome to do so.

## Why have I been asked to take part?

I am asking for trans, and gender-diverse people who are receiving care through the GIC 2, aged 18 - 29 to take part in this research. This includes those individuals who have both used and not used the social support pathway of this service.

If you are living with a serious mental health condition, I advise you don’t take part in this research as you may find it upsetting.

## Do I have to take part?

No, it’s completely up to you.

If you decide to take part, you’ll need to give your consent, which means telling me that you understand the research and would like to take part.

If you do decide to take part, any care and support that you are receiving will not be affected.

## What if I change my mind about taking part?

During the survey, you can take a break, or you can end the survey at any point by exiting your internet browser. You do not have to provide a reason for this. After the survey, if you would like to remove your data from the study, you can do so within 2 weeks of taking part. All you need to do is email me (contact details below). It won't be possible to remove data after the 2-week period

## How will information about me be stored and shared?

The project has gone through the relevant NTU research ethics procedures and has been given a favourable ethics opinion by Nottingham Trent University's Schools of Business, Law and Social Sciences Research Ethics Committee. All information that is collected from you during the interview will be stored securely for 10 years at NTU, UK. With your permission, anonymised survey responses will also be made available through the UK Data Service, accessible on a subscription basis. Identifiable information will be collected from you (e.g., names, where you live), but will be redacted from any publications, so data collected cannot be traced back to you.

Anonymous data may be published in academic research journals and shared at conferences or research talks. This might mean that direct quotes are taken from the interviews. To protect your confidentiality, no names, places or organisations will be used in these quotes: you will only be referred to by a pseudonym (false name). Other researchers may also ask for permission to use the anonymous research data; access to which will be granted only if the data is to be used in ways beneficial and affirming to trans and gender diverse identities.

If you would like to hear about the findings of the research, please contact me (contact details below).

## I have some questions

**Researcher:** Chase Staras (Email: chase.staras2022@my.ntu.ac.uk); Address: Chaucer Room 433, Nottingham Trent University, Shakespeare Street, Nottingham, NG1 4FQ; School of Social Sciences, Department of Psychology).

**Director of Studies:** Professor Daragh McDermott (Email: daragh.mcdermott@ntu.ac.uk, Phone: 0115 848 6106; Address: Nottingham Trent University, Shakespeare Street, Nottingham, NG1 4FQ, School of Social Sciences, Department of Psychology).

Please contact the Data Protection Officer at DPO@ntu.ac.uk if:

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- You would like to complain about how the University has used your personal data

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## What support can I access?

You can access support from:

**Mermaids:** Freephone: 0808 801 0400, Web Chat: https://mermaidsuk.org.uk/contact-us/, Forum: https://mermaidsuk.org.uk/young-people/mermaids-youth-community-application/

**Gendered Intelligence:** Website https://genderedintelligence.co.uk/projects/supportline.html Phone: 0330 3559 678, Email: SUPPORTLINE@GENDEREDINTELLIGENCE.CO.UK, WhatsApp Chat: 07592 650 496

**In an emergency, please contact Samaritans**:

Call 116 123 (or use their email service jo@samaritans.org)

## Consent

Please confirm:

- ☐ I acknowledge my participation in this study is voluntary.
- ☐ I confirm I am aged 16 - 29 years of age.
- ☐ I understand my right to withdraw and agree to the aims and objectives of the study.
- ☐ I provide fully informed consent to take part and for my data to be used in line with the above aims.
- ☐ (optional) I provide consent for my anonymised data to be shared on the UK Data Service.

# Demographic Information

Please complete the following:

**Age:**

**Pronouns:**

**Gender Identity:**

**Ethnicity:**

**Sexuality:**

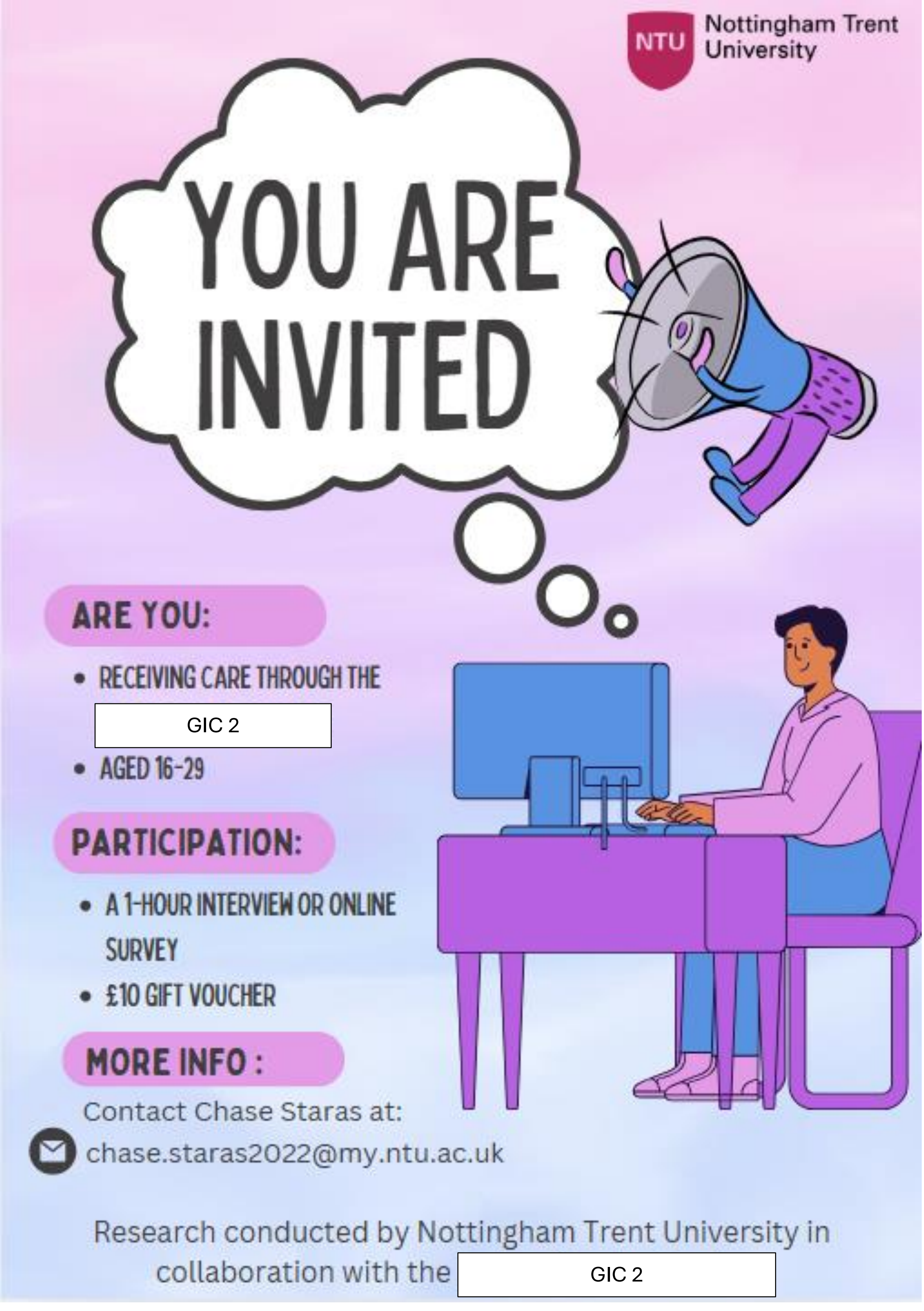
**Living arrangements:**

**Employment status:**

**Pseudonym*:**

*a pseudonym is a fictitious name that will be attached to your data to protect your identity.

## Appendix 7: Study Three Recruitment Material



Nottingham Trent University

YOU ARE INVITED

**ARE YOU:**

- RECEIVING CARE THROUGH THE GIC 2
- AGED 16-29

**PARTICIPATION:**

- A 1-HOUR INTERVIEW OR ONLINE SURVEY
- £10 GIFT VOUCHER

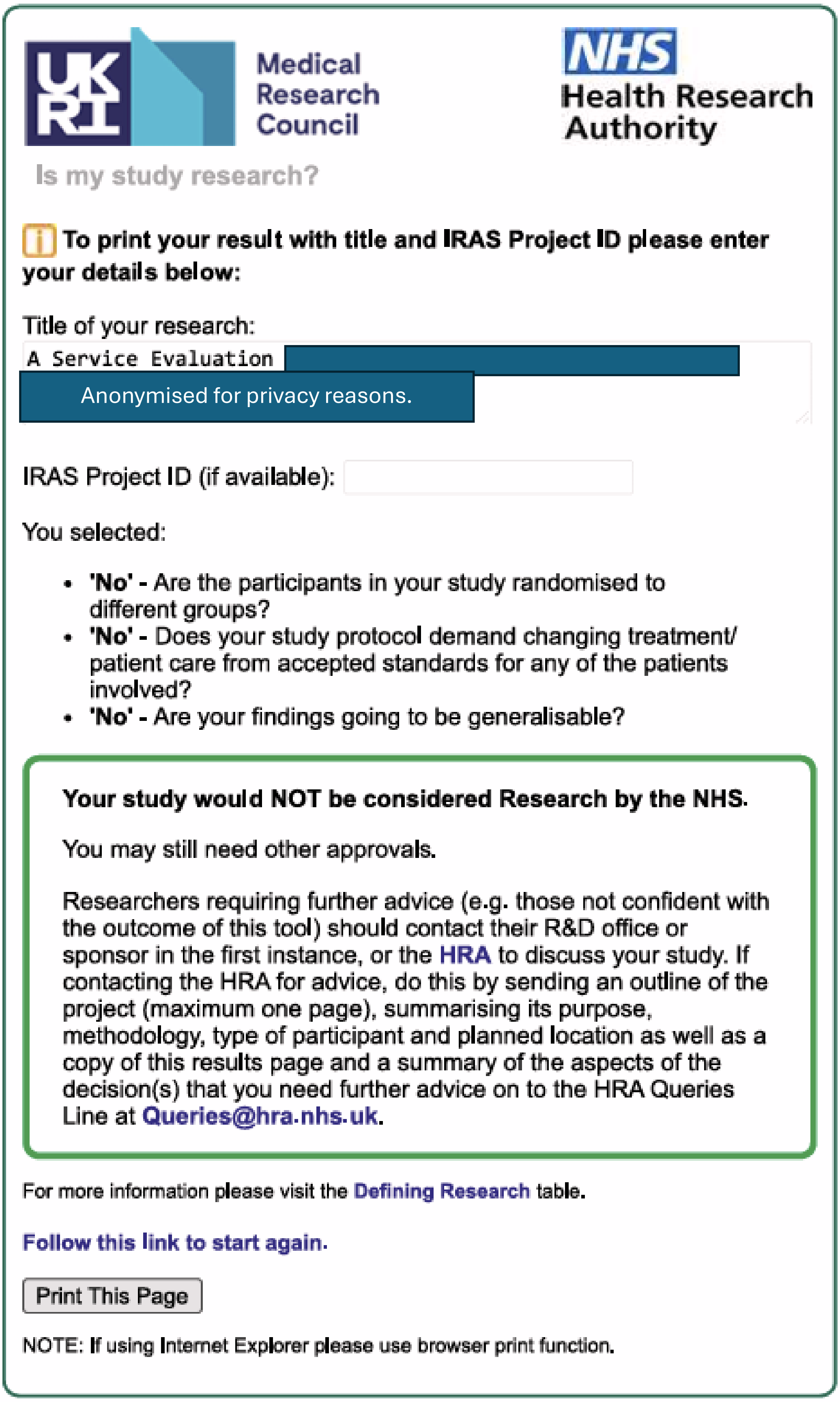
**MORE INFO :**

Contact Chase Staras at:

chase.staras2022@my.ntu.ac.uk

Research conducted by Nottingham Trent University in collaboration with the GIC 2

## Appendix 8: Study Three NHS REC Decision



Is my study research?

**To print your result with title and IRAS Project ID please enter your details below:**

Title of your research:
A Service Evaluation [redacted] Anonymised for privacy reasons.

IRAS Project ID (if available):

You selected:

- **'No'** - Are the participants in your study randomised to different groups?
- **'No'** - Does your study protocol demand changing treatment/ patient care from accepted standards for any of the patients involved?
- **'No'** - Are your findings going to be generalisable?

**Your study would NOT be considered Research by the NHS.**

You may still need other approvals.

Researchers requiring further advice (e.g. those not confident with the outcome of this tool) should contact their R&D office or sponsor in the first instance, or the HRA to discuss your study. If contacting the HRA for advice, do this by sending an outline of the project (maximum one page), summarising its purpose, methodology, type of participant and planned location as well as a copy of this results page and a summary of the aspects of the decision(s) that you need further advice on to the HRA Queries Line at **Queries@hra.nhs.uk**.

For more information please visit the **Defining Research** table.

**Follow this link to start again.**

NOTE: If using Internet Explorer please use browser print function.

**Appendix 9: Study Two Debrief Sheet for Trans and Gender Diverse Young People**

# Debrief: Understanding how valuable group memberships can benefit sense of belongingness, health, and wellbeing of trans and gender diverse young people in England and Wales.

## What is the study about?

My name is Chase Staras, and I am a PhD candidate at Nottingham Trent University. This study aims to understand the current engagement of young trans and gender diverse populations with community and social groups. It also aims to explore what types of group activities may be beneficial, how these groups may be valuable, and potential challenges to engagement. I hope that this knowledge will help inform effective interventions aimed at reducing loneliness among trans and gender diverse people.

## What if I change my mind about taking part?

After the interview, if you would like to remove your data from the study, you can do so within 2 weeks of taking part. All you need to do is email me (contact details below). It won't be possible to remove data after the 2-week period.

## How will information about me be stored and shared?

The project has gone through the relevant NTU research ethics procedures and has been given a favourable ethics opinion by Nottingham Trent University's Schools of Business, Law and Social Sciences Research Ethics Committee. All information that is collected from you during the interview will be stored securely for 10 years at NTU, UK. Identifiable information will be collected from you (e.g., names, where you live), but will be anonymised so data collected cannot be traced back to you.

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If you would like to hear about the findings of the research, please contact someone from the research team (contact details below).

## I have some questions

**Researcher:** Chase Staras (Email: chase.staras2022@my.ntu.ac.uk); Address: Chaucer Room 433, Nottingham Trent University, Shakespeare Street, Nottingham, NG1 4FQ; School of Social Sciences, Department of Psychology).

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## Appendix 10: Study Two Debrief Sheet for Health, Social, and Voluntary Care Professionals

# Debrief: Understanding how valuable group memberships can benefit sense of belongingness, health and wellbeing of trans and gender diverse young people in England and Wales.

## What is the study about?

My name is Chase Staras and I am a PhD candidate at Nottingham Trent University. This study aims to understand the current engagement of young trans and gender diverse populations with community and social groups. It also aims to explore what types of group activities may be beneficial, how these groups may be valuable, and potential challenges of engagement. I hope that this knowledge will help inform effective interventions aimed at reducing loneliness among trans and gender diverse people.

## What if I change my mind about taking part?

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If you would like to hear about the findings of the research, please contact someone from the research team (contact details below).

## I have some questions

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**Appendix 11: Study Three Debrief Sheet**

# Debrief: A Service Evaluation of the [information redacted for privacy reasons]

## What is the study about?

My name is Chase Staras, and I am a PhD candidate at Nottingham Trent University. This study aims to understand the current experiences of young trans and gender diverse people receiving care through the **[information redacted for privacy reasons]**. Specifically, it aims to understand whether referrals to social support as part of gender-affirming care are valuable for the health and wellbeing of young trans and gender diverse people. I hope that this knowledge will help inform effective interventions aimed at reducing loneliness among trans and gender diverse people.

## What if I change my mind about taking part?

After the interview, if you would like to remove your data from the study, you can do so within 2 weeks of taking part. All you need to do is email me (contact details below). It won't be possible to remove data after the 2-week period

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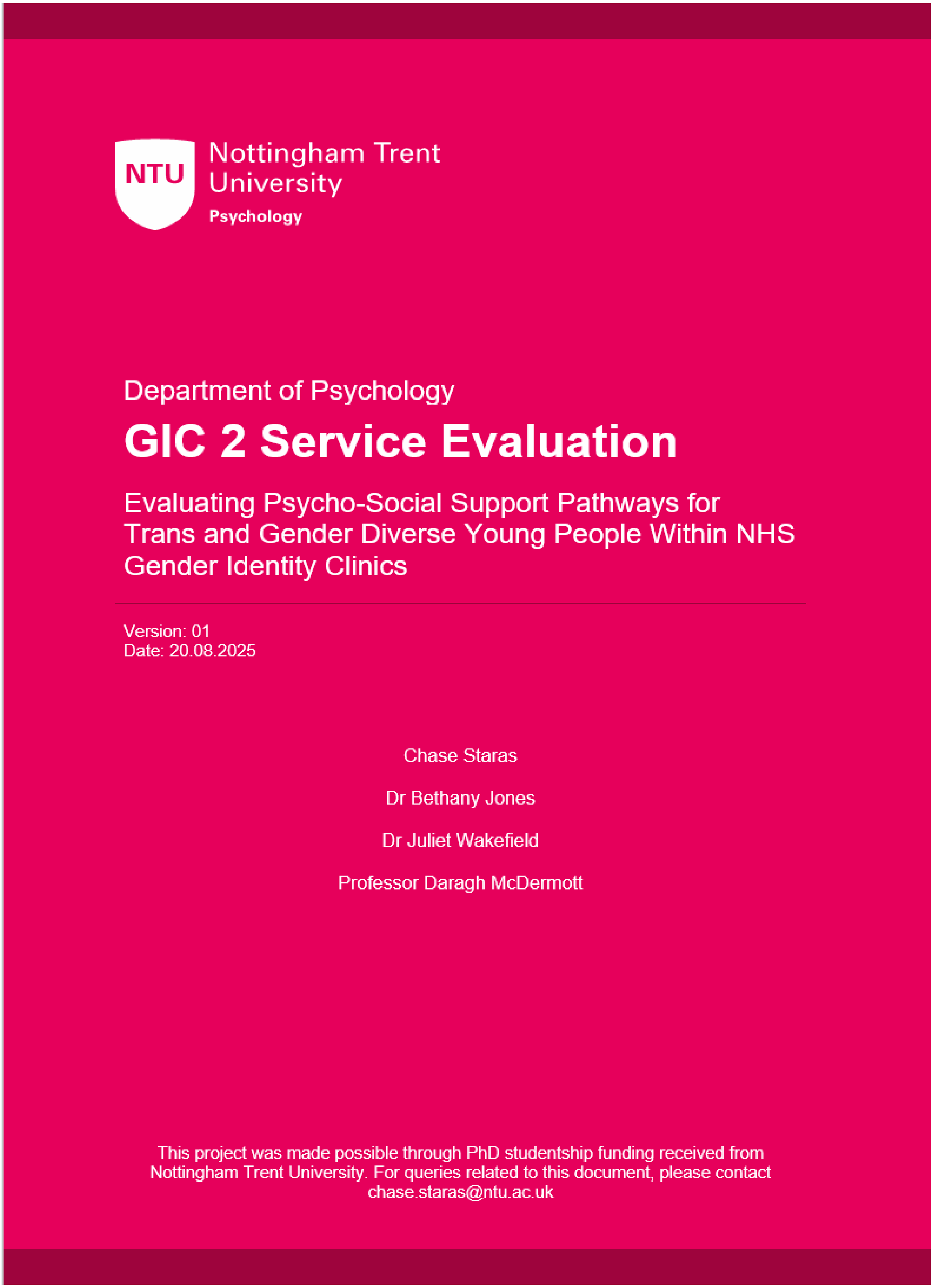
## Appendix 12: Description of Health, Social, and Voluntary Care Professionals' Job Titles (Study Two)

| Pseudonym | Job Description |
|---|---|
| EM | My job role focuses on working with marginalised youth across [City in the North of England] to take part in campaigns, use arts + creativity and engage in support sessions to empower them to change systems and change minds around their lives and how to support them best. I have worked specifically with trans and gender diverse young people for the past 4 and a half years- notably working with them to publish a book on what best practise looks like for supporting trans and gender diverse young people, as well as lobbying and working with the CQC to have better standards of care for trans and gender diverse people in health care practises. 92% of the young people within our organisation are trans, gender diverse and neurodivergent. |
| Jasy | As a counsellor, my main focus is providing support across various life aspects. While I don't exclusively work with many trans individuals, my practice is open and affirming. In sessions where gender-related topics come up, I ensure a safe and understanding environment. I stay informed to better assist clients facing unique challenges related to gender identity. My approach is to create a space where everyone feels respected and supported in their individual journey. |
| Minty | I have the amazing opportunity to support and care for transgender and gender diverse individuals. I provide counselling, help with their transition, and offer emotional support. It's such a rewarding role, being able to contribute to their well-being and journey towards self-acceptance and empowerment. |
| Bea | I am a GP developing a special interest in transgender healthcare. |
| Cee | I am a support worker for a charity that works with young people who self-harm. My boss noticed that around 30% of our referrals were for children and young people who were trans, non-binary or exploring their gender and established a wellbeing group to support them. I work with them as a one to one support worker and participate alongside them in our creative workshops. We also have counsellors available. |
| Lula | I am a manager in a youth work organisation that works with young people aged 8-25. Many of our young members are trans or gender diverse as we provide a safe space for them to be themselves, we actively listen and lift up their voices. |
| Minim | I am a gender specialist who works across Primary, Care and I deal with trans people of all ages. |
| Sonny | Gender dysphoria diagnostic assessments and psychological therapy for gender-related mental health difficulties. |

## Appendix 13: GIC 2 Project Report



Nottingham Trent University
Psychology

Department of Psychology

# GIC 2 Service Evaluation

## Evaluating Psycho-Social Support Pathways for Trans and Gender Diverse Young People Within NHS Gender Identity Clinics

Version: 01
Date: 20.08.2025

Chase Staras

Dr Bethany Jones

Dr Juliet Wakefield

Professor Daragh McDermott

This project was made possible through PhD studentship funding received from Nottingham Trent University. For queries related to this document, please contact chase.staras@ntu.ac.uk

# 1. Executive Summary

The experiences of trans and gender diverse people navigating England's healthcare system are frequently characterised by long waitlists, uncertainty, and a lack of trust. Access to gender-affirming care is influenced not only by clinical gatekeeping but also by wider patterns of social exclusion, including discrimination in education and employment, insecure housing, and disconnection from supportive communities. These pressures are often most challenging for trans and gender diverse young adults, whose distress is frequently medicalised while the underlying social and structural causes remain unaddressed. In the context of heightened debate over the future of gender-affirming care, it is timely to ask: what might truly meaningful care involve, and how can it extend beyond the boundaries of gender clinics?

Against this backdrop, a team of researchers at Nottingham Trent University have explored the feasibility of Social Prescribing pathways to connect trans and gender diverse young people to health-enhancing social support. In partnership with GIC 2, the first NHS Gender Identity Clinic in England to integrate psycho-social support (emotional, and practical help outside medical treatment, such as peer groups or counselling) into its care pathway, this project evaluated whether NHS-facilitated social support is perceived as beneficial. This research is based on survey responses from 30 service users.

## Key Findings

- Trans-Led Support is Vital: Despite the majority of service users choosing not to uptake psycho-social support provided by Indigo, knowing that support existed, especially when trans-led, created trust and a sense of being cared for.
- Timing Matters: Despite positive perceptions, uptake of support was limited. This was because support often arrived too late, after participants had found other help or were focused on medical transition.
- Systemic Barriers Persist: Communication gaps, unclear referral processes, and long waitlists accessing psycho-social support mirrored challenges trans and gender diverse people already experience in healthcare, undermining potential benefits.

# Recommendations

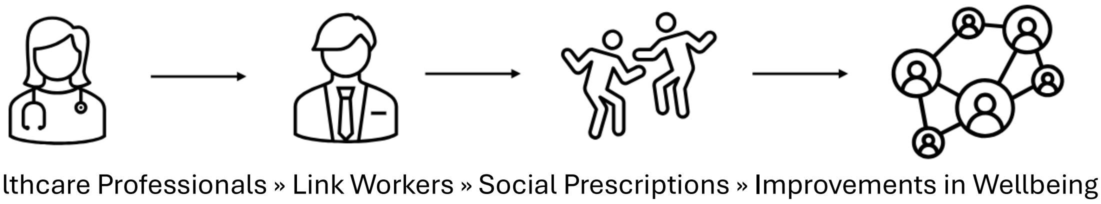
- Offer psycho-social support early (i.e., social support, counselling), ideally at or before the first clinical contact.
- Maintain trans-led delivery to enhance trust and authenticity.
- Strengthen infrastructure: clear communication, follow-up, and manageable wait times for psycho-social support.
- Explore hybrid models combining flexible voluntary sector support provision with clinical oversight.

# 2. Background

Trans and gender diverse young people (TGDYP) in England often face multiple, compounding barriers to accessing healthcare that meets their needs (Crowley et al., 2021; Scheim et al., 2024). Clinical gatekeeping, fragmented referral pathways, and limited continuity of care intersect with experiences of discrimination and social exclusion (Scheim et al., 2024). These factors contribute to loneliness and poor mental and physical health outcomes (Scheim et al., 2024). While gender-affirming medical care is important for many, medical interventions alone cannot address the social disconnection, loneliness, and mistrust that are commonplace in this population (White et al., 2023). In light of these shortcomings, NHS England has publicised calls for more holistic approaches to care that address social determinants of health (NHS, 2019).

Social support, such as peer groups, community activities, and practical help navigating services, can act as protective factors, improving wellbeing, building resilience, and helping TGDYP navigate and manage the complex processes involved in transition (Doyle, 2022). In wider public health practice, one mechanism for facilitating social support is Social Prescribing: linking individuals to non-clinical community resources that address social needs and improve health outcomes (Haslam et al., 2018; also see the NHS Long-Term Plan, 2019 and Figure 1).

**Figure 1.**
*Social Prescribing Process.*



Responsively, researchers at Nottingham Trent University have explored how Social Prescribing pathways can be adapted and implemented to improve health outcomes for TGDYP. Early findings suggested that many TGDYP would welcome Social Prescribing integrated into Gender Identity Clinics (GICs). However, the limited capacity of GICs, combined with widespread mistrust of statutory services among TGDYP, raised doubts about whether GIC-led SP would be utilised, and whether it could deliver meaningful social support rather than risk being perceived as a tokenistic gesture or friends on prescription. This highlighted the need to see GIC-led social support in practice.

GIC 2 was established as the first NHS GIC in England to integrate psycho-social support (emotional, and practical help outside medical treatment, including social support and counselling) into its care pathway through a [details redacted for privacy reasons]. Care Navigators refer service uses to non-medical services (e.g., counselling, local community groups). This integration of psycho-social support within Indigo offered a unique opportunity to study whether NHS GIC-facilitated social support is seen as authentic, accessible, and beneficial for TGDYP. This report overviews the findings of this evaluation conducted by the research team at Nottingham Trent University in partnership with Indigo. In sum, this project aimed to understand uptake, perceptions of, and barriers to engaging with, NHS GIC-led social support for TGDYP.

# 3. Methods

A qualitative service evaluation was conducted, collecting open-ended survey responses from 30 service users receiving care from GIC 2 at the time of data collection. This reflects 10% of GIC 2's total service users. Of these, four had accessed psycho-social support, eight, including one who had already received some form of psycho-social support, were awaiting access to psycho-social support, and 19 chose not to access this support (see Figure 2 for a visual breakdown). Participants were aged 18 – 27 and represented a variety of gender identities. Participant's provided pseudonyms to avoid identification of individual service users. Data were analysed using Framework Analysis (Gale et al., 2013).

**Figure 2.**

*Proportion of Service Users Accessing Psycho-Social Support.*

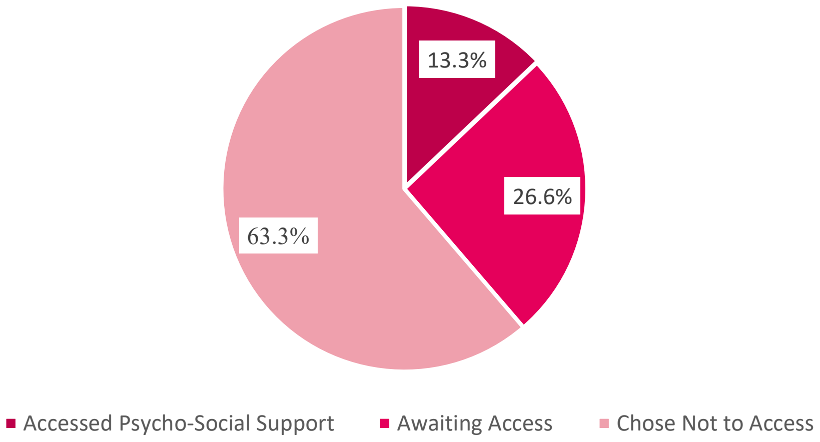


**Table 1.**

*Key Survey Topics and Exemplar Questions.*

| Key Topics | Exemplar Questions |
|---|---|
| **Experiences of Gender-Affirming Care** | Can you describe your current experience of NHS gender services? |
| **Uptake/Non-Uptake of Psycho-Social Support** | What influenced your decision to use or not use psycho-social support? |
| **How GIC 2 Facilitates Support Access** | How did GIC 2 facilitate access to these social groups? |
| **Service Improvement Suggestions** | What changes would make social support more meaningful for you? |

# 4. Findings

## Key Finding 1: Trans-led Support is a Key Component of Meaningful Psycho-Social Support.

Even when not used, the existence of psycho-social support, especially when delivered in a trans-led environment, gave participants reassurance and a sense of being cared for. Many contrasted this with previous GIC experiences where no such support was available:

> "*The most meaningful support has been knowing that if I needed help with anything, I could ask. Just having the opportunity and support there is enough*" (Oliver, Trans Man).

Specifically, trans-led delivery increased the perceived availability and genuineness of psycho-social support:

> "*[GIC 2] being so trans-run definitely helps me feel a lot more comfortable […] I'm very glad to be getting care by people who clearly genuinely care about me*" (Ria, Trans Woman).

Thus, non-uptake of psycho-social support did not equate to non-value. Instead, it allowed participants to feel meaningfully supported, even if they did not directly engage with such support.

## Key Finding 2: Timing of Support Matters

Despite positive perceptions, support was often offered after participants had already met their needs elsewhere or during periods when their focus was on medical care:

> "*I currently attend social events of the kind they [GIC 2] were referring*" (Fredrick, Male).

In some cases, delays meant social challenges had become entrenched, making engagement with support feel overwhelming:

> "*I was offered the groups […] but I was too scared to use them and just pushed on alone*" (Loncett, Female).

Ultimately, participants highlighted that earlier access, even before their first GIC appointment, could make a significant difference. Without this, support offered too late was experienced as tokenistic.

## Key Finding 3: Systemic Barriers to Accessing Psycho-Social Support Replicate Existing Challenges Within Gender-Affirming Care.

In addition to support coming too late, the infrastructure surrounding psycho-social support replicated familiar frustrations: unclear routes, poor communication, and long waits:

> "*I would love to take part in some community groups, but I haven't received any information about them*" (Nova, Trans Female).

While the intention was welcomed, the reality of delayed or unclear access undermined potential benefits. Some participants disengaged entirely because they perceived the offer as symbolic rather than functional, drawing parallels with their experiences of medically-based care:

> "*I'll probably have had like bottom surgery by the time I am able to access therapy through the GIC* […] *Whatever I try to access through a GIC is minimal as possible. I don't want to spend time there accessing support from them*" (OI, Woman).

These accounts demonstrate that in order for psycho-social support to be positively received and experienced, it *must* be matched by appropriate infrastructure to facilitate access. Without this, even well-intentioned care may replicate the systemic shortcomings it seeks to overcome.

# 5. Practical Implications

## Early Intervention

Our findings reveal that early intervention is essential to prevent entrenched isolation and maximise the benefits of social support. Support that comes too late is not utilized and framed as inauthentic rather than meaningful. However, timing of support is often shaped by resource and commissioning constraints rather than GIC desires. Thus, there is a need for early intervention to be part of clinical commissioning decisions.

## Lived Experience

Lived experience (i.e., trans-led) delivery fosters trust and encouraged engagement with social support pathways. This insight is important, particularly where institutional mistrust is common among TGDYP. This highlights the need for lived-experience practitioners to be an integral part of all types of gender-affirming care, including the delivery of social support.

## Operational Clarity & Hybrid Models

Operational clarity (clear signposting, timelines, and follow-up) emerged as equally important as feeling emotionally supported. This demonstrated the need for social support to be positioned within a service that has the capacity to offer tailored support for TGDYP that is trans-led and emotionally resonant alongside providing this in a timely manner. Hybrid models that combine voluntary sector flexibility with NHS oversight may deliver more timely, well-resourced support while maintaining relevance to clinical care.

# 6. Recommendations

## Short-Term (Within 6-12 Months)

- Improve communication and follow-up to ensure clarity on how to access psycho-social support.
- Retain trans-led delivery wherever possible.

### Medium-Term (1-3 Years)

1. Invest in infrastructure to avoid psycho-social support being delayed by the same bottlenecks as medical care.

- Offer psycho-social support at the earliest stage of the care pathway, ideally linked to GP referral. This may involve reshaping commissioning decisions over providing support to TGDYP while on waitlists.

- Create multiple access routes, including self-referral for those outside GIC care.

### Long-Term (3+ Years)

- Develop sustainable hybrid models linking NHS GICs with voluntary sector Social Prescribing providers.

- Ensure community-based options are inclusive, affirming, and equipped to meet TGDYP needs.

## 7. Closing Remarks

This evaluation demonstrates that while the integration of psycho-social support into NHS GICs holds considerable promise, its impact is limited when delivery is delayed, unclear, or constrained by systemic barriers. For TGDYP, meaningful care must extend beyond medical interventions to include timely, authentic, and accessible pathways to social connection and support. The evidence from GIC 2 highlights the importance of lived-experience leadership, early intervention, and stronger infrastructure to ensure such care is both effective and sustainable. Moving forward, embedding psycho-social support as a core element of gender-affirming healthcare will be vital in building trust, addressing social determinants of health, and improving outcomes for this population.

> "Thank you, [GIC 2], for helping me to become my true self"
>
> Skylar, Trans Woman

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## Appendix 14: Coding Matrix from Framework Analysis in Study Three

| | **Availability of Support** | | **Uptake of Psycho-Social Support** | | | **Perceived Impact** | | | **Barriers to Engagement** | | **Improving Psycho-Social Support** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Access to Psycho-Social Support | General Awareness | Did not Utilise Support | Utilised Support | No Need for support | Positive Change | Negative Change | No Impact | Personal Barriers | Structural Barriers | |
| A | The staff are sympathetic with the struggles of waiting lists and other issues, and provide various forms of social and medical support. | Aware of support across contexts with resources wherever you go, both in person and online, for social support. | Not applicable: No need for support. | Not applicable: No need for support. | Access to HRT resolved mental challenges and meant they didn’t feel any loneliness. Therefore, they did not want to take a | They feel stronger and more confident. A much more efficient clinic than others who take 15 million years to even get you a first appointment. | None reported. Participant explicitly highlighted that they do not see any negatives. | Not applicable: change was overwhelmingly positive. | | They wish it could be easier to reach out to them with a manned phone service rather than just via email. | They would like to find more opportunities to meet other queer people. Suggestion of notices for current LGBT social groups by GIC 2. |

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| | | | | | spot from someone who actually needed it. | | | | | | |
| **Apollo** | GIC 2 has made sure [they] get the right support and care. | Suggested awareness as they chose not to access it. | Not applicable: No need for support. | Not applicable: No need for support. | They didn’t really feel [they] needed it as [they] already had friends and family who supported [them]. | Access to care is quicker than expected and staff patience has been wonderful. They felt heard and able to take the lead with their transition. They haven’t had any issues with mental health while under GIC 2. | None reported. Participant explicitly highlights service was 10/10 can’t fault them. | Not applicable: change was overwhelmingly positive. | Concerns regarding non-gender specific services asking about transition/having negative views. | The healthcare system is horrifically underfunded with poor treatment of TGD people (as if they’re a disease). | Support needs to be given by all medical fields, not just at specialist clinics. |

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| **Aster** | | Suggested awareness as they chose not to access it. | Not applicable: No need for support. | Not applicable: No need for support. | Participant already had a very strong support circle and had publicly transitioned so did not wish to access it. | Experience with GIC 2 has been great. [They] were given [their] expectations, and they were met. A very pleasant change from GP interactions. | None reported. Participant explicitly highlights they were very satisfied with [their] experience. | GIC 2 has had no impact beyond transition-specific factors and mental health. | | | GPs and other NHS services need to be more honest about the support young people will receive and the waiting times for support. |
| **Bug** | Participant doesn't really know who to talk to in GIC 2 about things so usually approaches GP instead. | Uncertain of the support available. Remembers some therapy which [they] tried, but nothing | Not applicable: No need for support. | Not applicable: No need for support. | Social connection [was] not important to [them] at the present time. | No positive change mentioned: Participant explicitly states some negative interactions and minimal impact. | So far, their impact has been some invasive questions and signposting to support networks | Most staff are nice, but the actual impact GIC 2 has had on [their] transition has been extremely minimal. | Social settings are a nightmare so they wouldn't attend groups with other people. Also challenges around non-binary | Challenges knowing where to access support and non-binary exclusion. | Better communication of what options are available and how to go about accessing them and better inclusion for/education on non-binary individuals. |

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| | | beyond that. | | | | | [they] do not wish to enter. | | presentation and participant is exhausted having to re-explain [themselves] every time. | | |
| **Cait** | They have not been referred to any groups. | They did not know it existed. | They did not know it existed. | | | The service is better than expected and much quicker than other places. They answer queries quickly and efficiently. | | Physical health has not changed. | | They did not know it existed. They have not been referred to any groups. | More social support through clinics as voluntary sectors closed off. |
| **Cosmo** | They have not had too much contact with them. | Suggested awareness as they chose not | Not applicable: No need for support. | Not applicable: No need for support. | They are already in a good place mentally | Participant feels well taken care of, respected | None reported. Participant explicitly | Not applicable: change was overwhelmingly positive. | | Access to support is like a postcode lottery: it | Integration of social and medical support is very important. |

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| | | to access it. | | | with a good support system. | and experienced shorter wait times than anticipated. They specifically liked the check in [they] had before and after [their] appointment. The care always feels personal and genuine. | highlights they were satisfied with their experience. | | | massively varies depending on where you are. | Increased involvement from GPs to ensure continuation of care. |
| **Dexter** | The staffs' willingness to help and understand makes support feel within | Suggested awareness as they chose not to access it. | Not applicable: No need for support. | Not applicable: No need for support. | They felt it was unnecessary at the time. | GIC 2 is full of gender diverse staff […] which makes the experience overall more | None reported. Participant explicitly highlights they were extremely | Not applicable: change was overwhelmingly positive. | | More inclusivity within GP practices to facilitate access to GICs and the | Further community groups for making connections and more social activities for |

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| | reach. The community groups feel very authentic. | | | | | comfortable. A friendly, supportive, and efficient service. GIC 2 has positively impacted [their physical and mental health. | satisfied with their experiences. | | | associated support they can offer. | service users to make friends. |
| **Fredrick** | | Suggested awareness as they chose not to access it. | Not applicable: No need for support. | Not applicable: No need for support. | They currently attend social events of the kind [GIC 2] was referring to. | GIC 2 is a lot quicker and personal, so much more supportive. Improved mental and physical health and provided the service needed. | None reported. Participant explicitly highlights they were very satisfied with their experiences. | Not applicable: change was overwhelmingly positive. | | | More social spaces to explore. |

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| **Haz** | The clinic is easy to get hold of for support, responding quickly and are helpful. | | Not applicable: No need for support. | Not applicable: No need for support. | They didn't feel like [they] needed it. | Better access to support has impacted health in a positive way by providing timely and holistic care. This has reduced anxiety/stress around waiting for answers regarding care. | None reported. Participant explicitly highlights they were satisfied and glad [they] chose to go with them. | Not applicable: change was overwhelmingly positive. | | | More social support groups for people who feel like they have no one to support them. |
| **Jakey** | GIC 2 has helped a lot referring [them] to people. However, they are | Awareness of community support offered. | | Actively waiting to access social groups. | | Access to support has made them feel less alone. Being part of these groups feels | None reported. Participant explicitly highlights they were satisfied | Not applicable: change was overwhelmingly positive. | | They are still waiting to attend social groups referred to. | |

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| | still waiting to attend social groups referred to. | | | | like one big community. The quick paced and polite service allowed them to feel better in [themselves]. | with the service and would recommend to anyone who is transgender. | | | | |
| **Jane** | They have not been instructed on where to contact for these things yet as they are still new to GIC 2. | Suggestion that they are not aware of the support options available. | They would like further support, but do not know how to access it. | | GIC 2 has been nothing but amazing. This is the best they have felt about [themselves their] entire life. Their overall quality of life has increased | None reported. Participant explicitly highlights they were extremely satisfied. | Not applicable: change was overwhelmingly positive. | | They do not know where to access psycho-social support. | Recommend referral to dieticians for people undergoing HRT to help them with managing themselves better. |

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| | | | | | | drastically. Overall, they have been very positively impacted. | | | | | |
| **John** | GIC 2 is really good at providing access to services. | Suggested awareness as they chose not to access it. | Not applicable: No need for support. | Not applicable: No need for support. | They didn't feel like [they] needed it so [they] didn't access it. | They are impressed with GIC 2, which has a quick service compared to other waiting lists. Pre and post meetings with care navigators before and after your appointment particularly helpful as it provides an | None reported. Participant explicitly highlights they think GIC 2 is very good and glad [they're] with them. | No impact on physical health. | | The NHS within which GIC 2 sits means that despite GIC 2 providing great care, there are still limited clinics providing good care. Travelling to Manchester can be a struggle. | A bigger space and more clinics. Youth groups would be a great deal of help given this support was not available as they grew up. They are aware of LGBT groups, but looking for trans-specific groups. |

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| | | | | | | extra level of comfort, ability to vent, or ask any questions. | | | | | |
| **Josh** | Reassuring and comforting staff make access to needed support easy. This has been the most meaningful support within the service. | Suggested awareness as they chose which support they did and did not access. | | Accessed support on how to change [their] name with deed poll. | Other support not utilised because they don't feel like [they] need it. | They felt extremely supported and seen. Things happened quickly and their needs were understood. GIC 2 has improved [their] mental health. | None reported. Participant explicitly highlights they are very satisfied. | | | Difficulty with communication between GP and GIC 2. | Pamphlets on gender dysphoria and how to get support for those things.<br>More open communication about steps in transition, concrete dates or at least an estimate. |

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| **L** | The community groups they've suggested have played a role in making [them] feel [they] have the option to reach out. | Awareness of what options are available to them. | Overwhelmed with day-to-day life so they've never gotten round to accessing this support. | | | They did not expect [GIC 2] to be as good as they were. GIC 2's relaxed and comfortable approach eased their nerves, and they felt listened to and taken seriously; a contrast from other clinics. Excellent handling of queries. | None reported. Participant explicitly highlights they are extremely satisfied, and do not think they could have reasonably asked for a better experience. | Their physical health has been unaffected. | Busy personal life can limit time for accessing psycho-social support. | | |
| **Loncett** | | They were offered the groups, and even | Did not engage with groups as | | | GIC 2 had transitioned [staff] talk to [them] | None reported. Participant | | Social groups felt artificial, and they wouldn't go | The general NHS system than GIC 2 sits within is | Shorter lists and therapists being more open to |

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| | | said yes to some. | they were too scared to use them and just pushed on alone. | | | and answer some of their questions which was amazing. | explicitly highlights they are very satisfied. | | to something recommended by a doctor mental health wise. They were also too scared to use them. | very out of date. | transgender existence. |
| **Morgan** | They were given access to help and services while they were on the waitlist which helped greatly. Referral is so simple. Knowing [they] are around like-minded | Awareness of services and awaiting access to these. | | Actively waiting to access talking therapy and vocal training therapy. | | GIC 2 is the most helpful and professional. They feel seriously cared for and listened to and understood. GIC 2 feels very safe, protective and caring and the staff want to make [their] life better | None reported. Participant explicitly highlights they are incredibly satisfied. The service is amazing, and [they] are very proud to have gained | | | Waitlists to access psycho-social support. | Young trans people need to be given access to services much faster and mental health professionals within schools. |

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| | people who want to better [their] life makes it easier to reach out. | | | and help [them] in [their] journey. This was far above their expectations and differs from the negative climate in other healthcare contexts/with other GICs where fear of accessing these services initially delayed [their] coming out. | access to it. | | |
| **Nova** | Some challenges | They would love | Actively waiting to | There has been a | None explicitly | Months can go by | They would like more contact |

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| | connecting with/accessing this support. They wish there was more support particularly working with the care navigator. Socially [they've] not really had any support. | to take part in some community groups, but haven't received any information about them. | access therapy and voice training. | positive impact on mental health. | stated, although they do suggest that positive changes could be better by having more contact with the clinic. | | without contact with the care navigator. They usually make first contact if [they] need anything. Also waitlists for psychosocial support. | with [their] care navigator and to be told more about social groups. |
| **Ol** | Long wait lists mean access to support such as therapy feels out of reach. | They are unclear what is meant by social support. | Awaiting access to therapy. | A quicker service with less scrutiny from staff compared to other GICs. Some access to | | More satisfied than [they] would be at another GIC, but unsatisfied. Massively unsatisfied. | While GIC 2 is better than other GICs, obscene wait times and constant | Allowing people to access voice therapy. Trans healthcare not being […] separated into a special place. |

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| | | | | | care which has made [them] happier in [their] body. | | admin errors still an issue. Also waitlists for psycho-social support that can be just as long as medical support. Overall, while GIC 2 is better, it is still sitting within a completely stripped out, crashing health service. |
| **Oliver** | Perceives good access. | Not applicable: No need | Not applicable: No | It wasn't something [they] | The staff pay close attention to | None reported. Participan | |

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| | The most meaningful support has been knowing that if [they] needed help with anything, [they] could ask. Just having the opportunity and support there is enough. | | for support. | need for support. | felt necessary. Knowing it is there if they need it is enough. | detail and care about the wellbeing of patients. GIC 2 was very straightforward which was easier to navigate compared to other GICs. Improvements in physical health as GIC 2 has helped with selfcare. | t explicitly highlights that they were satisfied with the great level of care [they] received. | | |
| **Pyro** | | Suggested awareness as they chose not to access it. | Not applicable: No need for support. | Not applicable: No need for support. | They just wanted to get their transition started with | GIC 2 were great. They were the first medical professionals to listen | None reported. Participant explicitly highlights | Preference for medical over psycho-social support. | Support getting legal documents. |

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| | | | | | hormones rather than focusing on psycho-social support. They felt they didn't need social support. | and actually give me what I need. GIC 2 helped [them] when [they] had nothing and wouldn't be where they are without them. | that they are very satisfied and GIC 2 hasn't affected [them] negatively at all. | | | | |
| **Re** | Referral is easy, but waitlists are lengthy to access which limits ability to benefit from this support. | Counselling and therapy have been offered to [them]. Aware of options available and have begun to | | Referral to hair removal services and have already accessed. Awaiting appointment for voice training. | | Overall had a positive experience. What the service offered was far more expansive than [their] initial expectation. The service | None reported. Participant explicitly highlights that they were satisfied. | | | Waitlists are lengthy to access psycho-social support which is an issue given there was already a waitlist to join GIC 2. | Earlier opportunity for referrals to other services (i.e., voice coaching) could help instead of these only becoming available at first consultation. Sign up for other services when |

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| | engage with these. | | | | has impacted [their] mental health positively as [they] have finally been able to make steps towards feeling more comfortable in [their] body. | | | | | the referral to GIC 2 is initially made could help reduce the overall waiting times for some services. Better access to this social support would make accessing support a lot less overwhelming. |
| **Rei** | No awareness given they suggest that community groups would go a long way if they are | They were not aware that this support existed but express that they would like to see this | | | A service where client are seen quickly and efficiently in contrast to other GICs. Physical | None reported. Participant explicitly states that they are very satisfied and | | | Poor communication of psycho-social support options limits engagement. | They could be more communicative. Better organisation of resources may help with this. Also more of these niche services and |

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| | | not already implemented. They were not really offered this type of support. | type of support. | | | [health] has been good. | grateful for the help GIC 2 has provided. | | | | supporting a wider geographical area. |
| **Ria** | GIC 2 has not referred [them] to any community groups, and the psycho-social options they did express interest in they have not heard back about, | Awareness given they have expressed interest in available options. | Expressed interest in voice training but have heard nothing back. | | They have not pursued talking therapies due to having a good support network. Resultantly, they didn't want to use up NHS resources. | GIC 2 has a shorter waitlist and being trans run helps [them] feel more comfortable. They are more satisfied getting care by people who genuinely care about me. GIC 2 has | None reported. Participant explicitly stated they are satisfied. | | | Long waitlists for accessing psycho-social support options that replicates existing long waits TGD people are already experiencing. | Support with getting a gender recognition certificate. |

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| | making access difficult. | | | | | significantly improved [their] quality of life and mental wellbeing. | | | | | |
| **Roo** | They haven't been referred to community groups, so not able to access these. | They don't really understand what is meant by social support, suggesting limited awareness of available options. | They were unaware that these options were available so could not make an informed decision on if they wanted to access. | | | They have felt supported and understood. GIC 2 being run by trans people makes a massive difference and means their non-binary experience of gender is better understood | None reported. Participant explicitly states that they are very satisfied. | | | | Better support with the ID and deed poll process. |

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| | | | | | | than at other clinics. | | | | | |
| **Sheep** | While they discussed how they were working on improving their social connections themself, it might have ben nice to have been offered resources anyway. However, they felt GIC 2 was there for [them] and always ready to | They don’t recall being offered much in terms of social support. They know they do counselling. | They are not sure how clearly this option was presented to them. They know they do counselling, but many other charities do with shorter waits and can be very queer friendly. | | It might have been nice to have been offered resources anyway, but [they] did make it clear [they] was on top of working to combat isolation. | They love GIC 2 so much and have always felt heard and able to be honest with them. Their authentic perspective was understood, and the care navigator team puts [them] so much at ease. A real feeling of autonomy, that it was [their] needs and [their] | None reported. Participant explicitly states that they were very satisfied and think it is one of the best experiences out there. | | Focused on technicalities of transferring and getting prescription rather than psycho-social support. | Participant reflects on how they might not be deemed an important patient for psycho-social support options, limiting offering of these services. | Stay on the patient-focused path and patient autonomy. Also, more trans-safe spaces to build confidence to integrate into generic social spaces. |

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| | help, so could have asked more about access. | | | unique pathway. The care navigator team is pretty special, and amazing, and have a much better and more trusted reputation in the trans community. | | | |
| **Skylar** | | Limited discussion, suggesting limited awareness. | Support with changing [their] name. | It’s a great service. [They’re] happy with what [GIC 2] is providing. Everything is perfect. They’re on the road to | None reported. Participant explicitly states that they are very satisfied with everythin | Challenges reaching GIC 2 via phone. They don’t contact [them] regularly to see how [they] are getting on | Better phone contact and free travel vouchers to attend events/appointments. |

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| | | | | | [their] real self and [they're] happy. The staff being so kind, caring, and helpful is a big bonus. | g. 9 out of 10. | | | and they never answer the phone. | |
| **Terra** | GIC 2 made [them] aware of the groups and asked [them] on multiple occasions if they would like to be referred for them. They would not have | GIC 2 made [them] aware of the groups. | | They have been referred, but waiting to attend. | Their experience at GIC 2 has been entirely positive. The staff are friendly and professional. GIC 2 has helped [their] mental health as [they are] finally able to access | None reported. Participant explicitly states that they are very satisfied. | Their physical health has not been impacted. | | The wait [for psycho-social support] is quite long. | A clearer way of contacting the service if [they] have any questions. |

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| | accessed these groups without GIC 2. | | | | | gender-affirming care. | | | | | |
| **Theo** | Challenges getting in contact with them to ask about, and access, appropriate support. | They didn't know they had community groups. | Not applicable: No need for support. | Not applicable: No need for support. | They haven't felt [they] needed it since being with GIC 2. | They have been helpful with support. | None reported. Participant states that they are mostly satisfied. | | | Difficulties reaching out to them. There is no messaging service or easy way to reach out unless [they are] contacted first. | A better or more easily accessible messaging service. Also access to social support without the need to wait for a GIC. |
| **Willow** | | Suggested awareness as they chose not to access it. | Not applicable: No need for support. | Not applicable: No need for support. | They have a pretty good support system, so [they've] never | The wait times were a lot less than [they] expected. GIC 2 gender clinic was amazing. | None reported. Participant explicitly states that they are very satisfied. | | | Limited general NHS services that take TGD mental health seriously/just attribute | They need to offer more trans youth groups as it helps having someone who understands you. |

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| | | | really seen the need to. | Comparing it to other outlets for help with mental health, GIC 2 is 10x better. | | | | issues to being trans. |
| **Zari** | Trust in ability of GIC 2 to connect them to alternate support if [they] had any questions. They are sure they would provide something. | Personal barriers – lack of motivation. | | GIC 2 is a top performer when it comes to GICs. They doubt [they] would have come this far with any other service. GIC 2 was not in line with [their] expectations in the best way | None reported. Participant explicitly stated they are 100% satisfied with [their experiences] and struggle to see any negative impact. | Physically, [they are] unsure of any changes. | No challenges accessing support. They simply lack the motivation to pursue most suggestions. | |

possible. It performed way better than their expectations. Talking to care navigators and the fact they make a personal connection was endearing and gave them hope.

*Note.* Underlined text denotes verbatim text.