

Experiences of Transgender Men: A Phenomenological Investigation

Ellis Hobson

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Abstract

Transgender people often struggle to attend appointments with healthcare professionals due to fear of discrimination regarding their gender identity. This is apparent in the research conducted internationally, with all subpopulations of transgender people grouped as one. However, little research has been conducted into these healthcare experiences with solely AFAB (assigned female at birth) transgender people. There is even less when accessing healthcare that is not directly related to their transition in the UK, of which statistics have shown the high occurrence rates of discrimination. To understand the barriers and issues transgender men face when accessing healthcare unrelated to their transition, qualitative Phenomenological research was undertaken with 10 transgender men who have experience accessing healthcare that was not directly related to their transition. In-depth interviews were conducted, transcribed verbatim then analysed using Interpretative Phenomenological Analysis. Aspects of Minority stress theory (MST) were also addressed in relation to then men's experiences. Three main themes were established: Negative experiences; Normalisation, Social Norms and aspects of discrimination; and Healthcare interaction, community and relationships. All the men discussed the forms of discrimination they have experienced and how this was an everyday reality for them in healthcare services. The study also addressed the ways in which they adopted strategies for themselves when it came to navigating healthcare systems. Further understanding of these experiences is needed to inform interventions, training, and policies to target discrimination in healthcare practices.

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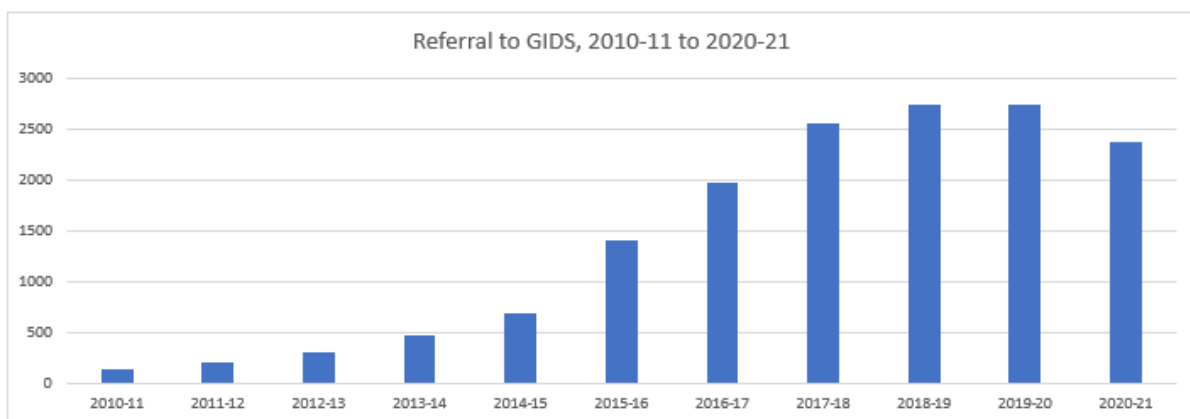
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Chapter 1: Introduction

In the UK, the term “transgender” is used as an umbrella term to describe a person whose sense of personal identity and gender does not correspond with their sex at birth (Hunt, 2014). For example, a transgender woman presents and lives as a woman at present but was thought to be male when she was born (Assigned male at birth – AMAB). Similarly, a transgender man lives as a man at present but was thought to be female at birth (Assigned female at birth – AFAB). Some transgender people identify as neither male nor female and often describe themselves to be non-binary. People who identify with the gender they were assigned at birth are referred to as “cisgender” (Hibbert, et al., 2018). Transgender people, just like cisgender people, seek healthcare professionals for routine reasons. However, they also seek care from these professionals for reasons related to their gender identity, for example attending their GP to receive a referral to a specialised gender clinic (Ellis, Bailey & McNeil, 2015). Previous literature reports that transgender people experience high levels of discrimination that contribute to detrimental health effects, especially on their mental health (Nemoto, Bodecker, & Iwamoto, 2011; Su et al., 2016). Given these high levels of detrimental healthcare outcomes for the transgender community, plus the need for accessing transition-related healthcare, accessing healthcare intervention is crucial.

Trans people and Transphobia in the UK

Until recently statistics in the UK surrounding the prevalence of transgender people were limited, however, following the inclusion of the first-ever question on gender identity in Britain’s National 2021 Census (Greenhalgh, 2021) it was seen that from the 45.7 million respondents, a total of 262,000 people (0.5%) indicated that their gender identity was different from their sex registered at birth (Office for National Statistics, 2023). Although this percentage may appear small, when looking at the rates of referrals to NHS Gender Identity Clinics (GICs) the increase in the population of transgender people becomes apparent. Graph 1 is included as an example to present the increase in rates of referrals to the Gender Identity Development Service (GIDS) which is one of the UK’s multiple GICs, specifically serving children and adolescents in England and Wales. Although important official statistics, these rates cannot be used as an accurate reflection of the population as these represent the rates of referrals to a service (the GIDS), rather than patient numbers throughout the UK for all GICs. Additionally, some individuals may not have gone on to seek any medical care, solely chose to socially transition or opted for a privately paid route.



Graph 1. Referrals to GIDS, financial years 2010-11 to 2020-21 (Gender Identity Development Service, 2021).

As the representation and visibility of the transgender community is becoming more prevalent, the need to monitor critical issues that affect this minority group is more vital than ever. Transphobia is a huge obstacle for trans people in many areas of their life (see *The Transphobic Hate Crime Report 2020* (Bradley, 2020)). Transphobia does not have a sole definition, however, can loosely be defined as the rejection of trans identity or a refusal to acknowledge that it could be real or valid. Transphobia generally refers to hostility, aversion, anger, violence, harassment, and discrimination against people who are – or are perceived to be – gender variant and who do not conform to societal gender norms (Chakraborti & Garland, 2009; Ellis et al., 2016). Transphobia can be presented in many forms, as both covert and overt behaviours (Ellis et al., 2016) and can range from, but not limited to: verbal and physical abuse, attempting to remove trans rights, misrepresenting and systematically excluding trans people from discussions that directly affect them. According to the *Transphobic Hate Crime Report 2020* (Bradley, 2020), invasive questions, being dead-named (using the name they used before they transitioned/see glossary), online harassment and verbal abuse were the most frequent forms of victimisation discussed, however, transphobia can also take many other forms (see Bradley, 2020).

Transphobia in the UK has always been prevalent, yet at present rates are relatively high and continually rising. From the National LGBT survey conducted in July 2017, we know that the number of hate crimes recorded by the police based on being transgender had risen by 45% (National LGBT Survey, 2017., p. 13). One of the most up-to-date reports in the UK, *The Transphobic Hate Crime Report 2020* (Bradley, 2020), also found that hate crimes, that have been reported, have doubled in the past three years and 93% of respondents stated that 12 months before completing the survey they had experienced some form of transphobia. It is worth noting, according to this survey, that only 14% of respondents officially reported their experience to the police. This could potentially mean that levels of hate crimes are higher than reported, this is further supported by the National LGBT Survey (2017) which found that 94% of respondents did not report the most serious incident they experienced where it involved people they lived with.

Accessing healthcare within the UK

As seen in graph 1 (above), the number of individuals wanting to access the GICs is increasing. Therefore, the need for transgender people to access healthcare and the issues they encounter when doing so is becoming a pressing issue. Wright et al. (2021, p. 2) discuss the pathways through which transgender people can access care related to their transition in detail. In the UK, for transgender people to access services that provide gender-affirming services, they must first go to a primary care physician, for example their GP, to gain referrals to secondary services like gender identity clinics (GICs). Note this can differ for areas such as Scotland, where individuals are able to self-refer to gender clinics, thus do not need to approach a GP first.

There are significant barriers for transgender people accessing transition-related care in the UK, for example, lack of clinics, location (Wright et al., 2021) and lengthy waiting times of >39 months (*NHS Gender Identity Clinics*, 2021). Healthcare providers (HCPs), such as GPs, can make this even more challenging due to a lack of knowledge about appropriate care and referral pathways (Adams et al., 2013; Pitts et al., 2009; Sanchez, Sanchez, & Danoff, 2009; Snelgrove et al., 2012; Taylor, 2013). This does not exclude the UK; participants (45%) said their GP did not have a good understanding of their needs as a trans person (TransActual UK, 2021). Furthermore, if a primary clinician holds negative attitudes and beliefs surrounding transgender people, it has an

impact on the provision of care for this minority group. Previous literature has shown that the transgender community is frequently subjected to stigma and discrimination from HCPs, which limits their access to healthcare provisions (Watkinson & Sunderland, 2017). This in turn often leads to the postponement of referrals to GICs, for example 90% of trans people reported experiencing delays when seeking transition-related healthcare, rising for trans men (94%) and non-binary people (96%) (TransActual UK, 2021). Furthermore, delays in treatment whether transition-related or not. Therefore, having the support of one's GP is critical for transgender people as it is their first point of call when attempting to access these gender-specific services through referrals and monitoring their health throughout their transition.

Satisfaction with healthcare in the UK

Health outcomes of trans people

With such a high prevalence of transphobia, it is apparent that this can and does result in adverse mental health issues for transgender people. The Transphobic Hate Crime Report (2020) showed that 72% of respondents identified transphobia as having a negative impact on their mental health, issues such as anxiety, depression and PTSD were identified. Exposure to transphobia and a lack of societal acceptance has been significantly correlated to increased levels of depression (Nemoto, Bodecker, & Iwamoto, 2011; Su et al., 2016). In comparison to the general population, transgender people have a higher prevalence of mental and sexual health concerns, HIV (Jaspal et al., 2018), self-harm and suicide, along with high levels of substance abuse (Connolly & Gilchrist, 2020; Reisner et al., 2016) and this is well supported by previous literature (McNeil et al., 2012; Nemoto, Bodecker, & Iwamoto, 2011; Su et al., 2016).

Disparities in healthcare among transgender persons in the UK

Given these high levels of detrimental healthcare outcomes for the transgender community, and this rising need to access transition-related care, healthcare intervention is inevitable. The National LGBT Survey (2017) showed that 80% of respondents, in the 12 months prior, had accessed public healthcare services and access was higher among trans women (87%) and trans men (89%). This becomes an issue when high levels of discrimination towards trans people have been found within healthcare services in the UK. Whittle et al., (2007) showed that one in five participants from the 2007 Engendered Penalties study said that their GP was 'not trans friendly' and 6% of cases refused to help. A further 17% of respondents had an experience with a HCP who did not approve of gender reassignment and hence refused services. Individuals (29%) also felt that they were treated differently by HCPs due to their trans status. Although these findings are relatively old, it is worth mentioning as a basis to show how rates of incidents have risen and that this issue has always been present. Watkinson & Sunderland (2017) discuss the findings from the Equalities Review (2010) and discovered that over half of the participants experienced discrimination because of their transgender status. This was by healthcare being denied altogether or where they felt that treatment was adversely affected (Department of Health, 2011; 2008). Results from the National LGBT Survey (2017) further support this where twenty-one per cent of trans respondents said

that when attempting to access healthcare services their specific needs were not considered and ignored completely.

More recently, findings from Transphobic Hate Crime Report (2020), which comprises 227 participants, showed that 46% of respondents had not received the correct medical treatment due to transphobia. Participants described the incidents to consist of being misgendered by medical staff, verbal abuse, transphobic comments, having to educate HCPs on trans issues and/or being refused treatment. In the 12 months before the survey, 59 respondents experienced transphobia from a medical professional. Within this sample, transgender people with disabilities, who relied on healthcare services, said that transphobia had a significant impact on their daily lives. Additionally, people with disabilities (12%) reported that transphobia had ‘very much’ impacted their experiences of non-trans-specific healthcare (TransActual UK, 2021). Moreover, TransActual UK (2021) showed that 70% (71% of trans men and 63% of trans women) of respondents reported being impacted by transphobia when accessing general healthcare services, and on account of being trans, 14% reported that they were refused GP care on at least one occasion. These statistics go to show the extent of discrimination transgender people face concerning generic healthcare in the UK.

Despite having these more recent statistics as evidence of the discrimination, previous literature set in the UK has neglected to look at the experiences of transgender people accessing healthcare, especially when it comes to looking at experiences unrelated to their gender identity. Research has looked at the experiences transgender people have had at these specialised GICs in the UK (Davies et al., 2013; Ellis, Bailey & McNeil, 2015; Speer & McPhillips, 2013; Taylor, Zalewska, Gates & Millon 2019; Willis et al., 2020) however there is very little looking at experiences in generic healthcare services.

The present study

The present study aims to explore the lived experiences of transgender men accessing healthcare and whether they face any issues of discrimination because of their gender identity. It provides original data that addresses a gap in the research about transgender people, and healthcare-related research more broadly. The study investigates what constitutes a negative or positive experience for the men. Additionally, focusing on how these men cope with any negative experiences they have, for example, whom they sought support from. In addition, how these experiences and coping mechanisms inform their navigation of healthcare-seeking (Roller, Sedlak & Draucker, 2015), with a particular focus on whether their experiences changed how they now approach seeking healthcare. The findings were analysed using aspects of Minority Stress Theory (MST) (Meyer, 2003). The research questions were as follows:

1. What are trans men’s experiences of accessing general healthcare services and healthcare providers?
2. What sorts of discrimination do trans men face, if any, from providers?
3. How do trans men’s experiences impact the strategies involved in negotiating the healthcare system?

Previous literature informed the research questions. As noted in the introduction, this literature is very focused on gender transition itself and issues directly related to transitioning, rather than people’s experiences outside of their transition. Previous literature (National LGBT Survey, 2018; Transphobic Hate Crime Report, 2020; TransActual UK, 2021), informed question 2 concerning the types of healthcare discrimination that have

been seen before and if the men have experienced these. Each of the research questions led to the development of how the interview guide was predicted to flow, aiming to follow the way that someone would discuss their experiences, see Appendix 1.

As indicated above, the present study addresses the lack of research investigating transgender people's experiences in generic healthcare settings in the UK, as well as making a specific contribution to transgender male-centred research, as this is severely lacking in the UK. The study aims to find what issues, if any, are prevalent for transgender men when seeking healthcare and contribute to the literature that is present in the field, as well as how trans men in particular cope with these experiences. The findings should lead to possible implications and outputs beyond this study, which will be discussed in more depth in the conclusions of this thesis. There are hopes of the research being able to contribute to knowledge informing change in terms of training and policy-making regarding transgender people seeking healthcare, and an overall improvement in the education provided to healthcare providers overseeing transgender patients.

The section that follows will provide an overview and literature review of the existing studies surrounding transgender male-oriented research, and transgender people accessing healthcare outside of specialised clinics and gender-related matters. Theoretical tools informing the research, drawn from MST, will also be addressed. Chapter 2 details the methodology, and the outcomes will be presented within the analysis chapters. In the conclusion the findings will be addressed with aspects of MST and applications for further study on transgender healthcare experiences will be discussed.

Chapter 2: Literature Review

2.1 Transgender men's experiences of healthcare in the UK

There is a limited quantity of healthcare research regarding specifically trans men, especially in the UK. A common issue is grouping all types of trans people as one (Mitchell & Howarth, 2009), including but not limited to trans men, trans women and non-binary people. For example, Speer & McPhillips (2013) had 21 participants, where only 2 of whom were transgender men, the rest being transgender women. This is problematic as just like cis men and cis women their healthcare needs are very different, and their experiences of discrimination also differ vastly (Nadal et al., 2014; Poteat et al., 2021; Talusan, 2016). Generalising findings to all sub-groups of the trans community is not appropriate in healthcare research, yet a lot of research continues to cluster trans people together.

International studies have investigated the experiences of solely transgender men in situations such as pregnancy (Falck et al., 2021; Moseson et al., 2021), sexual health (Bauer et al., 2013) and gynaecological care (Connolly, Hughes & Berner, 2020; Pulice-Farrow, Gonzalez, & Lindley, 2021). However, there is a large focus on the health disparities of transgender men compared to cis women and little research looking into the experiences of the trans men themselves in these situations.

There is also very little research regarding general healthcare experiences and services not related to their gender identity and transition, and even less regarding how this influences their future decision-making in terms of healthcare. One international study by Shires & Jaffee (2015) investigated factors associated with healthcare discrimination among trans men specifically, which touched on discrimination in general healthcare. Overall, 41.8 per cent of FTM participants reported verbal harassment, physical assault, or denial of equal treatment in a doctor's office or hospital (Shires & Jaffee, 2015). Seelman, Kattari, Harvey & Bakko (2021) also investigated factors associated with mistreatment in healthcare settings among different subgroups of transgender men and found mistreatment was associated with participant race/ethnicity, disability, poverty status, education, and sexual orientation. In addition, Hughto, Pachankis & Reisner (2018) found that in a sample of 150 trans masculine (TM; see glossary) individuals, 68% had experienced some form of mistreatment in healthcare in their lifetime and 43% had avoided healthcare in the last 12 months. All three of these studies used quantitative methods, and were international, with a lack of focus on the experiences the men had and their first-person accounts.

The most prevalent body of research regarding trans men's health internationally is about cervical cancer screening and accessing services. Berner et al. (2021) looked at the experiences of transgender men and cervical screening in the UK. Out of the sample, 64 were eligible for screening and out of this 58% had attended a cervical screening, however, 65% stated they had delayed this process at least once. Using thematic analysis, it was seen that having a male gender marker was a major barrier to accessing this treatment. This was through not being called for screening and/or refusal to sharing of results; 'I changed my gender marker to male, so I am not invited at all anymore.' and 'The NHS refused to give me my results as they were under a male gender marker.' (Berner et al., 2021, p.617). For over half of the sample, their gender identity was also the reason for non-attendance. This is due to anticipated discrimination, which is reasonable given one participant was turned away entirely, and due to issues of dysphoria (distress relating to the mismatch between their gender identity and their sex assigned at birth). Participants (approximately one-third) at their last cervical screening test reported a negative experience related to their gender identity due to uncomfortable questioning and a lack of understanding of trans health (Berner et al., 2021).

In the UK there have been studies looking into the experiences of navigating Gender Identity Clinics (GICs) (Speer & McPhillips, 2013; Taylor et al., 2019; Wright et al., 2021). Wright et al., (2021) expanded on these accounts of referrals to GICs by also looking at experiences with primary care physicians (GPs). Positive experiences were perceived with GPs when they treated the individual as a whole person. Instead of seeing their trans status as either a distraction, cause, or obstacle to receiving basic care. Good care was generally seen to include a GP's willingness to learn and be educated on how to provide care, including a good awareness of pathways and processes, as well as taking on the responsibility of their care and not transferring them to someone else. Positive experiences were also formed when the referrals were straightforward and did not include additional complications, such as unnecessary interim referrals to mental health services beforehand. This study looked at the overall pathway in accessing gender-affirming care for transgender people in the UK with the focus surrounding their transition and trans identity. As noted above, my study aims to explore experiences that are not related to transition-related care, which Wright et al., (2021) neglect.

One study by Atnas, Milton & Archer (2015) explored the transition experience of 11 transgender men navigating the UK healthcare system and social transition. Barriers were identified in the process, a major one being the perceived power imbalances they felt between themselves and healthcare professionals, as seen in international research (Bauer et al., 2015). The men felt as though the HCP held a gatekeeping position, leaving them to feel vulnerable, having to fight for treatment and needing to say the 'correct' thing to access it. This effect of power imbalance also led individuals to feel as though they had to submit to inappropriate and personal questioning (Atnas, Milton & Archer, 2015, p.11). Another theme that repeatedly came up amongst participants was fear, particularly fear of being rejected on all levels, fear of social contexts for example family and friends and fear of the medical transition itself.

As presented, there is a lack of health-focused social science research with transgender men in the UK, especially regarding generic health. There is a major need for research to be conducted in the UK as access to healthcare via the NHS can be different to other healthcare systems internationally. The section that follows uses international studies to decipher what has been seen to make up a positive or negative experience with healthcare professionals.

2.2 Exploring experiences within non-transition-related healthcare (International studies)

International studies have provided research to navigate these situations and recommendations for practitioners (Redfern, & Sinclair, 2014; Ross & Castle Bell, 2017; Vermeir, Jackson & Marshall, 2018). UK-based research in this area is limited, however, we can draw from international studies, which are much more prevalent in numbers, to create a basis for what will be worth considering when discovering these experiences in a UK setting. Throughout international studies, mainly conducted in the USA (Kattari et al., 2019; Kcomt, 2019), Canada (Bauer et al., 2015), Australia (Pitts et al., 2009; Riggs et al., 2014) and Sweden (Persson Tholin & Broström, 2018; Westerbotn et al., 2017), the main themes that impacted an experience with a healthcare provider (HCP) were as follows: HCP knowledge; HCP communication; HCP-patient relationship dynamics; and expectations and consequences of meeting with a HCP. Note the following studies are looking at the transgender community as a whole, not just transgender men.

HCP knowledge and attitudes

A key element in influencing transgender individual's experiences of healthcare interactions is the perceived knowledge and former education that the HCP possesses on transgender healthcare needs. Unfortunately, a lack of knowledge for healthcare providers outside of specialised gender identity services is common, this is partly due to a lack of training provided for HCPs concerning transgender issues and healthcare (Women and Equalities Committee, 2016). Ross et al. (2016) interviewed healthcare professionals who disclosed that there was no formal training regarding trans health in their education (Ross et al., 2016, p.242).

Transgender individuals often face the burden of having to adopt an educational role to inform the HCP themselves to ensure that appropriate care is given (Persson, Tholin & Broström, 2018, p.428). This is perceived as positive if the HCP demonstrates genuine interest and willingness to pursue further information (Vogelsang et al., 2016) and admits they are not well educated on the matter. HCP knowledge, specifically on transgender issues and relevant services available to them, was key in determining the direction of the experience (Ross et al., 2016). On the contrary, if the HCP does not show this disposition to learn and does not seek out information themselves to better understand their patient, transgender individuals perceive being the educator to be tiresome, in turn, the experience is perceived as negative (Von-Vogelsang et al., 2016). Riggs et al., (2014) found a moderate positive relationship between the need to educate GPs and levels of discrimination and a moderate negative relationship between the need to educate GPs and feeling respected.

HCP communication

Another element important in determining the direction of an experience with a HCP is communication. Von Vogelsang et al. (2016) were able to define 5 subcategories that determine a positive encounter regarding communication: professionalism, integrity and respect, responsiveness, trust and confidence, and the transgender person's part in the encounter. Patients have said that a positive encounter consisted of the HCP being empathetic, considerate, and compassionate towards the transgender patient (Pitts et al., 2009). Furthermore, protecting the trans person's privacy and not questioning the patient's gender identity was a sign of respect. These findings are supported by Heng, Heal, Banks & Preston (2018) who found that 18 of the 20 studies included in their review highlighted the importance of HCP communication in determining the experience. Positive experiences were associated with respect/perceived acceptance of the patient's identity and demonstrating a nonjudgmental approach to providing healthcare in need (Hinrichs et al., 2018; Hoffman, Freeman & Swann, 2009; von Vogelsang et al., 2016). Pitts et al. (2009) found that individuals described negative encounters when they sensed the HCP being uncomfortable, resentful and where they were met with hostility. Westerbotn et al.'s (2017) participants discussed how the HCP's own opinions and feelings about transgender people influenced how they were treated, for example being met with hostility.

Insensitive use of language and use of improper pronouns and names lead patients to feel as though their identity was being dismissed (Riggs et al., 2014). Already difficult situations for transgender patients, i.e., sex-specific medical clinics, were made more challenging because of these issues (Pitts et al., 2009). HCPs partaking in intrusive or irrelevant questioning about the patient's gender, even when the matter at hand was not related to

their transition, was also seen as negative (Hobster & McLuskey, 2020). This can be questions regarding what genitals an individual has, whether they have had ‘the surgery’ or their sexual behaviour.

Other issues include blaming the patient’s transgender status as a cause for their healthcare issues. Westerbotn et al. (2017) found that HCP sometimes hyper-focused on the patient’s gender identity rather than treating them for the issues they sought care for, irrelevant of gender. As a result, participants from this study were cautious to disclose their transgender status in fear of it being the sole focus of the interaction leading them to receive poorer care or even being denied care altogether. One UK study looking into trans and non-binary patients’ experiences of interacting with the ambulance service found that 40% of participants were asked intrusive questions about their gender by the ambulance crew when it was unrelated to the issue at hand (Barley & Tooms, 2019). Pearce (2018, p. 111) discusses this phenomenon, frequently referred to as “Trans Broken Arm Syndrome” within the trans community. It is the notion that no matter the issue, the patient’s trans status is viewed as the cause for the issue (Graham, 2021; Oliver, 2021) and that the trans person is defined entirely as their trans status. This is particularly present within mental health services; Hunt (2014: pp. 293-294) found that 43% of patients seeking counselling for something entirely unrelated to their gender and transition said that their counsellor wanted to explore transgender issues in therapy. This makes it difficult for transgender people to access support for their mental health issues which are not tied to their gender. However, “Trans Broken Arm Syndrome” can be applied to any form of healthcare. Although not a formal research participant, Payton (2015) spoke with a community member who provided a list of physical problems they sought care for (a sprained ankle, broken ribs and arm) “where their trans status and hormone replacement therapy with discussed at length and in unnecessary detail”.

HCP-patient relationship dynamics

Relationship dynamics between the HCP and patient further influence how interactions are perceived on behalf of the transgender individual, including power imbalances (Dewey, 2008; Guss et al., 2017), further seen in the UK literature above. Heng, Heal, Banks & Preston’s (2018) systematic search found that 9 articles discussed how participants felt as though the HCP held a ‘gatekeeping’ position about their care due to patients being dependent and vulnerable towards their HCP. There were feelings of being powerless that everything is in the hands of their HCP (Linander et al., 2017). Intrusive and irrelevant questioning on unrelated private matters was seen as a way of the HCP exploiting their position of power (Kosenko et al., 2013) and patients felt as though they were expected to answer because of power imbalances (von Vogelsang et al., 2016). Whether purposeful or not, HCPs have professional capital and this is reflected in transgender people’s experiences.

As previously mentioned, it is of common occurrence where, due to the lack of knowledge on transgender patients, patients must educate healthcare providers on their healthcare needs. Patients felt as though health professionals did not take them seriously and that their knowledge was doubted and discredited (Bauer et al., 2015; Hobster & McLuskey, 2020; Linander et al., 2017; Poteat et al., 2013) due to this power. Discrimination has become apparent from HCPs, whether subconsciously or consciously, as a defence mechanism in instances where trans people educate the HCP on the matter at hand, challenging the HCP’s medical authority. Participants in von Vogelsang et al.’s (2016) study discussed how they felt that HCPs purposely adopted a distanced attitude by using one-way communication through academic language patients are unlikely to

understand, to reinstate their authority in this context. Furthermore, Bauer et al. (2015) discuss an example where a HCP dismissed the trans patient's knowledge, despite admitting not being well educated and then further blamed the patient for the negative encounter they perceived. This process of positioning transgender patients as inherently problematic through shifting the blame upon them reinforces the medical provider's authority (Bauer et al., 2015).

Positive relationships were perceived when patients felt that they had some involvement with the encounter and had some form of partnership with their HCP (Heng et al., 2018; Hinrichs et al., 2018; Pitts et al., 2009; von Vogelsang et al., 2016). If patients felt respected by their HCP, a positive relationship between patient and practitioner was created through elevated levels of comfort (Riggs et al., 2014).

Expectations and consequences of meeting with HCP

Although trans people's experiences in healthcare have been studied, mainly internationally, there is little research investigating the outcomes of these experiences and how this impacts their future decision-making and experiences. There have been a handful of studies looking into what transgender people expect when they access healthcare due to prior experience and experiences shared by other transgender people. People expected to lower their standards when going to speak to a HCP and expect lesser treatment (Heng et al., 2018). They also accepted making sacrifices and tolerating certain aspects, including educating the HCP and enduring inappropriate questioning (Hibbert et al., 2018; Roller et al., 2015; Vermeir et al., 2018) just to get access to the care they need. Trans patients seemingly share the expectation that generic HCPs, like GPs, will lack the understanding of how to engage with a trans person respectfully, especially when not discussing trans-related matters. This expectation of rejection is discussed further in relation to MST below.

A consequence of negative experiences is the disclosure of their trans identity. Patients have been seen to conceal their trans identity when accessing non-transition-related care to decrease the risk of discrimination and increase the likelihood of gaining the non-transition-related care they need (Dewey, 2008; Lindroth, 2016), Persson Tholin & Broström (2018, p.430) described this as the "tactical" thing to do. Furthermore, because of meeting with a HCP who generated a negative experience, understandably transgender people have felt avoiding healthcare is the best way to cope with discrimination. This avoidance and delaying of healthcare for trans people is common due to anticipated discrimination; this is unsurprising due to the prevalence of discrimination with HCPs. Patients often feel anxious before the interaction due to the fear of being treated differently because of their transgender status and this is a huge factor in avoiding seeking healthcare (Westerbotn et al., 2017). Many studies internationally have shown that trans people either delay accessing necessary treatment or avoid accessing healthcare altogether for this reason (Grant et al., 2011; James et al., 2015; Reisner et al., 2014). In the UK, The National LGBT Survey (2017) showed that 18% of respondents said they avoided treatment for fear of discrimination or intolerant reactions. More recently this number has increased as according to the Transphobic Hate Crime Report (2020); medical treatment was avoided by 77% of respondents due to being afraid of receiving transphobia. Furthermore, TransActual UK (2021) found that 57% of trans people reported avoiding going to the doctor when unwell for these reasons likewise.

It is worth noting that not all the literature primarily focuses on the negative consequences and expectations of meeting with HCPs. It is also important to consider agency in this aspect and how trans people have used agentic action in difficult situations. Agency is the idea that individuals can perceive their environment

and therefore act in a way that will change the environment to achieve an intended goal. Individuals can select and perform efficient actions and behaviours that are available in each situation to achieve this intended goal, for example, identity concealment. Ross et al. (2016) found on a micro level, trans individuals have been seen to use strategy development to receive the care they need. This is based on individuals being independent, patient, and persistent in their approach to healthcare and the notion of using agency to improve personal power and have authority over their own choices. Furthermore, on a meso level, individuals have been seen to use informal networking as a means to share and obtain knowledge from other trans individuals (Ross et al., 2016). Accessing external support through local and interpersonal levels, for example having friends who were allies to the transgender community was found to be a key support when dealing with healthcare disparities (Ross et al., 2016). This was also highlighted through the seeking of support groups to feel supported through the process and to build social networks with other transgender people in similar situations. Additionally to gain knowledge surrounding navigating healthcare (Dewey, 2008; Poteat et al., 2013; Roller et al., 2015). Patients have been seen to challenge a HCP when experiencing a negative encounter, one participant in Poteat et al.'s (2013) study demanded better care from their HCP and others have been seen to change HCP completely. Many trans individuals actively seek out trans-friendly providers by researching thoroughly the services they intend to use (Roller et al., 2015). By changing GPs completely or actively seeking out a trans-friendly HCP, an individual has taken control of their situation and evaluated the best way to get the goal they are trying to attain, in the context of these studies it is healthcare. This can be seen as empowering for individuals in a situation where they feel that they lack power.

2.3 Theoretical Resources – Minority Stress Theory (MST)

Minority stress can be defined as the high levels of stress that members of a stigmatised group face, because of the reasons that lead them to be a part of that minority group. Minority stress itself can be caused by different factors from societal and institutional discrimination to poor social support or interpersonal prejudice. When these minority individuals are exposed to these stressors for extended periods it can, and does, result in negative health outcomes both physical and mental. Minority Stress Theory (MST)(Meyer, 2003) attempts to explain how and why this occurs. It builds on aspects of social and psychological theories surrounding stigma and prejudice; social structures and health; and stress (Meyer et al., 2021). The theory built on the social causation hypothesis (Dohrenwend, 1966;2000) by saying that it is not the situations themselves that cause bad health, as Dohrenwend proposed, it is the prolonged added stress as a result of the situations that cause health implications (Meyer, 2003; 2007). MST (Meyer, 2003) is one of the most used theoretical frameworks in explaining minority health disparities. It is used as an asset by academics in social and health psychology to understand the experiences of stress processes in minority group members and to help contextualise the negative health outcomes present among these populations. Although the MST framework was originally proposed to help understand sexual minority health issues, it has been successfully applied to other populations. Pascoe & Richman (2009) found a significant negative effect of perceived discrimination on both mental and physical health overall from studies relating to racism, sexism, and sexual orientation.

A minority stress perspective has been applied to transgender people with experiences of misgendering (McLemore, 2018); substance abuse (Connolly & Gilchrist, 2020); mental health (Scandurra et al., 2017; Testa et al., 2017); and rejection (Rood et al., 2016). Again, these studies tend to inappropriately group all transgender people together, as discussed previously. Little research has shown the application of MST being applied to

transgender men alone, however, a study by Velez et al. (2016) did investigate common objectification theory constructs (internalization of sociocultural standards of attractiveness, body surveillance, body satisfaction) in transgender men whilst also applying MST amongst other theories.

Put briefly, minority status leads to an increase in stressors, as well as lifetime experiences of harassment, maltreatment, discrimination, and victimisation (Marshall et al., 2008; Meyer, 2003). Subsequently resulting in excessive levels of stress which cause adverse mental health outcomes. MST proposes that stressors specific to a minority group can largely explain these health disparities, that otherwise, the general population would not experience. Stressors are events and conditions in which individuals are required to adapt and change to navigate new situations; these are mainly socially based. The stresses can be defined into two groups: distal stressors and proximal stressors. **Distal stressors** are presented in external forms outside the individual's perception of self (such as prejudice, direct experiences of violence and harassment, restriction of civil rights and discrimination in healthcare) which are direct results of their minority status (Staples et al., 2018). Distal stressors can consist of social structural issues (e.g. cisgenderism and sexism), low socioeconomic status and poor social support (including friends, family, and acquaintances). As well as governmental discrimination, typically taking the form of constitutional discrimination until equal protections are applied. When an incongruence between societal structures and the individual exists, stress is exacerbated, and health is compromised as a result. Rates of distal stressors for transgender people in comparison to their cisgender counterparts are much higher in areas such as employment (Chope & Strom, 2008), education (Goldberg, 2018), housing (Kattari et al., 2016) and healthcare (Jaffee et al., 2016). **Proximal stressors** are assumed to be a result of distal stressors; they take the form of internal processes (Dohrenwend, 2000) and are more related to self-identity. Although not researched as much as distal stressors, proximal stressors have been seen to take three main forms: expectations of rejection, identity concealment, and internalised stigma. These three forms can be in conjunction with each other and are not necessarily stand-alone forms of proximal stressors.

The fear of rejection has been seen as a significant minority stress process (Meyer, 2003), for trans people likewise (Rood et al., 2016). Previous research into minority stress has shown that individuals who have experienced forms of discrimination are more likely to expect rejection (Feinstein et al., 2012). Within this rejection, individuals begin to expect experiences such as discrimination or stressful events. Rood et al. (2016) discuss how this is a result of individuals knowing the hostile stance society holds against their minority group and the likelihood they are to receive discrimination. Research has shown that transgender individuals do expect rejection directly resulting from their gender identity and how it negatively impacts their mental health. Bockting et al.'s (2005) study showed rejection expectation was positively associated with psychological distress, and negatively associated with levels of outness. Furthermore, Rood et al. (2016) found that expecting rejection was a frequent stressor for transgender people and the responses to this stress consisted of anxiety and situational avoidance. Consequently, identity concealment has been viewed as an adaptive behaviour to cope with these situations (Rood et al., 2016) and is viewed as a unique stressor to this minority group as it goes beyond the experience of a general life stressor. Although this can be beneficial in certain situations to avoid victimization (Levitt & Ippolito, 2014; Xavier et al., 2013), mental health can take an impact due to the stress of having to decide whether it is the correct thing to do and the stress of the experience itself (Meyer, 2003; Pachankis, 2007), especially as it can become dangerous if they are 'found out'. Rood et al. (2017) reported that participants found

concealing their identity as a frequent source of stress and feeling anxious about their personal safety in the process further amplified this stress.

Distaste for one's own minority group is another identified proximal stressor. When exposed to societal ideations for extended periods minority individuals can begin to accept these as true (Bessenoff & Snow, 2006) which leads to self-hatred and poor self-regard/deprecation (Malyon, 1982). This internalisation can present itself in many forms, starting from anxiety and depression leading to a decrease in self-empathy and tolerance (Stitt, 2020). Internalised hatred has been seen to lead to higher rates of depressive symptoms, suicidal ideation, and suicide attempts, as seen by Lee et al. (2020) who found that internalized transphobia was significantly correlated to these mental health issues. The literature also provides quantitative studies that show an association between psychological distress and internalised transphobia (Breslow et al., 2015; Perez-Brumer et al., 2015; Testa et al., 2015). Additionally, internalised transphobia has been linked to sexual health risk behaviours (Nemoto et al., 2004). Therefore, the research suggests that the internalisation of negative societal attitudes begins to have an impact over time on minority groups' mental, as well as physical, health.

Stress-Ameliorating Factors

Scholars have used MST in many ways, as the model intended it has been largely tied to studies identifying associations between stressors and mental health disparities (Lefevor et al., 2019; Marshal et al., 2008). However, it has also been used to explore how minority group members cope with stress and explore the ways in which stress can be alleviated (Breslow et al., 2015; Lefevor et al., 2019; Pflum et al., 2015; Singh et al., 2014; Trujillo et al., 2017). It can be used to explore the ways that group members use strategies and coping mechanisms to deal with the negative impacts of prejudice-related stress. Minority status is often a source of resilience and strength and Meyer (2003) highlights the importance of Stress-Ameliorating Factors among minority group members and how they respond to prejudice with coping, resilience and social support, and also the importance of these factors as its meaning is only comprehensible in its relationship with stress (Scandurra et al., 2017). "Resilience refers to the quality of being able to survive and thrive in the face of adversity. It includes anything that can lead to more positive adaptation to minority stress and thus, mitigates the negative impact of stress on health" (Meyer, 2015, p.210). Resilience has been studied as a mediator of the effects of minority stress in LGB populations successfully (Storholm et al., 2019).

Social support/affiliations with one's community have been seen to help shield the effect of the stressors, act as a protective factor and aid as a preventative for negative health outcomes. This affiliation allows individuals to identify as within-group members (Hendricks & Testa, 2012) rather than continually comparing themselves to majority groups, allowing for validation. Transgender people have been seen to use social support with trans-specific community forums for all aspects of their lives including health-related concerns (Ross et al., 2016). Social support has been seen to lower the effects of negative mental health issues associated with minority stress by providing group coping strategies; Pflum et al. (2015) found that social support was significantly negatively associated with anxiety and depression. Participants in Singh et al.'s (2014) study discussed the necessity of having access and relationships with trans peers and how group solidarity and cohesiveness are major aspects of resilience. Therefore, it is important to acknowledge these adaptive factors when researching minority stress amongst transgender communities and how they can function as a buffer to adverse health outcomes.

An adaptation of the Minority Stress Model (Meyer, 2003) has been put forward for transgender and gender-nonconforming populations by Hendricks & Testa (2012). They described how expectations of future victimisation and rejection, as well as internalised transphobia, result from prior experiences related to an individual's gender identity. It also addresses the unique stressors experienced by trans people and how they are related to vulnerability and mechanisms of resilience to cope with their mental health are also addressed. Using suicide attempts as their example, Hendricks and Testa (2012) show support for the relationship between minority stress factors and suicide attempts. Distal stressors were identified to have an impact on mental health; individuals who had experienced sexual and physical assault were four times more likely to have made a suicide attempt and had a significant relationship to alcohol abuse (Xavier, Honnold & Bradford, 2007). Furthermore, individuals within a school environment, who reported being a victim of gender-based hostility were also four times more likely to make a suicide attempt (Goldblum et al., 2012). Although there is no causal link between these external events, a correlation is present and demonstrates support for the MST's application to transgender populations. Hendricks & Testa (2012) deliver recommendations to clinicians for ways in which to apply areas of the MST when providing services for trans people, these were: prior discrimination, expectations of rejection and victimisation, internalised transphobia, and resilience.

Minority Stress Theory has informed my thinking when conducting this research and I have drawn on aspects of this in the analysis and conclusion. The main aspects of MST applied to the present study are the unique distal and proximal stressors, specifically identity concealment; fear or rejection; and avoidance experienced by the men. As well as the Stress-Ameliorating factors trans people have been seen to use in previous research. This combined helped address the research questions in how the men have adopted strategies for healthcare seeking and ways in which they alleviate the effects of negative mental health outcomes.

Conclusion

The literature review demonstrates the limited literature on transgender men and generic healthcare. It uses international studies on the transgender community as a whole to decipher what elements were worth exploring in the present study. Factors such as HCP knowledge, communication and relationship dynamics were influential in determining experiences. The consequences of said experiences, such as healthcare avoidance and identity concealment show how these experiences continue to impact transgender people seeking healthcare. Exploring how transgender people perceive positive and negative aspects of HCPs may help develop recommendations for healthcare practices to improve care for transgender people and help decrease the high rates of avoidance presented. This is extremely important as we can see from the levels of healthcare disparities and the increased risk the transgender community have, specifically mental health concerns. Investigating these issues may help understand how trans individuals react to these situations and how to help increase their own positive experiences in accessing care (see Heng et al., 2018). The research presented and Minority Stress Theory provides a basis for the present study. The chapter that follows details the methodology and rationale for the use of Interpretive Phenomenological Analysis with an acknowledgement of reflexivity.

Chapter 3: Methodology

3.1 Justification for IPA in the present study

As seen from the literature review more research is needed from a qualitative social science approach to involve transgender people's experiences rather than from statistics and biomedical explanations, to gain more in-depth first accounts. Interpretative Phenomenological Analysis (IPA; Smith, 1996) is appropriate when the research aims compromise open-ended questions rather than that of a hypothesis; hence it is exploratory rather than explanatory in nature. For example, a research question in the present study is as follows: "What are trans men's experiences of accessing general healthcare services and healthcare providers?". IPA's main use is when research is focusing on a participant's lived experience of a phenomenon; it offers a systematic approach to the interpretation of first-person accounts of experience. A narrative procedure is needed to address the research questions and gather data to perceive the experiences that transgender men have been through, of which a quantitative method would not entail. IPA focuses on getting to the essence of people's experiences and to understand their experiences you must get as close as possible to understanding how people see and experience things, this is very important in the present study.

IPA has been used to research phenomenon that is complex, ambiguous and emotionally laden (Smith & Osborn, 2015). Many studies have utilised IPA as a means for analysing difficult or sensitive topics, most frequently experiences of chronic illness in health psychology (Lindsay et al., 2014; McGeehan et al., 2018). Although IPA was originally developed in the field of Psychology its increased popularity has expanded its application to the different fields of human, social and health sciences. In particular: sexuality (Dewinter et al., 2017), relationships (Bin Ibrahim & Barlas, 2021) and key life events/transitions (Ahn et al., 2017; Connolly & Gersch, 2016), including identity transitions (Miron et al., 2021; Smith, 1999). IPA has been successfully used when researching transgender populations and their experiences with certain contexts (Coppola, Gangamma & Hartwell, 2021; Eisenberg & Zervoulis, 2020; Wilson, Malik, & Thompson, 2021). When it has been used regarding healthcare it has been done so with success; Applegarth & Nuttall (2016) explored the lived experience of transgender people surrounding talking therapies, IPA was applied and they successfully generated a total of four master themes. Similarly, Delaney & McCann (2021) used IPA to explore transgender people's experiences of mental health services in Ireland. Blodgett, Coughlan & Khullar (2017) conducted an IPA analysis on overcoming the barriers to transgender healthcare in rural Ontario. Overall, IPA has been seen as a useful methodology when investigating transgender people's experiences in varying contexts and has proven itself to be an appropriate methodology in the context of the present study.

As the present study is exploratory due to the focus on experience, IPA was chosen over Grounded Theory (Glaser & Strauss, 1967) for example, as Grounded Theory focuses on attempting to explain a process or action and develop an explanatory framework, or "theory" for the contextually bound process through drawing from existing literature and theories (Strauss & Corbin, 1997). Grounded Theory is more concerned with peoples' accounts surrounding how social structures and processes influence how things are accomplished through a given set of interactions with others in social processes (Blumer, 1986; Charmaz et al., 2016).

3.2 Theoretical roots

Interpretative phenomenological analysis (IPA; Smith, 1996) focuses on meanings, experiences, and subjectivity it 'is concerned with the detailed examination of personal lived experience, the meaning of the experience to participants and how participants make sense of that experience' (Smith, Flowers, & Larkin, 2009, as cited in Charlick, Pincombe, McKellar & Fielder, 2016, p. 206). The approach's ideographic focus aims to give an insight into how a particular phenomenon is experienced and what it means to that individual in that precise context. It involves the use of thick description and close analysis of lived experience to comprehend how meaning is created through embodied perception (Sokolowski, 2000; Stewart & Mickunas, 1974). IPA stems from multiple theoretical roots: phenomenology, hermeneutics and ideography thus is considered distinct from other qualitative phenomenological approaches (Gill, 2014). IPA is considered unique and has gained its popularity due to it being able to explore, describe, interpret, and situate the participants' sense-making of their experiences (Larkin, Watts, Clifton, 2006; Smith, Flower, Larkin, 2009, cited in Tuffour, 2017). Edmund Husserl (1963;1989), Martin Heidegger (1962;1982) and Maurice Merleau-Ponty (1974) are often cited in IPA work, as they were precursors to the development of IPA through providing philosophical writings that had helped inform the approach.

Phenomenology is the philosophical study of 'being' and how people make sense of their own experiences. It is concerned with personal perception of the situational context, rather than producing an objective statement regarding the situation itself (Smith et al., 1999). The founder of the phenomenological movement in philosophy, Edmund Husserl (1859–1938), put forward the notion of focusing on the way the world seems to appear to people to be able to understand their experience. In this thesis, the position of Husserl is taken to see how the world appears to people and to be able to get as close as possible to their experience. Husserl attempted to construct a philosophical science of consciousness drawing on previous philosophers' ideas of dualistic thinking (difficulties with the separation of mind and body) by changing the focus onto the experience itself. Following on from this initial focus, existentialist philosophers such as Martin Heidegger, Jean-Paul Sartre and Maurice Merleau-Ponty emphasised the lifeworld (the way that all experience must be understood in the context of the person having the experience and the way that they see the world). These later philosophers argued Husserl's approach of viewing a phenomenon from an outside perspective, often described as a 'God's-eye view' and said that individual embodied experience should be viewed in the context of the phenomenon being studied.

Hermeneutics is the second major theoretical underpinning of IPA, which is the study, theory and practice of interpretive structures of experience, and views individuals as interpreting and sense-making individuals. It has been applied to areas of general questioning, especially in areas of humanities and was introduced into the IPA approach by phenomenologists, such as Heidegger (1996). Building on Husserl's previous work Heidegger (1996) wanted to shift the emphasis onto having a more grounded stance by keeping the core element of meaning however having more focus on people, relationships and language. This was incorporated to understand the social world and how individuals articulate experiences using language and how this reflects relationships. According to a hermeneutic approach, research can be considered a dynamic process where the researcher takes an active role in trying to understand and make sense of the participants trying to make sense of their personal and social world (Smith (2004) refers to this as 'double hermeneutics').

Ideography makes up the third theoretical underpinning which aims to focus on the particular (for example a particular group of individuals or particular experiences) rather than the universal and understand the case as a case in its context. This allows the focus to be centred on the subjective lived experiences of the

individual, unlike a nomothetic approach that attempts to make overall generalisations about populations and understand large-scale social patterns. IPA is concerned with the detail and in-depth understanding, with a focus on how individuals understand contextual experiences from their perspective, usually within a narrower subject of study. In the context of this study, the experiences of participants are extremely unique as it is related to health experiences, therefore the findings do not apply to everyone in this population and cannot be overstated into a general understanding of the phenomenon.

The data keeps its relevancy, accuracy and detailed collection and analysis by imploring these three core principles. Phenomenology allows us to see how people make sense of their own experiences and what it personally means to them with hermeneutics allowing the interpretation of these experiences. Lastly, the ideographic nature allows the detailed exploration of the individual's accounts from their perspective. These principles are crucial in determining the direction of the research as it provides a basis for collecting an accurate reflection on the experiences recounted by these transgender men.

3.3 Procedure

Data collection in the present study used semi-structured interviews which lasted approximately one hour, ranging from 30 to 90 minutes, and were conducted between March 2022 and June 2022. The interview schedule involved open-ended questions relating to varying aspects of the individual's life, including how this not only affected them but how it informed their way of navigating healthcare (see Appendix 1). As IPA usually requires personally salient accounts of richness and depth, the process of gathering data from participants generally takes the form of interviews, more specifically semi-structured interviews. This creates a sense of normality as it reflects real-world conversation more so than a structured interview (Jennings, 2005). Additionally, it allows participants to discuss the experiences they feel are most important in detail (Longhurst, 2003).

3.4 Sample

Participants need some element of common experiences with the research questions as an IPA analysis investigates how a phenomenon is understood within a given context and from a shared perspective. Therefore, self-identifying transgender men were recruited from community forums on Facebook, explicitly trans-masculine support groups. Access was already granted to such platforms as an emic researcher; hence access did not need to be granted by group moderators (Pike, 1954; 1967; 1982), however, permission was obtained before posting the advertisements. To ensure confidentiality and anonymity comments and any other form of interaction with the post was disabled. The provision of the researcher's email address meant participants had to email voluntarily and initiate contact. From initial contact more information was given surrounding the study through an information sheet so participants could ensure participation. The choice of recruiting online was made as finding participants in the local areas proves hard as transgender men make up such a small percentage of the population, this method allowed for a larger scope of participants from varying backgrounds such as location, socioeconomic status, ethnicities, and age.

3.5 Participants

Due to the ideographic nature of IPA and its rigorous analysis, sample sizes are relatively small, usually around six to eight (Turpin et al., 1997). Participants in the present study consisted of 10 self-identifying trans men from various areas in the United Kingdom, ranging from but not limited to: West Yorkshire, London, Blackpool, Liverpool, Scotland (Edinburgh) and one participant who moved to the UK had previously lived in France, Singapore, and Indonesia (for this participant only UK experiences were focused on). Participants also varied in age ranging from 19 to 45, and sexual orientation.

3.6 Data Analysis

The process of IPA analysis is similar to that of thematic analysis (Braun & Clarke, 2006) in the sense that similar steps are taken in the analytical process, however IPA includes the adoption of a phenomenological viewpoint, and the process of coding differs slightly. It also adopts the concepts of the lifeworld (Langdrige, 2007) and the lifeworld has four essential themes: temporality (the experience of time), spatiality (the experience of space), embodiment (the experience of one's own body) and intersubjectivity (the experience of relationships with other people). See Appendix 6 for a full account of the methodological process of analysis.

3.7 Conduct of the research and ethical considerations

The British Psychological society's guidelines were adhered to (British Psychological Society, 2021), and the University of Huddersfield's Ethics panel approved the plan of the present study (see appendix 7). To protect confidentiality and anonymity, all participants' confidential data was stored on a password-protected computer and only I, the main researcher, had access. Participant names were removed and replaced with a unique identifier (a number), allowing me to regain access to the participant's corresponding original data if needed, and pseudonyms were used in this thesis. The same applied to any individuals the participants mentioned by name.

Interviews were conducted via online video call (Teams) due to the risk of COVID at the time of fieldwork, therefore no physical risks were involved in the study. Online calls also allowed participants to choose a time best suited to themselves. A consent form and an information sheet were provided to each participant prior to any arrangement of interviews being made (see Appendix 3 & 4). The main potential harm associated with the research is the sensitive nature of the topic. Individuals were aware of the nature of the study from the onset and were made aware that if they felt distressed at any point, they were allowed to withdraw from the study without any explanation and not have to answer certain questions. The use of online interviews did appear to make it easier for the men to be forthcoming and easy to establish rapport with, potentially due to de-personalisation during data collection. The use of the interview guide provided the type of data expected however, the lack of concrete questions did cause an issue with one or two participants who needed probing to provide in-depth responses. Overall, the online interviews were successful and yielded good data.

3.8 Reflexivity

It is important to discuss my role as the researcher and reflect on my standpoint and personal relation to the topic. I was consciously aware of the sensitive nature of the topic at hand and how it must be approached with caution to show the findings to be an accurate reflection of the issues related to healthcare discrimination towards

transgender men. As a transgender man myself, I am deemed an ‘insider’ to the research (Gair, 2012) and the need to reflect on my research position is important as it is an epistemological matter (Griffith, 1998). Being an insider gives advantages to approaching research, particularly when disclosing their position to participants (Perry, Thurston & Green 2004). This disclosure generally results in richer, deeper data however there is the risk of researcher-participant boundaries being crossed and participants viewing the researcher as a friend or counsellor (Birch & Miller, 2000). It allowed for the appropriate formulation of research questions and interview schedules, alongside the added advantage of having access to this group of participants. My understanding of what is deemed acceptable to discuss with transgender men put me in a stronger position in conducting the study ethically and minimising potential harm to participants. Despite these advantages, some issues can present themselves in the aspect of analysis and the risk of my experiences in influencing the findings. I was aware that even though there was shared commonality, it did not guarantee that I understood the participant’s experiences more than an outsider, as other aspects such as personal, social and situational characteristics can be very different (Bridges, 2001). Epoché, a key concept within IPA, is very relevant for this reason. As proposed by Husserl (1931), it is very important to ‘bracket’ off (epoché) one’s natural attitude to recognise ‘things in their appearing’. Phenomenologists differ in the extent to which bracketing is possible, and this concept has been argued against by Heidegger and Sartre and Merleau-Ponty (existential phenomenologists). They claimed it is an imperfect process and by arguing that it is not completely possible to take a stance from nowhere (ricoeur) as all experience is grounded in our embodied being in the world. Therefore, although the concept is imperfect, it was still important to be able to continually attempt to put my own experiences and knowledge to one side to capture the participants understanding only and by reflecting on my role as the researcher and take a reflexive approach to the whole research project. I endeavoured to see things as the participants saw things, to understand how they made sense of their lifeworlds. Arguably gaining a richer description of their experiences, not only as a researcher but also with my trans identity.

Despite this, my positionality creates some complexities in the sense that I am an outsider to some participants by being an able-bodied white man and my perspective will have limitations in understanding the intersectionality between transphobia and racism/ableism. This could have reflected in participants’ responses and how comfortable they were discussing these aspects with me due to a perceived lack of understanding as a white man in the dominant culture. Additionally due to my positionality and sampling method going through known contacts, I may not have reached certain networks of people in the first place.

Chapter 4: Findings and Analysis

As readers are aware, the present study is looking at transgender men’s experiences of discrimination within healthcare. The research questions were regarding: What are the men’s experiences of accessing general healthcare services and healthcare providers and what forms of discrimination they experience. Further how the men’s strategies and decision-making have adapted post lived experience.

There were a total of 17 primary themes established through the 10 trans men’s narratives that were categorised into three main themes. The three main themes were: “Negative Experiences”; “Normalisation, Social Norms and aspects of discrimination” and “Healthcare interaction, community and relationships”. Table 1 (see Appendix 2 for concordance rates) shows the participants consistent with the main themes and subthemes, which are discussed in the following section, a simplified version is displayed below.

Negative experiences.	Normalisation, Social Norms and aspects of discrimination.	Healthcare interaction, community and relationships.
<ul style="list-style-type: none"> • Barriers to care • Misgendering • Denial of care • Lack of Knowledge & educating • Inappropriate comments/questions 	<ul style="list-style-type: none"> • Normalisation • Expectation • Anxiety • Passing privilege and social norms 	<ul style="list-style-type: none"> • Support systems <ul style="list-style-type: none"> ○ Community • Agency and barriers to action • Changing approaches and decision making <ul style="list-style-type: none"> ○ Prior Research ○ Sacrifices ○ Avoidance ○ Identity concealment

Table 1: A table to show overarching themes and subthemes.

Participants did discuss their negative experiences within healthcare spaces. Due to the length of this thesis and more coverage by previous literature (Kcomt, 2019; Persson Tholin & Broström, 2018; Seelman et al., 2021), an overview will be given of these experiences however the analysis will not delve into this area as these experiences make themselves apparent under the remaining two themes. This is largely due to the previous research expanding on this in more depth and showing the key issues that arise compromising: HCP knowledge, communication and dynamics (Heng et al., 2018, Persson Tholin and Broström, 2018; von Vogelsang et al., 2018), misgendering (Westerbotn et al., 2017), inappropriate comments (Allison et al., 2021; Riggs et al., 2014, Kattari et al., 2015) and denial of care (TransActual UK, 2021). This thesis seeks to explore areas that presented themselves in the analysis which are significantly less explored, such as the normalisation of treatment and what trans men’s strategies are in terms of healthcare seeking, having been through negative experiences like the ones mentioned below.

4.1 Negative experiences

All the men in the present study discussed elements of healthcare interactions that they perceived as negative due to their trans status and aspects of discrimination, whether implicit or explicit. The main experiences that came up were: Having to educate/lack of HCP Knowledge, Inappropriate questions/comments, Denial of care, Misgendering and Barriers to care.

Barriers to care

The majority of the men addressed issues related to accessing care including referrals being conducted wrong, inability to access care, prescription issues (all related to their hormone replacement therapy) and waiting times. The most prevalent of these were issues with HRT prescriptions and referrals being conducted wrong (as seen by TransActual UK, 2021). Participants in the present study experienced complexity in accessing their HRT due to HCP providers preventing or complicating access (Haire, Brook, Stoddart & Simpson, 2021). Examples in the present study included bad correspondence between GPs and GICs, the need for more “evidence” to prove the prescription was legitimate as it came from another country previously, even though the participant was already on HRT for a prolonged time prior, and transitioning from private care to NHS care. Referrals to GICs were conducted wrong, partially due to physicians lacking knowledge on how and where to send them (Snelgrove et al., 2012). Examples consist of unnecessary referrals to mental health-related care (Jason and Miles) before being referred to a GIC, as seen in previous UK studies (Wright et al., 2021). Or in Noah and Andrew’s case, simply the referral was not put through correctly and never received.

An interesting barrier to primary care was location. In Charlie’s case, his GP surgery was in a town located far from where he resided, as his hometown GP surgery would not prescribe his HRT. Andrew also describes his GP being far way. This due to the lack of GICs in the UK and not wanting to disturb the care they receive from their GP that is closer to the GIC. As a result of this distance, Andrew stated they do not look after their “*normal health*” as much as they should do because they don’t always have access to it:

When I had COVID, I have asthma, so I had to get steroids prescribed to me and basically my GP was like 2 hours away from where I stayed, so they couldn't even come around to give you it, they had to actually send the prescription to another pharmacy that was near me and then they had to like come out and get it. So it just took a lot longer for me to get the medication I needed. – Andrew

Generally, issues with prescriptions, referrals and location all contributed to preventable long waiting times for care and annoyance on behalf of the participants.

Misgendering

Almost all of the men discussed experiences of misgendering and using the incorrect name in the forms of verbal and on file, such as prescriptions. The majority of the time this was down to issues with system changes. Multiple men had issues with their names and prefixes being incorrect even after they had provided the legal

documents of the change. This had caused issues with incorrect names being shouted out in waiting areas and in one case a participant was in A&E and they were unable to find him on the system. However, a couple of the men were understanding of not having their gender marker changed in healthcare services due to the need for cervical cancer screening reminders, which would not be given if categorised as male or simply because, as Miles said: “*I am not bothered about my gender marker being changed because who’s going see it, not anyone other than the medical professional so*”. Some participants did not appear to show annoyance or distress when discussing their experiences of being misgendered; rather the men in the present study showed a level of understanding if it appeared to be innocent in nature. They argued how ‘*it’s not always that person’s fault*’ especially if they are their first trans patient. Even though generally participants were understanding of being misgendered this wasn’t necessarily definable as a positive encounter. A clear-cut positive experience for multiple participants was when HCPs asked them for their preferred name and pronouns:

*She was really well educated on everything trans, like she knew the correct pronouns. She asked, obviously what I’d prefer to be called because at this point my notes obviously said that was *Birth Name* and obviously she asked my pronouns. - Ollie*

Previous research has also expressed the positive notion of asking for pronouns and preferred names as it elicits the feeling of acceptance and respect on behalf of the trans person from the HCP (Persson Tholin & Broström, 2018). The men showed appreciation for changing medical documentation easily without question and delays as it implied a sense of safety, acceptance and non-judgment for the men (Guss et al., 2017; Hibbert et al., 2018).

Denial of care

Denial of care was another factor that accounted for a negative experience through outright denial, fear of denial and not being taken seriously. Two participants discussed the denial of their HRT for no legitimate reason and another individual was denied a hysterectomy due to the given reason of being transgender. Freddie was denied getting the birth control pill, as they wanted it for ‘*trans reasons*’ and it was denied ‘*on the basis of being trans, for no other reason*’. Further, there were instances where participants did not receive care due to the HCP blaming their issues on being transgender. This phenomenon has been noted in the literature before as Trans Broken Arm Syndrome (Pearce, 2018, p. 111). Charlie had an instance when seeking help for recurrent seizures where the cause was stated to be because he was on Testosterone injections and no further investigations were completed. The same participant also had bowel issues, for which they went to seek help, and again the symptoms were blamed on being transgender and being on HRT. This participant received no further care:

The doctor didn’t read my past before he told me this. And he actually gave me, like, a prostate exam. And I was like, well, hold on a minute. I don’t have a prostate. And then once I told them, they were like it’s because of my testosterone and they sent me home and didn’t do any further investigations. - Charlie

Freddie went to seek help for their mental health to which their struggles were blamed on being trans and were “*brushed under the rug*”. Similarly, when seeking help for their mental health issues Andrew was cut off from

treatment because the service said “*we can't help you anymore because you're trans so we don't like offer any those like support*”. This over-evaluation of the men’s trans identity contributing to treatment outcomes, when seeking non-transition-related care, has been seen in studies by Bauer et al. (2009); Ross & Bell (2017); Westerbotn et al. (2017) (Cited in Heng, Heal, Banks & Preston, 2018; Whittle, 2007).

Some participants also felt fear that if they tried to stand up for themselves or did not answer inappropriate questions that their care would ultimately be affected or denied. This was partially due to the feelings of power dynamics between patient and HCP (Kosenko et al., 2013) and the feelings of HCPs holding a gate-keeping position and the dependence on the HCP for their care (Linander et al., 2017). Freddie discussed how they are scared that the problem they were there for would be discredited and thus not receive care and he worries about becoming a “*problem patient*”. This was shared by another participant:

Especially in a professional environment like that where they have power over you and how they treat you. And if you don't just play along and be nice, you might not get your injection for example. – Tom

Although not outright actions of denying care, some of the men felt as though they were not taken seriously enough when seeking care:

I've had it where they don't want to run proper tests when I've had really extreme symptoms of something and I felt that it's because I'm trans because other people in the exact same situation have been taken seriously. I just don't feel like I've been taken seriously by a lot of like healthcare professionals based on the fact that I'm trans, because if I was a cis man going into that situation, especially like in the hospital for example, I would have been taken more seriously definitely. – Noah

Something interesting throughout this research is that this idea of not being taken seriously is reflected in some other statements where the men used comparable examples to display how important their care is and how seriously it should be taken. When talking about blood tests not being conducted for HRT by HCPs Harley stated: “*It's part of the healthcare. You don't do a cancer screening and then not do the chemo*”. When Charlie was denied the continuation of his HRT, he likened it to not granting a diabetic person their insulin and the lack of support he received during this period of denying his care was compared to cancer, exclaiming he would get adequate support in that scenario but not in his real-life situation. As mentioned previously, Freddie’s mental health struggles were blamed on being transgender and they said: “*It's like if a cis patient was also disabled, you wouldn't just say oh you're depressed because you're disabled, because you would know that they're two different things*”. This application of extreme examples was used in a way to portray to people how they felt that their care was not as important as other patients and how it is not taken seriously enough.

Lack of knowledge and educating

Having to educate healthcare professionals and their perceived lack of knowledge constituted a negative experience for the men. Some of the participants had to explain what being transgender was and all of the participants reported having to educate and explain aspects of being transgender and the appropriate healthcare

they need to a HCP at some point. This reflects findings from Persson, Tholin & Broström (2018) where patients were “burdened” with the educational role. The men reported that they did not particularly enjoy having to educate HCPs and some found it frustrating: *“It's frustrating to have to keep teaching people who should know”* (Tom). Participants found it especially frustrating having to educate when the HCP was reluctant to learn and educate themselves, as seen by Von-Vogelsang et al (2016), for example, Lucas said *“In my mind, I think he just didn't care to learn about it ...they were so kind of reluctant to be educated on treating trans people”*.

When it came to HCP's lack of knowledge there were instances across multiple participants that because of the lack of knowledge, treatment was denied. An example is Freddie being refused birth control:

He just told me to go to a sexual health clinic or something and that he kind of had no clue what it was (regarding being trans) and wasn't interested in helping me because of that – Freddie

Charlie discussed how his GP denied the continuation of his HRT when he moved from being in private care to NHS care, the practice expressed it was because *“our practice doesn't know enough about it. We don't know about the side effects. We don't know what we're looking for”* within the board meeting that had to take place. Charlie also stated that doctors refused to conduct blood tests because they will not understand the results. Lucas further experienced this when the denial of HRT was *“Something to do with me being trans or just he wasn't familiar with being trans or treating trans patients, so he just didn't”*. This has been seen before in Bauer et al.'s 2015 survey where HCPs openly admitted they were not educated enough to provide transition-related care. This lack of knowledge on behalf of HCPs overlooking care was also a source of anxiety for one participant who said:

With any situation like if you were a cancer patient, being treated for cancer and everyone who was treating you for cancer had no idea what cancer even was. You would be nervous – Noah

Despite most men in the present study, having to educate HCPs was not always perceived in a negative light. A couple of participants were understanding that transgender people are a small percentage of the population, and that *“it's not an everyday occurrence for them so we kind of do have to educate them a bit”* (Jason).

Inappropriate comments and questions

Inappropriate comments and questions was the final subtheme regarding negative experiences. This compromised of inappropriate questions and the irrelevancy to the reason for seeking help. For example, Freddie went in about his autism and was asked about his transition and Harley was being treated for a ripped tendon and the same situation happened. Questions regarding bottom surgery were prevalent for half of the men when seeking non-transition-related care. Two participants reported HCPs citing their views in appointments such as: *“I don't agree with your decision, but I suppose I'll do it”* and *“because you're transgender and we don't support it”*. Another overheard a nurse discussing he must *“be susceptible to things on the internet because he is both trans and tried to kill himself”* when in the hospital for an overdose. When Charlie was at his GP to seek help for bowel issues, he described how his nurse discussed his time working as a prison nurse after seeing he was trans and said

“oh yeah, but a lot of trannies these days just do it so they can rape the women”. The presence of overtly transphobic comments and personal biases have been seen in other research (Kosenko et al., 2013).

The perceived power imbalances and authority of HCPs was an aspect brought up by a few of the men when it came to inappropriate questions and comments. The men discussed that because of the HCP’s position of power, they felt pressured to answer any questions *‘even though it wasn’t relevant to anything’*. There was also confusion about whether to answer as there may be potential reasoning behind it, this compelling them to answer.

Noah had a prolonged experience with his mental health coordinator who continually disregarded his trans identity by questioning his sexual partners’ sexuality for being with a transgender man and continually brought this up in appointments. This participant was sexually assaulted by a male manager at his workplace and this HCP kept insisting that the perpetrator must have been straight, insinuating that Noah is a woman. This HCP also told Noah to educate himself and recommended a book that’s stance was a very critical view of trans activism and in the participant’s words written by a *“TERF”*. This continued harassment from this HCP led Noah to begin recording the telephone appointments or have a friend present and eventually participant began missing appointments, this situation will be discussed further within the following themes.

Conclusion

The negative interactions experienced by the participants in this study correlate to the existing literature exploring transgender people’s experiences in healthcare. Particularly the Transphobic Hate Crime Report (2020) and TransActual UK (2021) which addresses experiences of being misgendered by medical staff, verbal abuse/transphobic comments, educating HCPs on trans issues and being refused treatment. This theme alone addresses the research questions regarding trans mens’ experiences of accessing healthcare and the barriers in place, as well as what forms of discrimination present themselves in the mens’ narratives.

4.2 Normalisation, Social Norms and aspects of discrimination

Throughout the analysis it became clear that due to ongoing experiences with HCPs and the negative elements that come alongside it, the men began to normalise this treatment and it began to manifest itself in such a way that the men begin to expect maltreatment. This in turn fed into the men's anxiety surrounding healthcare and how they began to feel about themselves in this context. The following section will explore these areas, which seemingly have not been directly studied in previous research.

Normalisation

The issue of normalisation and becoming accustomed to negative experiences was discussed throughout most of the men's narratives of their experiences within healthcare. Elements of being treated differently than cisgender patients because of their trans identity, having to educate, inappropriate comments and the influence of the people around them were discussed in correspondence with normalising their healthcare experiences.

In relation to being treated differently than other patients, participants in Lindorth's 2016 (p. 3516) study described themselves as being living teaching material and "feeling like a monkey in a cage." Similar resemblances were seen in the present study, such as Tom who said, "*It feels like you are like a novelty to them, and so they think they can ask all sorts of questions*". Some participants also expressed this feeling of differentness with having to educate by saying they never want to feel objectified in a healthcare encounter and stated they would "*want them to at least know my name and know what I'm about*". Harley made an interesting statement surrounding how certain questions have inadvertently provided him with an almost automated response and that he has a "*speech prepared*". He said he has come to recognise instances of educating less and less over the years because he is constantly having to explain what transgender is and what trans health entails. The recognition of this goes to show that because insurances of lack of knowledge occur frequently in healthcare encounters it seemingly does not begin to register that this is not necessarily normal, and it is something Harley has adapted to and accepted as an everyday occurrence.

The men discussed that being treated differently than cisgender patients was something they experienced and had become accustomed to. It was a surprise or shock for them when they were treated as a "*normal*" patient, as Noah demonstrates: "*The fact that if I'm coming out of a situation like healthcare situation, I'm over the moon if I've been respected as a human being, like that's how bad it is*". Another participant felt that even if HCPs treated them nicely in face-to-face contact, they believe the HCP will still view them as a "*spectacle*" and discuss their case with co-workers.

When the men were asked to describe what a positive experience was to them, participants simply said they wanted HCPs to "*treat them like they are normal*" without the role of their transition playing into the experience and inappropriate questions when it is not of relevance. Noah emphasised how they view a positive encounter as "*being seen as a person*" and not being made to feel like a "*joke*" or a "*freak*". He describes how he is "*not treated like a human*" like everybody else and refers to trans people as "*subhuman*". Another participant shares similar feelings:

I feel like times where I've just gone into an appointment and just been treated like a regular patient. That to me is seen as a positive experience just because I'm so used to being, having experiences that are a bit negative, so just going in and being treated as anyone else to me is seen as a positive experience. – Freddie

When Freddie was attending his GP surgery to seek care for a prolonged skin condition he felt as though he was not taken seriously and received poor treatment. Due to experiencing healthcare as a trans person and the recurrent issues Freddie encountered, he said he “*just sort of took being treated poorly as how I'm supposed to be treated*”. He further believes he did not take a stance when the care was not reaching an adequate standard because he was used to being treated poorly:

I just kind of was so used to being disregarded and treated like lesser than other patients that I feel I didn't sort of advocate for myself in the way that a cis person would have done in the situation because I was just used to being treated unfairly. – Freddie

Another instance was when Lucas went to see his GP to seek an autism assessment referral, and this was denied on the basis of the GP perceiving him to be comfortable with eye contact. He described how he felt about this refusal in the terms of being “*disappointed but not surprised*” as he perceives this to be a normality for trans people:

Throughout the interviews some of the men became apologetic because they felt that they could not directly recall specific examples as they felt that all experiences “*blurred into one*” and because most experiences contained elements discussed above. It had become an everyday reality for them so they began to not even acknowledge these experiences anymore. Andrew expressed this, “*I think you just get normalised to that or stuff like that. After a while you don't really even think of them as being problems because it just becomes so normalised to you*”. Another participant also expresses this well:

It's just normalised to me that I'm going to be treated differently because I'm trans that it goes over my head. That's why it's so hard to remember things because it's everything; every experience is like that to some degree. – Noah

When discussing issues of inappropriate questionings and comments, particularly surrounding their genitals and surgeries, the men discussed how at first this was a shock and did affect them emotionally, however as time went on and similar issues were experienced repeatedly, the element of surprise was removed and the men started to become accustomed to these topics. Tom described that when it came to questions about genitals and bottom surgery, they said it was such a common occurrence that they began to just find it annoying rather than realising the true extent of the circumstance:

During the first one I experienced, I like freaked out, but it happens so often that like, I don't even think about the nuance of it anymore and how creepy it is. I'm just like this is annoying. – Tom

Noah also expressed this:

I also like didn't realise until sort of later on that it was like a problem because I was like wait, why did they ask me that? But it's just so normal to me that like I would get asked things like that. – Noah

To further add to Noah's experience, because he was so used to being asked these questions and had an extreme experience with his mental healthcare coordinator he even started to view inappropriate questioning as a good experience when it "should have been a negative experience". Participants also discussed how they begin to not see the issues as being inappropriate and how it was outsiders from the situation (specifically family and friends) who made them realise the issues with the situation and how it is not acceptable:

Other people might make a bigger deal out of it than I do... And like it doesn't always come across to me as being wrong until maybe somebody else says something about it. – Andrew

With Noah's prolonged experience with his mental health co-ordinator and how he feels the need to have a friend accompany him for the call, he says:

She seems more horrified by the phone conversations than I do 9 times out of 10 because I'm so used to how I am being treated by this guy and she's like this is so bad. I just forget because it's literally become normalised to me that I'm literally like having transphobic shit just put in my face. – Noah

Expectation

As the men begin to normalise their experiences it is no surprise that they began to expect to be treated in this way. Previous research has addressed this aspect of expectation (Heng et al., 2018; Hibbert et al., 2018; Roller et al., 2015; Vermeir et al., 2018) and showed that individuals expect lower standards of care and lower their standards by accepting certain sacrifices and tolerance of certain practices. All the men in the present study expressed some remarks about expecting to be treated poorly by saying this directly or insinuating that they feel lucky that they had a good experience.

There were mentions of expecting HCPs to lack knowledge and asking inappropriate questions and that it is something that will always happen no matter the circumstance for being present. Participants discussed that they mentally prepare themselves for the attitudes a HCP may have towards transgender patients and what might get said, what questions could be asked or how they will be treated. Participants stated being more prepared for those kinds of attitudes now they have experienced them in the past and they are aware they exist. With this expectation to be treated differently or poorly, half of the men discussed ways in which they prepare for these instances prior to appointment:

Even if something doesn't happen, you just presume that it's going to or you kind of have your guard up a little bit just in preparation anyway. – Freddie

A couple of the participants stated that they expected the HCP to lack knowledge on the subject matter and went in armed ready to explain the healthcare they need. This was either because of their own past experiences or through communicating with other transgender men: *“everything I’ve heard prior to going was that GPs know jack all”* (Jason). Another participant brought a folder of information in with them when seeking a referral to the GIC as they anticipated that the HCP wouldn’t know anything surrounding the process. When it came to misgendering, a participant expected this to happen often in appointments, whether due to system changes or the understanding that early in their transition being “passable” was not as frequent. To prepare for this Tom would *“get it out there before them”* so they could establish whether the HCP was making an innocent mistake or if they are doing it as a form of discrimination. Harley discusses how trans people have known people to have had negative experiences within healthcare spaces and acknowledges that this contributes to the expectation of maltreatment even if personal experience is not present. Harley goes on to say that even though this contributes to the expectation and anxiety as *“it is a lot to take in”* at least *“having that prior knowledge allows you to make strategies for later”*. This preparation aspect is important in the sense of showing this expectation the men have, however will be explored more in the following main theme: Healthcare interaction, community and relationships, within the changes in healthcare strategies the men have adapted sub-theme.

The men expressed gratitude in the sense of being lucky when they receive appropriate care or when issues discussed in the previous theme did not make themselves apparent. This sense of feeling lucky when being treated as a ‘normal’ patient alludes to the fact that they expect to not be treated in such a way. A good way to portray this to create an understanding is if a cisgender patient approached their GP in respect to an issue they were having, got treated and did not receive questions about their genitals or surgeries they have had, this is normal as cisgender patients do not expect this to happen. It is not experienced or common knowledge such as it is within the transgender community. The reality is the transgender men have not been lucky, they have retrospectively been treated how they should be treated when receiving healthcare. It could be argued that this contributes to the normality dimension that the men have created for themselves. When it came to getting shared care, Noah, said he was *“really lucky”* as he does not know of anybody else in his area who was able to get shared care between their GP and their private GIC. Tom described the equivalent with the fact that he has received good mental healthcare and that his trans status did not take up his appointments when seeking help for other issues. Lucas stated he feels he is lucky because aside from his GP surgery and the experiences he has had there, he cannot recall any negative experiences with any other form of medical practice or clinic. Overall, Ollie proclaimed he has been *“really lucky”* that he has not had a really bad experience with any healthcare professionals. As discussed previously some of the men had issues with location and distance when it came to accessing care. One participant, Miles, had an endocrinologist not far from where he lived and he described this as lucky because this particular HCP was experienced in treating transgender patients. This same participant described how he *‘struck gold’* with his GP and when he returned from the army he reregistered with that specific GP as he knew that he would be treated there. Miles also states that they have been lucky because most of the HCPs he has encountered have been *“pretty well educated”*.

Anxiety

Anxiety in this study presents itself arguably as a result of normalisation and expectation. Anxiety was present for the men before appointments due to the fear that they would be treated poorly because of their gender identity, as seen by Westerbotn et al. (2017). Having to move GP surgery or attending a healthcare environment they have not been in before and worries of not receiving treatment due to being trans were major sources of anxiety. Anxiety has additionally been understood in trans healthcare research before in the aspect of fearing denial of care as discussed previously; Bauer et al., (2015, p.12) found that patients were anxious to bring up to their GP issues regarding their transition due to the “potential for the physician to restrict or deny access to transition-related care”. A lot of the men discussed how they experience anxiety before any healthcare encounters. This anxiety stems from thoughts of: *“Am I going to be respected? Am I literally going to get hate-crimes while receiving care?”* (Noah). There were also mentions of the anxiety stemming from the expectation of having to answer inappropriate questions. Charlie says that *“even approaching things like doctors to help, what sort of bread and butter, what they see every single day because I know it's just going to be something completely inappropriate”*.

An interesting point from Lucas was that having an experience with a doctor caused more anxiety than seeing nurses or healthcare assistants. He is warier *“of doctors than other healthcare professionals”* as doctors *“have a whole air of kind of superiority and they have a really terrible bedside manner and they don't even know how to speak to people”*. Anxiety was heightened when participants were going to a place they had not attended before. This was apparent, especially for Jason who had to attend a “women’s health unit” as he suffered anxiety for the initial appointment but especially with the second due to it being in a different hospital and his first visit being negative. Jason stated he would still be feeling anxious if he had to return, even at the same hospital due to the circumstances as to why he was there. He worries about being questioned as to why he is there, being a man in a women’s health unit, due to the experience he had with this at his first appointment where the nurses stood there, looked at him and said: *“I think you're in the wrong place”*. This caused *“embarrassment”* for Jason especially because he *“did not want to draw attention to himself”*. Jason expanded on his anxiety increasing surrounding appointments transferring to his interpersonal relationships as his feelings of worry and upset affect his partner and family as they worry about him. Jason further explains that past negative experiences contribute to his anxiety for example there was an instance where Jason was attending his first appointment at the ENT department when the HCP asked, behind closed doors but was overheard, if the next patient was male or female He says: *“If that experience hadn't happened, I perhaps would have gone into the Women's Health unit feeling less worried and anxious”*.

Noah also shares this anxiety about new environments, particularly around hospitals due to the wide range of staff bodies with varied cultural backgrounds. He discusses worrying about having to navigate these cross-cultural situations as he is not sure what transgender biases they have and whether they had specific training about how to deal with him. He *“especially feels more anxious and nervous knowing that they probably have very little knowledge of what he's going through”*. Tom also shares this saying they understand why people do not want to go to appointments when the HCP is not *“from the same community and culture as you are”*. This idea of the unknown attitudes of a practice is also expressed in one of the men’s worries about moving GP. Lucas says that moving GPs when you are transgender is difficult anyway, without the worries of not knowing *“how your*

new GP is going to be with trans people". He worries whether the new GP will be receptive in wanting to treat them and take over their care or if they are going to "*understand what any of it means*".

Participants expressed the desire to see the same HCP at their GP due to anxiety surrounding being unaware of what the HCP knows about them and having to re-explain to every new HCP their situation. Anxiety is reduced when participants are attending an appointment with a HCP they have established a relationship with. Harley said he is more likely to seek help from his private GP he has known for a long time because he knows her and trusts her, he is more likely to go to her if he ever had a query. However, is less likely to seek help from an NHS GP, for example he had a lump towards his groin area and he stated he would never go to an NHS GP with that. There was also discussion in the men's narratives of holding on to the same GP once they are aware they treat them well. There were a few instances of men keeping hold of their GP even if it meant sacrifices had to be made such as location; "*because it is rare you have to cling on to that person for the rest of your life*". Establishing a relationship with a HCP has been seen to be positive for transgender people (Hinrichs et al., 2018; Pitts et al., 2009; von Vogelsang et al., 2016.)

The element of trans broken arm syndrome (Pearce, 2018) came up again under the subtheme of anxiety. The men expressed feeling anxious that their issue will be blamed on either being trans or the trans-related care they are received such as HRT. This was a shared anxiety through a few of the men's accounts:

I'm scared of any ailment that I have, being something that's going to mean that I'm going to have to get off testosterone. Like I'm scared that people won't look any further than that and just make me get off testosterone - Tom

There were also specific mentions of mental health and that they are worried that the current state of their mental health will be perceived as due to being trans and they will not get the help they need.

Passing privilege and social norms

A couple of the men discussed their experiences with being more "passable" and how this equips them with fitting into social norms and thus feeling more respected in healthcare environments. 'Passing' within the transgender community refers to when a trans individual is perceived and read as the gender in which they identify, usually without the acknowledgement that they are trans.

When you are, like, more palatable as a trans person, you definitely are given more respect, unfortunately. Which really like I think for me personally, that's a good thing for me, which I really hate. Like I feel validated when I'm being validated. – Lucas

Where men lacked experiences of discrimination, they also mentioned the idea of passing privilege and how this may indirectly impact their treatment within healthcare. A couple of the men expressed gratitude to the fact that they can be perceived as cisgender, Harley talks about being fortunate that he is able to not have to disclose his

trans status, partially due to the type of surgery he had leaving no scars and acknowledges how this could be a benefit to him. One participant discussed how he feels that being 'passable', even when a HCP becomes aware, does not have a significant impact because he is still perceived as male:

Very fortunate in the fact of everyone's been pretty respectful and I think it comes down to that trans men pass well.... But because people look at me and think and see me as male, even when they read things, it doesn't really make much of a difference. – Miles

These experiences were not as common across the whole group, yet it is important to acknowledge how the men can be strategic in accessing cisgender privilege and the sense of agency these men have.

Conclusion

The men in the present study discussed how they have become normalised to how they are treated in healthcare settings. This in turn has led to the expectation and anticipation of said treatment, specifically surrounding having to educate, being treated differently and being misgendered or asked inappropriate questions. This expectation appears to ruminate into anxiety surrounding appointments (Westerbotn et al., 2017), especially in new environments or with new healthcare providers. The idea of feeling lucky when they have a positive experience demonstrates normalisation and expectation and of the few men that spoke on the idea of passing, throughout these men's narratives they on average showed fewer experiences of the types of discrimination explored in this study.

4.3 Healthcare interaction, community and relationships

The following theme explores how the men used interpersonal relationships and support systems to cope with their experiences. The men spoke about how they interact with healthcare systems and their experiences with resilience and taking a stance in moments of discrimination. On the other hand, why they felt that they could not stand up for themselves. The men also discussed ways in which they have changed how they now approach seeking healthcare due to their lived experiences. This includes, but is not limited to being their own educator, sacrifices they have had to make, and issues of vulnerability, secrecy and avoidance.

Support systems

The men relied heavily on their social support systems throughout their experiences of maltreatment; family, friends and significant others came up frequently. This was mainly through simply talking about their experience, having a safe space to express their emotions and having people by their side. There were instances where their networks stepped in for them in relation to the experience itself. For example, in Charlie's case, his partner spoke up and corrected the HCP when using the wrong pronouns in a hospital setting.

Although this support was appreciated by the men, a couple of participants mentioned issues with validation when seeking support from cisgender friends and family. They mentioned feelings of dismissal from these people due to their lack of relatability and being able to empathise. Lucas acknowledged this was not intentional saying: *"I think if you've not been through that, it's difficult to fully understand what it's like and that they don't quite understand the weight of it"* even if they are supportive. Tom goes on to describe how he feels that cisgender/heterosexual people are not fully aware of the extent of experiences and are quick *"brush it off"* because they *"don't understand why you're complaining, like it's not that big of a deal"*. Tom expressed that how people reacted to the situation at hand was a big factor in determining whether he felt validated for being affected by an experience. He says he is allowed to joke about it but he wished these people could be angry for him because he has *"been protecting himself from that and trying not to feel anger"*. Tom discloses that he does not have any non-queer friends and therefore has not had a problem receiving support, affirmation, and validation of his experiences. It was mainly issues of dismissal from his family who were not queer. He said this element of validation is what made him come to realise how inappropriate some situations he had experienced were.

Community

Whether due to the perceived lack of validation from cisgender people or the shared commonality of experience, the men expressed an overall preference to seek out help and support from other transgender people. This idea of community was very important, and it is reflected in the literature. Trans people look to one another to find information and advice on navigating healthcare systems (Poteat et al.,2013). Although community was discussed as a way of seeking emotional support and life advice, the main focal point was for education and researching viable healthcare options to ensure the best healthcare outcomes, as seen by Roller et al. (2015). My research data showed that the use of social media, in particular Facebook groups, was like a lifeline for the men.

Nearly all the men expressed that they were part of Facebook groups and used these to seek advice and self-educate, especially in the initial stages of their transition, on how to navigate healthcare systems and general support while transitioning. These groups have been praised for being “*useful groups if you're asking a question because people generally know*” (Miles). When Harley was seeking a referral to a GIC from his GP he said he ‘*researched absolutely everything in every single Facebook group about what I needed to do*’. One thing that was mentioned was that through the use of these Facebook groups, a list of trans-friendly services and GPs in the UK has been collectively produced. This public Google document details the GPs that are trans-friendly around the UK that people from the community have attributed personally. It provides contact details, location, why they are good and what they are experienced with. When Harley was moving GPs he actively used this to try to govern his decision: “*after changing GP to London, my friend said sent me the big Google Doc...So that's something that I've looked at to see if I could bounce around GPs in London*”. There are further lists and files which have been co-operatively made regarding things such as top surgery to facilitate the men’s decision on what surgeon they want, what the process is like and what they will need to have a comfortable recovery, which Lucas and Ollie found *really helpful*.

When asked why they would rather seek support from the trans community the men discussed how being trans is so specific and personal that that level of understanding can only be achieved by in-members:

I feel like it's quite a specific situation and I feel like they're the only people that would understand it and have a similar experience and most of them had. It was more rare to see someone that hadn't had a negative experience than someone that had had a negative experience. – Freddie

Lucas said they find Facebook groups to be “*affirming and supportive*” and the other members can relate to what they are going through. It appears as the men aged and were further into their physical transitions the need to use Facebook groups diminished, as discussed by Jason. A couple of the men spoke about how they are not necessarily avid readers in the groups however will remain present in the groups and will scroll through occasionally.

Some of the men expressed a preference for seeking help and support directly from their trans friends, rather than trans people on the internet. Talks of how having close relationships with trans people is a benefit to them and that they are among the “*most supportive and affirming people*” in their lives. For situations that were very specific and not relatable in the wider community, trans friends were seen as a more viable option for support:

*Trans friends rather than trans groups because I don't know I feel in groups it is too broad and very, very few people I think have had my specific experience. Because there's a lot that comes into my situation other than me being trans, obviously like with my mental health support and stuff. A lot more outside stuff so it's very specific to me. However, if it's like *friend's name* is probably my go-to because he is elder trans, he knows more. But if I didn't have that I'd probably turn to trans groups if I didn't have close trans mates. – Noah*

The men used their trans peers as a source of information and were recommended services that their friends had used which provided a sense of trust and safety for them to use them also: “*OK that's fine for me to use that as*

well” (Andrew). Similarly, Miles accessed his endocrinologist due to a friend of his being under his care, saying he knew he was trans-friendly because of this.

Moving on to another related topic, something that was prevalent throughout the research participants’ narratives was a sense of community and looking out for each other even in times of discrimination. A few of the men discussed how even if they had an experience they perceived as negative they found a positive out of it in the sense that they might help the next transgender person who enters that situation. As Miles explains it *‘I’d rather people be more comfortable because I’ve educated somebody’*. This was mainly seen when the men were discussing having to educate a HCP. They felt that although at the time they did not enjoy doing so and felt they should not have to, they expressed that they felt a sense of pride as it is going to help the next person who encounters this professional. Jason states this well: *“It’s a positive afterwards that, yes, I’ve actually educated this person and they will treat the next person who goes in better and they’ll have some understanding”*. Ollie said because he is more open about his identity than some transgender people he would rather a HCP ask him questions and he gives information rather than them ask somebody else who may not be as comfortable as he is. Harley is a PhD researcher in the trans health area and even though he is far into his medical transition he feels *“the need to stay in the loop”* with what is going on within the community and healthcare to be able to direct and advise people. Harley also uses social media to read other people’s blood tests for them *“because at least then people get them”*. This is because it has been a common issue with trans healthcare that blood tests get overlooked or HCPs do not know what they are looking for and do not realise how important they are. So Harley uses this as a form of activism and helps out other members of the community by educating them on their healthcare. When it came to reporting a situation, the men felt a sense of fault that they should have to *“make life easier for other people”*. For instance, Tom spoke about reporting instances, invasive questions for example, being a good thing as it helps transgender people who may not be as far into their transition or only just starting their transition known in the community as a “baby trans”.

I feel like a lot of the time complaining about something is probably good, even if it’s small because you know, if you’re a baby trans and you come in and it’s your first time experiencing a doctor asking you invasive questions you wouldn’t want that to happen. – Tom

Overall, the men in this study have demonstrated the importance of being part of the community and the usefulness of doing so. This being for accessing information on navigating transgender healthcare and receiving the most beneficial outcomes, as well as the mutual understanding of each other’s experiences and being able to offer support and validation. The sense of community was also strong even if the men did not know each other, as shown by the men sacrificing their experiences in order to make someone else’s easier.

Agency and barriers to action

As noted above, agency is the notion that individuals can perceive and in turn are able to change the environment to achieve an intended goal, in other words, individuals have some element of control when it comes to their situations. When it came to dealing with negative experiences in real-time, some of the research participants complained and reported the incident whereas others actively did not want to. When it came to the

point of taking a stance, examples were writing and emailing official complaint handlers (such as NHS England and PALS) and speaking with practice managers. Charlie used both PALS and NHS England when attempting to amend the discontinuation of his HRT. Noah discussed how with his mental health coordinator he emailed his managers to which the situation was not resolved. Noah also had issues with his name change on the systems and he described how it kept happening so there was no point being *“passive about it because they're not going to learn”* so when he rang again to amend the situation being a lot firmer and threatened to take the situation higher up as a scare tactic. Another participant (Miles) says they threaten with PALS when they needed to.

The mentions of passing privilege came into play when discussing filing complaints. Miles acknowledges this privilege and the confidence it has given him to allow him to bring light to the issues. Lucas also shares this confidence as when *“you are palatable as a man to them”* it fosters more respect to be able to hold a HCP accountable for their behaviour. Out of all ten participants only one participant mentioned that they said something directly to the HCP when an instance happened. Jason, when being told he is in the wrong place when visiting the women’s health clinic, outright said *“right, go have a look at your list. I'm in the right place and you'll find my name on it.”* This was in the middle of the waiting room and Jason described this as demeaning. The same participant when attending an ENT appointment and the HCPs were overheard asking if he was male or female told the HCPs he found this very inappropriate, to which the HCP was very apologetic.

When it came to reasonings for why the men did not report an instance, most of them felt as though they would not be taken seriously or that the complaint would not go anywhere:

I'd love to be able to complain about it but it really feels like none of those types of things are taken seriously, especially when it's the smaller things – Tom

Harley also said that there is no guarantee that they will *“respect my words and what I was saying to them as someone who wasn't a healthcare professional”*. Harley goes on to discuss that after his referral denial because he was fortunate enough to be able to attain private care, he chose that as the easier option as *“it was just easier and it would have been less trouble for everyone really”*. Harley says if he did not have that option he potentially may have been more determined to take action however as he has gotten older he says he will not bother because:

Even when we have a chance to speak, it's never without motive, and without bias. Trans people only ever get the opportunity to speak if it's to spark a conversation. It's not to say, OK, we're listening, we'll change a lot of the time. – Harley

One of the men complained via an automated text service post-appointment and said he did not receive feedback regarding if anything has been changed or put in place as a result. From this point on Jason said felt as though he would not bother again. This feeling that a complaint would not go anywhere and felt going through the process was pointless was a shared experience across participants: as summarised by Freddie: *“I never complained because I just didn't think it would ever go anywhere”*. Noah discussed how he used to complain about his mental healthcare coordinator and argue back, get very angry with him and it would ruin his day when he had to see him. With no change in this HCP’s behaviour, Noah began to become passive with him and *“nod his head and zone*

out”. Noah described giving up trying to get his mental health coordinator changed because “*there's only so many times you can fight against something and be knocked back before you give up, it's literally a case of that*”. This notion of giving up was also experienced by Charlie, who took the issue of his GP not prescribing his HRT to PALS and NHS England, to which both parties did not help or give advice/support. Therefore, he also got to the point where he just had to give in and “*wouldn't waste the time again*”. One participant discussed how they did not complain as they felt as though it was their fault they were having these experiences:

No, I think like in those situations I just kind of left it how it is and just chosen not to really say or do anything about it because I think you kind of blame yourself anyway, and sometimes it's like, well, it's my problem because I don't fit into the way society is built. So it's like it's a me problem, not a them problem. – Andrew

This way of thinking feeds into the normalisation aspect of the experiences, as discussed in the previous theme, and could be a potential link to how internalised transphobia/distaste for one’s group presents itself, as Stitt (2020) describes a decrease in self-empathy and tolerance. Even though the men revealed agency in attempting to improve their situation by making formal complaints, the negative experiences arising because of this (e.g., nothing happening) ultimately highlights the lack of agency the men have due to a problematic ‘dualism’ between their agency and the imposing structural constraints.

Changing approaches and decision making

As noted previously, the present study investigated how men have changed their approach to navigating healthcare and what influence negative experiences have had on their strategies. The literature shows that strategies are a vital part of navigating healthcare for transgender people (Ross et al., 2016). My research demonstrated the importance of men’s strategies, such as having to do their own prior research and sacrifices they have had to make regarding healthcare. For example, “*Trans people that I know or just in general make strategies for appointments because they have to plan it in advance*” (Harley), and the men in the present study demonstrate. This section of the chapter discusses the following broad strategies used by the research contributors: prior research, sacrifices, avoidance, and identity concealment.

Prior research

Roller et al. (2015) discuss the way trans people need to research their options to navigate healthcare systems and dodge barriers. Nearly all the men in the present study described doing their own research before appointments at some point to ensure the healthcare they receive is adequate. The majority of research surrounded referrals to GICs and a lot of the men researched the process to advise the HCP on how to conduct it to prevent mistakes resulting in longer waiting times. There was also prior reach into whether the HCP they were approaching was trans-friendly. There is a cross-over with the previous theme of community as this is largely where trans people use informal networking to source their information (see also Ross et al., 2016). This was either by word of mouth, Facebook groups or the google document as previously mentioned. Some of the men spoke about

actively seeking out these trans-friendly services and a desire to attend a very specific service they have found, for example in Tom's case he knows of a Queer sexual health clinic he wants to attend. There were instances where after an appointment participants researched something that was said by a HCP. For example, when Charlie was denied his HRT:

I did my own research because I'm on Sustanon (a form of testosterone) and I was like, you literally give this treatment to cancer patients. What is the difference? And they were like, "because you're transgender and we don't support it" basically is what they said to me in a nutshell. – Charlie

Charlie in this case had to conduct their own research to fight a cause between patient and provider. Ollie had a similar instance where his endocrinologist said he was unable to do self-injections however Ollie said they had done a lot of research into this and told the HCP otherwise. The HCP then, post-appointment, contacted him to say he was right and is able to. This need to conduct prior research before appointments seems to be a pre-conceived notion that has succeeded for multiple participants and appears to be a strategy that works to get the healthcare they need.

Sacrifices

Participants discussed the role of strategically making sacrifices when it came to their healthcare and there were mentions of having to weigh up the pros and cons including waiting times, financial costs and being treated with respect:

I had to research about, who would be cool because there's a few things you've got to balance. It's like, am I going to be respected by this medical professional? Is this medical called professional going to drain my bank account? and also will I have to wait for four more years to get seen by this medical professional? You've got to tally up those things because you can never have it all. – Noah

A big sacrifice a lot of the men took was going private and the financial obligations that come alongside it. A few participants went private with their transition-related care due to the long waiting times for NHS gender clinics, one participant stated that this cost was in excess of £11,000 and stated that he could have bought his own house for that. Another participant went private for their transition as the doctor, who was a senior of the GP surgery, said he did not know what being transgender was when Harley went to seek his referral to a GIC and that the county he lived in would not cover the costs. Harley described this as “a massive kick in the teeth” and it left him and his mother feeling confused about what they were going to do, hence they ended up going private for his transition. He describes how even though this was a long time ago, it still has an impact on his life:

Knock on effects of that is the effect has lasted me up until this point where I'm still paying for this stuff because he wouldn't refer me. - Harley

The cost of his medical transition meant that Harley did not learn to drive as he would not be able to afford both. Although this experience of private gender transition is of importance, the present study is not looking into GICs and their experience of these directly. Transition-related services were not the only private care the men sought out, after the bad experience Lucas had when trying to gain a referral for an autism assessment from his GP, which was denied, he decided to go private for this assessment as he “*could not face that again*”. This came at a cost, nonetheless Lucas was willing to take this sacrifice to be able to cope with the process and feel like he was being listened to. Going private for mental healthcare was present in the data from a few participants. For example, Andrew discusses how it affected him financially as he was unable to access mental health services on the NHS and did this privately. Harley also discusses how when he was struggling with his mental health, he did initially receive care via the NHS but did not find it helpful and productive, so his parents decided to gain this care privately. Harley thought this “*was very telling of NHS mental healthcare*” and how he had waited to be seen and when he finally was receiving the care “*nothing was happening*” and expressed his frustration. He described a huge contrast between the two types of care and the quality of care he received when going private. Not only did Harley go private for his transition and mental health, but he also had a private GP. This private GP was his first point of call and was also the location where he got his HRT injections. Harley discussed the sacrifices that came along with having a private GP; due to the distance he had to travel to get his injections he had to take full days out of school during important years when he was doing his GCSEs/A-Levels and the cost associated with this travel. This distance also affects his social life at present as he is unable to go out with friends if he knows he has an appointment the following day. Harley spoke about how he took over the costs of his healthcare when he was 19 years old and it has always been stressful for him, however it is worth it for the level of care he receives:

There's always a knock-on, but I always say it's that weigh up, isn't it? It's I pay this money, but I know my doctor likes me. I know that I'll get my blood test and I know that it's on time. So that's important things, it's just shit. It's just one of those things. - Harley

When asked to describe any changes in his healthcare approach he said his approach is “*just fucking having to spend money for the rest of my life*” and he hated the thought of “*paying this money forever and how much that total will be by the time he dies*”.

The research participants discussed a range of other sacrifices, which were addressed in the first theme under barriers to care, including waiting times, distance and location and how they were willing to travel significant journeys to receive appropriate care (Roller et al., 2015). Harley describes how he had a preference for women when it came to a GP and as a result of this he has had to wait longer to see a female GP “*which was a comprise*” and he would rather do this than seek help from his NHS GP even if it “*would cost him an arm and a leg*”. This notion of a sacrifice being waiting times was shared across a couple more participants, Tom expresses a preference for being seen at a sexual health clinic that is specifically for queer people and would be willing to wait the long waiting lists. Charlie discusses how he attended A&E over a GP, as he avoids going to the GP due to past experiences and was willing to wait six hours in A&E for a course of antibiotics. He described the guilt he felt from this and the waste of resources he felt he used up, however “*it makes it so much easier mentally, to go there rather than it does go into the doctors which definitely is wrong*”.

Participants additionally expressed how they felt they had to take their care into their own hands, Harley sums this up well: *“I feel that a lot of the thing in trans healthcare is the onus is on you, It’s like you’ve really got to make yourself heard. But being a trans person, doing that is really hard in any scenario”*. A few men had to do the correspondence themselves between different services through physically having to transport the letters back and forth as the practices were not receiving them. For example, Noah said: *‘I had to get all the information myself off both parties and do the correspondence for my medical care myself with the GP’*. When Charlie was denied his HRT due to a lack of knowledge on behalf of the GP practice, he had to ring his GIC for them to send the GP a breakdown of what they needed to be testing for in blood tests. He said he had to make it as easy as possible for them and get all the information himself. Andrew discussed how when he was struggling to receive mental healthcare due to being discharged as the service felt they were unable to support his transition, he described how he gave up seeking mental health support, due to constant mix-ups with waiting lists, and decided to *‘take matters into his own hands’* and become his own therapist up until recently when he was able to get private care. One participant has even given thought to the idea of “DIY hormones” (DIY hormones tend to be obtained from online or other people and result in the effects being unmonitored). Another participant self-injects their HRT as they went private until their care was taken over by the NHS and this self-injecting was denied.

Another strategy shown by three of the men was altering their appearance when they have a medical appointment. They felt the need to appear more masculine so that their identity was not up for questioning and to be able to fit into social norms for the sake of being treated with respect. Lucas said they alter how they appear around people they do not know generally however in healthcare situations *“very much so”*. Although not in a generic health setting, Charlie had an appointment at the GIC and his nephew wanted to paint his nails for him but he declined due to the appointment and fear of not being taken seriously regarding his gender identity. Tom sums up how the men felt very well:

Even going to the doctors, I’ll find myself dressing a certain way different than how I would usually dress just to be a bit more like binary masc. So that they don’t treat that transness, like it is a difference, but I feel like they will treat it on like a scale of difference, depending on how you present yourself. And I feel really disgusting for doing that because I’m like I should be proud. – Tom

These sacrifices on all levels, from simply changing their appearance to life-altering decisions when it came to financials are a huge part of how the men navigate healthcare systems and show the calculated decision-making that must take place.

Avoidance

The men’s experiences in the present study provide support for assertions in the literature regarding the avoidance of seeking healthcare due to anticipated discrimination (Grant et al., 2011; James et al., 2015; Reisner et al., 2014) and past experiences (Costa et al., 2018). For instance, Charlie stated, *“I don’t want to go into the doctor’s purely because of the bad experiences that I’ve had”*. Tom discussed how all these past experiences with multiple different HCPs, even if they are small, *“pile up after a period of time and it gets to you”* and they start to attend less frequently. Most of the men admitted to actively avoiding seeking healthcare at some point in their

life. Participants described how they will only go to seek medical help, in particular from their GP, if it is absolutely necessary. Participants described how it is just “*one of them things I try and avoid*”. Furthermore, if it was anything that could be slightly related to their medical transition they would skip seeking advice from a GP and go straight to their GIC for help. A couple of the men said they avoided going to the doctors because they were worried that their issues would be blamed on being trans and told they cannot have their HRT. This idea of Trans Broken Arm syndrome (Pearce, 2018), as discussed previously, seems to be very prevalent in a lot of different ways for these men. Tom further described how the process for transitioning and the intense assessments that you must go through have had an impact on seeking healthcare:

Once you go through that assessment process, I think it completely puts you off medical professionals in so many ways and that affects you know, the fact that you're not going to go in for smaller things, which could, you know, end up being bigger things and end up killing people – Tom

Tom admits to not seeking out help for the chronic pain he has been dealing with for a long time for the above reasons. Similarly, Noah was prescribed a medication that needed supervision via ECGs and he admitted to not attending these because this HCP was not respectful of boundaries and was aggressive when pulling his top up. Noah said his avoidance was due to this HCP and it had been uncomfortable because of him being trans. The same participant stopped attending his appointments with the mental health coordinator due to his maltreatment. Charlie actively avoided seeking help for a chest infection, which needed antibiotics, saying “*they're not going to help me and I'm just going to get loads of questions I don't want right now*”.

The most shared form of healthcare the men avoided was anything related to their genitals. For the men that were old enough to fit the criteria, cervical smears were of great anxiety and avoided when possible. Jason stated he has “*avoided smears like the plague*” and will not actively seek them out as the doctors will not ask due to being down as male. He says it is uncomfortable, specifically when having to explain why you need one and disclosing that you are transgender. Miles was required to have a smear before his hysterectomy and refused to do so due to it being too uncomfortable, even though he was aware of the health implications. He said the staff were accommodating for this and he ended up being permitted to have an MRI scan instead. Freddie has had issues when it came to vaginal bleeding and his sex life and has refused to get this looked at:

I do have some problems with vaginal bleeding that's related to sex stuff and I feel I just wouldn't, I haven't, I've never had it looked at and I probably wouldn't just because I feel like on my side it is quite awkward and personal, but I would be so nervous about the way that I would be treated in that regard because I guess I would just assume that it's something they've never come across before, like a man with a vagina. So I just avoid it. – Freddie

Noah had an incident of being sexually assaulted and he felt unable to report it due to not wanting to have the DNA evidence taken as this would be further traumatising for him:

When I was sexually assaulted a main reason I didn't report it is because the idea of getting a swab at the hospital and having DNA evidence taken for it was so horrifying and I genuinely believe that it would

have been as, if not more, traumatic as the event itself, especially as a trans person. I just couldn't face it and I think it's a big reason why a lot of people don't. – Noah

Overall, the avoidance of healthcare by the men in the present study aligns with what has previously been researched with transgender people. Additionally, it supports UK-driven data from the Transphobic Hate Crime Report (2020) and TransActual UK (2021) surrounding avoidance. The avoidance of cervical smears within this study also supports the UK data from Berner et al. (2021) who found: gender markers facilitated avoidance, their gender identity being the reason for avoidance and issues of comfortability due to dysphoria.

Identity concealment

A few participants in the present study discussed how they actively avoid having to disclose their trans status when in healthcare settings and when they do have to acknowledge this it was “tricky”. This non-disclosure has been seen as a strategic thing to do in the literature (Persson Tholin & Broström, 2018, p.430) to raise the chances of the men receiving the non-transition-related care they need and avoid instances of anticipated discrimination (Lindroth, 2016). Some of the research participants said avoidance was something they did unless it was of relevance to why they were there, and this was a shared strategy for many of the men:

I wouldn't ever really disclose that I was trans to the doctor or GP or anything unless I really had to. You know apart from that, you don't really want to anyway. – Andrew

Participants described how they will avoid mentioning it whenever possible though are aware that the HCP could potentially know without it being mentioned due to the medications they are on and their medical files:

If I can avoid mentioning it I will. But it's difficult now as well because it comes up so much and I feel like any interaction with any healthcare professional I have, I'm under the impression that they know because they've got my medication list up in front of them that I'm on T and my medical history is probably found out pretty easily. So I'm always conscious of that. – Noah

Tom also shared this awareness and debates whether they still “*should just not say anything and hope they don't check the depths of my file*”. Reasons for “hiding” their identity in the present study were mainly surrounding how they feel that the attitudes of the HCP shift and they can sense a difference in how they were cared for: “*I would hide it if possible because it'll change the way that person approaches me and we know that that happens for a fact. So I just try and avoid that*” (Harley). A further reason was that participants felt that “*the whole conversation is skewed*” and it opens that conversation for questions to be asked when this is not something the men want. When Charlie was discussing how he likes to remain as “stealth” as possible in his personal life, this includes medical settings, because “*it's just another person to have to explain the whole situation too because I know they're going to ask me about it*”.

Some participants discussed how they do not mind coming out; issues only arise when it comes to the relevancy of the reason to do so. The men were upstanding of the need to disclose when it was relevant to the

medical issue they were having and would only mention it for that reason but described how it bothers them when it is something completely non-relevant. Tom spoke about how sometimes they find it hard as non-medical professionals to decipher how much the HCP needs to know and what is important when it comes to their biological sex, although they describe how they still hate having to give this information. A couple of the men were unphased by disclosing their transgender status and would not actively hide this. Reasons for this were that they had not chosen to change their NHS number (therefore their gender marker still indicated female) so the HCP would know anyway and hoped that “*no matter what they actually think that they remain professional anyway*”. A couple of the men described their pride in being trans:

I don't bother hiding it because I don't see that there's nothing wrong with me being trans, so why would I hide it? No, it doesn't bother me. Either way, if they're a healthcare professional, they're a professional in their field. It would not bother me whether they agreed with my lifestyle or not. – Ollie

I like being trans. I think being trans is cool and I like to talk about it and I know that's not everyone's experience. So usually when I'm having a medical thing that isn't trans-related I will kind of usually disclose that I'm trans if it's relevant. And for me a positive experience will probably just be like “Oh, OK.”. – Lucas

Overall, the element of disclosure from the present study indicates that due to experience (Sutherland, 2022) and anticipated negative experiences, as discussed under the previous theme, the men find it beneficial to use their disclosure as a strategy to improve their personal experiences. Further, potentially as a way to lessen their appointment anxiety. It also gives support to previous literature that trans people do use identity concealment as a strategy to escape conflict (Dewey, 2008). Previous literature has also suggested that individuals do this to reclaim the power they feel they do not have due to the gate-keeping position the HCPs hold (Fainzang, 2002).

Conclusion

The sense of community for the participants in this study was of great importance for informing their navigation of healthcare and receiving emotional support. The men described fearing their treatment would be taken away if they filed any complaints about HCPs and that they would not be taken seriously. Additionally, the men spoke about how they have changed their approaches to healthcare, conducting their own research appears to be a common occurrence and Roller et al., (2015) describe this as “doing due diligence”. Sacrifice also appears to be something the men must accept and weigh up the pros and cons to receive competent care. Identity concealment and avoidance of healthcare were present in this study and support what has been seen in past research. The next and final chapter will provide a summary and analysis of the three themes with respect to previous literature, the theoretical underpinnings and the contribution to knowledge from the findings overall.

Chapter 5: Discussion and Conclusion

The present study's research questions were as follows:

1. What are trans men's experiences of accessing general healthcare services and healthcare providers?
2. What sorts of discrimination do trans men face, if any, from providers?
3. How do trans men's experiences impact the strategies involved in negotiating the healthcare system?

The goal of the study was to capture the men's first-account experiences of navigating general healthcare and to uncover what forms of discrimination the men have experienced in an attempt to fill the gap in the present literature surrounding transgender men in UK-based research. This will hopefully help inform policymakers and healthcare professionals on how to treat transgender patients to prevent healthcare avoidance and detrimental health effects, as proposed in Minority Stress Theory.

Negative experiences

The first theme was surrounding what the men classed as a negative experience and showed the types of discrimination that was prevalent. This theme was included to address research question 2, as well as support the existing UK literature surrounding the types of discrimination that occur in healthcare spaces. Five subthemes made up this theme which were barriers to care, misgendering, denial of care, lack of knowledge and educating and inappropriate comments/questions. All of these have been seen before in UK samples (Transphobic Hate Crime Report, 2020 & TransActual UK, 2021).

Barriers to care largely comprised of referrals to GICs being conducted incorrectly, resulting in longer waiting times for the men to access gender-affirming care, supported by Wright et al. (2021). Another issue was the handling of prescriptions, specifically hormone replacement therapy, resulting in delayed access to their prescriptions and further waiting times. Almost all the men spoke on being misgendered by healthcare professionals, both purposefully and by accident, and McLemore (2018) has shown that misgendering is a likely stressor for transgender people. Legal name changes and updating documents proved difficult on behalf of HCPs as these changes caused issues for the men for extended periods due to not being changed correctly. Some men discussed being denied care on the basis of being trans, examples were being denied birth control, hormone replacement therapy and a hysterectomy. A few men discussed how their health issues were blamed on being transgender and the gender-affirming healthcare they were receiving; examples were seizures and bowel issues being blamed on taking testosterone and mental health issues being blamed on their gender identity. These findings are supported by a previous study (Wright et al. 2021). The men in the present study further described how they felt as though they were not taken seriously regarding their issues. Healthcare professionals were found to be uneducated on the men's care and openly admitted they were unsure of how to handle their requests, causing anxiety for the men. A couple of the men were understanding surrounding the lack of knowledge due to that trans population being small and felt as though they have helped the next patient coming in as the HCP will now have more knowledge. The men were often subjected to inappropriate questions unrelated as to why they were there, for example asking about what genitals they have when that is not the reason they are seeking care. Some of the men felt compelled to answer such questions due to power dynamics and the fear of not receiving the care they

need if they do not. There were instances where HCPs voiced their opinions to the men about their gender identity and how they do not support it. There were also instances of overtly transphobic comments being said to them, and this was a continued form of harassment for one participant.

Aspects of Minority Stress theory, relating to distal stress were really relevant for the men in this study because of the high levels of direct and indirect discrimination, including structural issues. As we can see from the research, there were a vast number of distal stressors these men faced in healthcare settings. These were presented in external forms outside the individual's perception of self and are direct experiences of discrimination only transgender people in this context will experience.

Normalisation, Social Norms and aspects of discrimination

This theme was not necessarily predicted to arise due to lack of coverage in previous literature, however, all the men to some degree discussed their experiences with normalising their maltreatment. It became a more important finding from the research than expected and this theme addresses research question 1. The term normalisation in the present study was used in the context of how trans men became so used to their treatment in healthcare settings that it was now an everyday reality for them and what they saw as their 'normal'. The men spoke about how the negative experiences (see above) were normal for them and how being treated as different from cisgender patients was something they had become used to. Resulting in the men being shocked when they were treated positively. The men showed a desire to be treated as 'normal' people and not as living teaching material or "*spectacles*". The men described being accustomed to educating their HCPs and receiving inappropriate comments and questions and how it did not shock them anymore. Following the aspect of normalising their experiences, as a result, the men began to expect this maltreatment. The men expected HCPs to lack knowledge and therefore prepared themselves to inform them by using prior research and physically bringing in resources for the HCPs. Attitudes and opinions of HCPs were also expected, and the men described preparing themselves for how they could be treated and prepared to be misgendered. This sense of expectation has been addressed by previous research (Heng et al., 2018; Hibbert et al., 2018; Roller et al., 2015; Vermeir et al., 2018). Preparation appeared to be a protective strategy for participants. Because of this expectation, the men described a sense of feeling lucky when these instances did not occur and felt like they had been treated as 'normal' patients. Anxiety was a further component of normalisation and expectation; participants felt anxiety/fear prior to appointments, as seen in other research (Reisner et al., 2014; Transphobic Hate Crime Report, 2020; TransActual UK, 2021; Westerbotn et al., 2017) and were particularly anxious when attending a HCP or service they had not encountered before. This anxiety stemmed from previous experiences and the expectation of how they were going to be treated. The men in the present study spoke about how they were anxious as to whether they were going to be treated with respect, the HCP having negative attitudes towards trans people, having to answer inappropriate questions, and being taken seriously or having their issues blamed on being transgender. Due to this, participants expressed a desire to keep the same HCP as a means to not have to explain themselves or their situation, thus reducing their anxiety. More specifically related to IPA, the men made references indicating the lifeworld concepts, specifically intersubjectivity and embodiment. The men expressed a desire to be treated as 'normal' due to their experiences with being treated differently by HCPs (intersubjectivity). Following on from these

conversations the men specifically addressed embodiment by saying they do not want to be viewed as a *spectacle, freak, joke, or subhuman* and that they *want to be treated like a human*.

The idea behind this normalisation aspect that the men appeared to display comes from the internalisation aspect of discrimination from Minority stress theory (Meyer, 2003). Although MST has a large focus on this internalisation manifesting itself in ways of mental distress (anxiety, depression, self-hatred) and its impact on people's health. It also explains that individuals can begin to accept and internalise these experiences as true (Bessenoff & Snow, 2006; Pyke & Dang 2003) and as what should be considered normal for them. Dewey (2008, p.1353) discusses that the narratives of transgender people in their study show the internalisation of societal beliefs and ideologies through their medical experiences and how they begin to expect lesser treatment and expect doctors "to treat them as stigmatized individuals, as strange patients asking for nonconventional treatment". Although not in the same vein of healthcare, Rood (2017) investigated the impact of negative social messages on internalised transphobia and found that throughout the interviews participants began to discuss how they internalised these messages and experiences and began to believe that their existence and their identity was "wrong" and "unwanted" in society. Although not directly influenced by healthcare experiences itself Rood's findings support the notion that internalised transphobia and acceptance of others' beliefs can occur when exposed to certain ideologies for extended periods. This internalisation of stigma has been seen to lead to issues of "anxious expectations of rejection and stigma avoidance, stigma concealment, and reduced self-efficacy to cope with stigma-related stressors" (Hughto, Reisner, & Pachankis, 2015), which are all predominant in research regarding experiences of transgender healthcare.

Minority Stress Theory also highlights that the fear of rejection is a significant stressor for minority group members (Meyer, 2003) and the findings from the present study can provide support for this. The phrase expecting rejection refers to the expectations of stigma/discrimination making itself present in a situation due to an individual's minority status. The men in the present study began to expect discrimination and being treated poorly in the forms of inappropriate questions, lack of knowledge, misgendering and being treated differently. Hendricks & Testa (2012) show support for how expectations of future victimisation and rejection arise due to prior exposure to such. Furthermore, Feinstein et al. (2012) have shown that expecting rejection is higher in individuals who have had previous experiences of discrimination, and this was seen in the present study by participants who implied that if they had not had as many experiences in the past, they would not go into healthcare situations expecting them to happen again. It has also been said that these external negative experiences (distal stressors) lead individuals to be more expectant of said experiences and rejection (Mendoza-Denton et al., 2002). To summarise, the men in this study support this aspect of MST as these direct experiences in healthcare (distal stressors) seemingly contributed to their expectations of reoccurrence (proximal stressors). Rood et al. (2016) found an association between expecting rejection and stress/anxiety, and as seen in the present study the men did begin to experience anxiety before any form of healthcare interaction, especially if they had not seen that HCP or service before.

Healthcare interaction, community and relationships

Under this theme the men discussed their coping strategies for healthcare decision-making and how their previous experiences now inform how they go about navigating healthcare, addressing research question 3. The

men further spoke about support systems and how although they found having family and friends for support useful, the men preferred to pursue support from other trans peers. This was said to be because of the shared level of understanding that only in-group members can understand, and not having to completely explain themselves. Participants largely used transmasculine private Facebook groups to seek validation, as well as advice and information regarding healthcare. In the present study, this sense of community was a focal point and the men described how even though they had a bad experience they tried to view the positives in the fact that they have now taken on that experience and hopefully the next trans person to encounter this HCP will have a better experience. This sense of community amongst trans populations has been said to be a vital component of resilience (Singh, Meng & Hansen, 2014) and has been seen to tackle stress by providing group coping resources (Frost & Meyer, 2012; Hendricks and Testa, 2012, cited in Pflum et al., 2015). Minority Stress Theory also addresses community connectedness and states that social affiliations with within-group members allow for support and validation (Hendricks & Testa, 2012) and helps reduce the effects of stress, in turn mediating the mental health impacts (Pflum et al., 2015). This social support has been seen to reduce psychological distress (Tan et al., 2021). The idea that men are using social groups as critical resources for advice and information provides support for its inclusion in MST and supports the previous literature that shows the importance of said connectedness. This sense of community connects to the IPA concepts of lifeworlds and intersubjectivity, and the men discussing their experiences of their beneficial relationships with their trans peers shows this.

The men also touched on agency and the barriers they found to standing up for themselves or complaining. For the men that did file complaints this was through official complaint handlers (NHS England and PALS). Only one participant felt confident enough to say something to the HCP themselves. When it came to reasons for not taking a stance the men said that they would not be taken seriously, and the complaint would not go anywhere. The men who had previously completed a formal complaint did not do it again as nothing was resolved the first time and it felt pointless. Ways in which participants now approach healthcare were discussed, and one recurrent strategy was prior research and self-education. They did this to ensure they were equipped when it came to getting what they needed for HCPs and to prevent mistakes to ensure shorter waiting times. They also researched to be able to advise the HCP on what to do and what medical care they need. As seen above, the men discussed how they sourced a lot of their information from these social networking groups and word of mouth from their trans friends. The men also discussed the sacrifices they have had to make when navigating healthcare systems, examples being waiting times, financial costs and being treated with respect. Some of the men went private for their general healthcare and some would travel long distances to access the care they needed. Another sacrifice mentioned was taking their care into their own hands by doing the correspondence between services themselves, being their own therapist, self-injecting and one participant mentioned thinking about DIY hormones to avoid the financial burden. Within sacrifices, a couple of the men mentioned how they conformed to social norms and changed their appearance in hopes of being taken more seriously in a healthcare encounter.

Minority Stress Theory speaks on how due to previous rejection and expecting rejection, a coping mechanism used by minorities is identity concealment. Rood et al. (2017) claim this to be an adaptive behaviour to be able to cope with this. Meyer (2003) says identity concealment is a specific stressor to minority group members as the majority of individuals will not be able to experience this and has been seen to have an impact on the mental health of minority individuals (Meyer, 2003; Pachankis, 2007), transgender and gender nonconforming people included (Rood et al., 2017). The findings support identity concealment as a coping strategy as some

participants described actively hiding their trans status whereas others will simply avoid mentioning it unless it was necessary to the health issues. The reason for doing so was the men felt that once a HCP was aware they were trans the tone of the conversation changed and it allowed for questions to be asked regarding their transition when it was not relevant. On the contrary, some participants do not mind disclosing their trans status unless it is not relevant to the reason for being there. For the men that did not mind disclosing, it appeared to be because they were very open about their identity and very proud to be transgender. This is reflected by Kcomt et al. (2020) who found that individuals who were comfortable being out to everyone about their transgender identity were less likely to avoid seeking care.

Avoidance as a protective strategy is also addressed by Minority Stress Theory (Meyer, 2003) and in this context, individuals become hypervigilant to expecting rejection/discrimination so much so that they begin to avoid potentially threatening interactions (Link & Phelan, 2001, cited in Wilson, Malik & Thompson, 2021). Rood et al. (2016) found that individuals engaged in avoidance strategies and would avoid the whole situation to protect themselves. In health research with transgender people, it has been seen that trans people do avoid seeking healthcare due to the anticipated discrimination (Grant et al., 2011; James et al., 2016; Reisner et al., 2014), because of past experiences. Transgender men (31%) are more likely to avoid care out of fear than transgender women (22%) and non-binary respondents (20%) (James et al., 2016). Kcomt et al. (2020) found that almost one-quarter of their participants avoided healthcare due to anticipated discrimination, with the highest prevalence being among transgender men. The men in the present study support these previous findings as they engaged in avoidance tactics because of their previous experiences with healthcare. Some men disclosed that they only seek healthcare when it is absolutely necessary, and the rest of the men would avoid it completely. This avoidance was due to being worried that the HCP will blame the issues they are having on their HRT and consequently take them off it, past experiences and anticipated inappropriate questions. This avoidance was enhanced when it was related to their genitals (as seen before by Berner et al., 2021) and an extreme case in the present study was an individual who has vaginal bleeding when he has sex and he refuses to get this looked at. A couple of men in the present study completely avoided getting smears even though they were of age to require them, and they admitted they will not actively seek these out as it causes too much anxiety and dysphoria, as seen by Berner et al. (2021). The same applied to another participant who was sexually assaulted and did not engage with the police to get DNA evidence via a smear as he said this would be even more traumatising. The IPA concept of embodiment can be referred to here in terms of the avoidance due to how the men experienced their own bodies and the uncomfortableness with these certain situations. These extremes are not uncommon and are such a huge issue of risk. It must be noted that although avoidance and identity concealment are spoken of as potential coping mechanisms in the context of minority stress, they are not necessarily positive ways of alleviating stress and expectations of rejection for trans people accessing healthcare. Kcomt et al. (2020) discuss how delaying and avoiding seeking healthcare can have detrimental effects on mental and physical health (Seelman et al., 2017). Further, identity concealment can lead to sex-related health issues being untreated (Bauer et al., 2009; Hughto, Reisner, & Pachankis, 2015) and can also lead to inappropriate care and ultimately increased morbidity and mortality (Lombardi & Banik, 2015; Unger, 2014). A participant in this study showed awareness of this and discussed how avoidance of smaller issues can lead to devastating outcomes which end up killing people, yet he still chose to avoid going to the doctors when possible.

Throughout this research Minority Stress Theory proved a useful framework to apply to the findings. Although the present study did not focus on the health outcomes of trans people, which the original MST was developed for, it did focus and align with elements of the theory such as the unique stressors that only this minority group can experience both distal and proximal. Examples of the proximal stressors included in the theory that were present in the present study were fear or rejection, identity concealment and avoidance. Stress-Ameliorating factors resembling resilience and group affiliations were also seen in the findings.

5.1 Reflections and recommendations

Despite the sample size being over what is considered in line with IPA guidance, and the participants covering various locations in the UK, it was still small and therefore cannot be representative and generalisable to all transgender men. However, this sample size did produce strong in-depth data and narratives. Demographics in this study were not at the forefront of the research. Therefore, it lacks an understanding of how other variables interact, such as the intersections between other elements that may have also played a part in the men's experiences. For example, some participants in the present study were a POC (Person Of Colour) or had a disability, which could have overlapped with the discrimination they faced regarding being transgender. Riggs & Bartholomaeus (2017) explore the nexus between disability and diagnosis discussing how clinicians focusing on gender related matters often results in potentially chronic mental health concerns experienced by trans men being ignored due to the influence of cisgenderism and how the assessment of transgender people often relies upon assumptions of neurotypicality. Additionally, findings from LGBT Foundation (2022, p.8) stated that 'the fear of poor-quality care was often compounded by other experiences of discrimination such as racism'. For example, when discussing being given appropriate advice at the start of labour, people of colour and those who stated they were disabled reported lower levels of receiving appropriate advice than the rest of the sample. Additionally, multiple participants provided specific incidents of medical racism and transphobia that demonstrated how different forms of discrimination overlap and interact. These pieces of research highlight the interaction between transphobia and issues such as racism and ableism in health care settings. Due to the historic whiteness of trans studies as a field itself, it is important to address where certain perspectives may be informed by forms of privilege. For example, a participant in the present study, exclaimed that not treating a transgender person is on par with racism and not treating a POC, "*which they won't get away with, so why are they getting away with this*". He wrongly suggests that people of colour do not experience denial of care due to racism, however it is well documented that this is not true (Anekwe, 2020). Similar, another participant makes assumptions around hospital staff having '*varied cultural backgrounds*' and makes assumptions/implies that individuals with different cultural backgrounds to himself are more likely to possess transgender biases. It must be acknowledged that these perspectives in the present study may be informed by unexamined whiteness, as well as oppression, on behalf of the participants. As discussed in Chapter 3, my personal positionality will have had its limitations and there is a need for other people to conduct similar research to provide a varying array of perspectives on these issues.

The findings from the present study indicate that transgender people would benefit from systematic changes in healthcare systems, such as HCPs having to be educated as part of mandatory training. Largely surrounding the basics of transgender healthcare and the available pathways, being respectful and safe appropriate care. This is supported by previous literature such as Jaffee et al. (2016) who found that transgender patients who

need to teach their providers about transgender people are significantly more likely to postpone or not seek needed care. Educating HCPs would replace this need for patients having to educate and help healthcare avoidance for transgender people as seen in the present study. The interviewees also spoke on the need for this education and how it would help prevent these negative experiences through knowing how to be respectful to trans patients and having the knowledge of what barriers they face to provide efficient care. Although simple solutions such as training sessions are beneficial, this level of discrimination these men face requires, where legislation exists such as the Equalities act, to be implemented. There is a need for systematic change where the culture and practices of these institutions need to adapt and consider equality and diversity policies as the need to tackle this discrimination is not being done.

To summarise the findings from the present study, the forms of discrimination previously seen (denial of care, miscommunication, outright transphobia, and the barriers in place) were present amongst this sample of transgender men in the UK. Unique key contributions concerned the normalisation of their maltreatment and the consequences of strategy development, avoidance and social affiliations that arose as a result. The study builds on existing literature and brings a new focus to the men's experiences themselves. Furthermore, how the men discuss such events, which has previously been lacking with trans men in the UK. A bigger research project with trans men could be conducted, for instance a survey, to see if the present findings are generalisable. Future research could benefit from acknowledging the different intersections of participants' lives such as socio-economic status, disability, race, religion, and culture to see if there was any overlap in their experiences. As well as including more varied samples of trans people, for example, intersex transgender men and non-binary people. In addition, research should also be conducted with HCPs to improve HCPs' work with trans men and should be conducted across the different groups of HCPs.

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GLOSSARY

Transgender/Trans = Transgender is a term used to describe people whose gender identity differs from the sex they were assigned at birth.

Transgender/Trans Man = A trans man is a man who was assigned female at birth.

Transgender/ Trans Women = A trans women is a women who was assigned male at birth.

AFAB – Assigned female at birth.

AMAB – Assigned male at birth.

Non-Binary = People whose gender is not male or female use many different terms to describe themselves, with non-binary being one of the most common.

Cisgender/ Cis = denoting or relating to a person whose sense of personal identity and gender corresponds with their birth sex.

FtM = Female to Male trans person.

TMNB = Transgender men and non-binary people assigned female at birth.

TGNC = Transgender and gender nonconforming.

GIC = Gender Identity Clinic.

Dysphoria = distress a person feels due to a mismatch between their gender identity—their personal sense of their own gender—and their sex assigned at birth/describes a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity.

Passing = when someone, typically a transgender person, is perceived as cisgender instead of the sex they were assigned at birth.

Misgendering = refer to (someone, especially a transgender person) using a word, especially a pronoun or form of address, that does not correctly reflect the gender with which they identify.

Dead named = Deadnaming occurs when someone, intentionally or not, refers to a person who's transgender by the name they used before they transitioned. You may also hear it described as referring to someone by their “birth name” or their “given name.”

Stealth = Being perceived as the gender they are presenting as without the knowledge they are transgender.

Outing = Disclosing of trans status without permission from the trans individual

Doxing = Form of cyber-bullying that uses sensitive or secret information, statements, or records for the harassment, exposure, financial harm, or other exploitation of targeted individuals.

APPENDIX

Appendix 1 – Interview schedule.

Introduction

Thank you for agreeing and taking the time to participate in this interview. The purpose of the interview is to explore transgender men's' first account experiences in accessing health care that is not directly related to the gender transition in order to understand how discrimination presents itself in these circumstances and how trans men cope with these experiences. So there are no right or wrong answers, I am just interested in your experiences.

Participation in this study is voluntary and your decision to participate, or not participate, will not affect you in anyway if you wish to withdraw. The interview should take approximately one hour depending on how much information you would like to share. With your permission, I would like to audio record the interview because I don't want to miss any of your comments. All responses will be kept confidential. This means that your de-identified interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. You may decline to answer any question or stop the interview at any time and for any reason.

Are there any questions about what I have just explained?

May I turn on the digital recorder? And if you wish to turn off your camera feel free to do so now.

Establishing rapport

Before we begin, it would be nice if you could tell me a little bit about yourself. Tailor a question here to specific person and/or situation. For example: "This is part of my masters degree, did you go to university or what job do you do?". More general everyday questions to get them comfortable.

1. Previous health experiences with GP

Begin asking about general GP;

Prompts: Have you been to your GP in the past few years and can you tell me about these experiences?

Prompts: Did you go to your GP for a very specific reason? How did you go about bringing this issue up?

Prompts: Is your GP aware that you are trans?

Prompts: Do you feel they are educated on treating transgender patients?

2. Specific previous health experiences

Begin addressing specific health care experiences. For example: Secondary and tertiary referrals, Walk-In Centres ect. Touch on a referral to a Gender Clinic if applicable, but mainly focus on other referrals.

Prompts: Have you ever been referred to a specialised service from your GP? For Example, getting your referral to your gender clinic? Was this difficult to obtain? Did you have to educate them on this and how they should do it?

Prompts: Have there been any other referrals to services unrelated to you transition, for example a dermatologist. How did you find this process?

Prompts: (If applicable) Had your experiences from getting a referral to a gender clinic influence how you got this referral? Or Vice-Versa.

Prompts: Have you had access to mental health services within the NHS? How was your transgender status dealt with? Did you seek this mental health support regarding being trans or to deal with other issues you have which aren't directly related? Did they respect this or did they make your issues still being related to being transgender?

3. Negative health experiences

Begin addressing specific negative health care experiences

Potentially say; "Research shows that GPs can lack knowledge on trans and non-binary health care needs

Prompts: Overall, would you say your experiences are negative or positive? (Then probe to ask about the negative ones).

Prompts: Do you believe this was because of your transgender status? What happened that made you feel like this was a negative interaction because of your gender identity?

Prompts: What did they do that made you uncomfortable and how did you react to the situation? Did you answer questions that you did not feel comfortable but did so anyway?

4. Coping with negative previous health experiences (if applicable):

Can you tell me about how these experiences made you feel? Did you feel you had people to turn to for support when you felt you needed it?

Prompts: What were your particular concerns about how these experiences made you feel? (ie sadness/depression, ability to participate in social life, ability to participate in personal relationships, etc.)?

Prompts: What were you doing to cope with these experiences? Who did you turn to for help/advice (clinician, family member, friend, online forum etc.)?

Prompts: If you chose to take the situation further, were you provided any advice/resources that assisted you in understand your rights in filing a complaint? (e.g. pamphlets, pictures, etc.)? If so, how useful or not useful were they in helping you navigate this situation?

5. Future health experiences after negative (if applicable):

Can you tell me about how these previous experiences affected how you sought out healthcare?

Prompts: What were your particular concerns about seeking health care after a bad experience? How did this affect you emotionally prior to going to the appointment?

Prompts: Have there been any changes in the way you now approach seeking health care? Did it change how you approached situations in which your transgender status was brought up? Have you ever avoided disclosing your trans status due to a negative experience before?

Prompts: Did you research the HCP before attending to ensure they were trans friendly? Have you actively sought out trans friendly services or providers for health care concerns?

Prompts: Do you feel you would now bring up when a HCP has been disrespectful or is that something you are not confident in doing? How do you think you would approach this?

Prompts: As a result of a negative experience, has this ever made you avoid seeking health care when you needed it?

6. Positive health experiences (if applicable):

Can you think of any specific health care encounters of which you perceived as positive? Can you briefly describe these to me?

Prompts: What did the HCP do that you particularly liked? Did they acknowledge your trans status or were they unaware?

Prompts: What elements of the interaction made you feel safe and listened to?

Closing off statement

Prompts: Do you have comments or questions for me, or anything you would like to elaborate on?

Is there anything you would like me to explain?

What would you like to tell me that you've thought about during this interview?

That concludes the interview and thank you for your time! I will email you to provide you with some resources in the event you feel you need them! Don't be afraid to email me if there is anything you need to know further about the study.

*Turn off recorder.

Appendix 2 – Table of main themes and subthemes with corresponding number of participants.

Master themes	Participants consistent with master theme (N)	Subthemes	Participants consistent with sub themes (N)
Negative experiences.	10	<ul style="list-style-type: none"> • Barriers to care • Misgendering • Denial of care • Educating • Inappropriate comments/questions 	<p>8</p> <p>7</p> <p>7</p> <p>10</p> <p>6</p>
Normalisation, Social Norms and aspects of discrimination.	10	<ul style="list-style-type: none"> • Normalisation • Expectation • Anxiety • Emotional effects • Extreme comparisons • Passing Privilege 	<p>8</p> <p>9</p> <p>7</p> <p>10</p> <p>4</p> <p>3</p>
Healthcare interaction, community and relationships	10	<ul style="list-style-type: none"> • Support systems • Agency and barriers to action • Changing approaches and decision making <ul style="list-style-type: none"> ○ Prior Research ○ Sacrifices ○ Avoidance ○ Identity concealment 	<p>10</p> <p>9</p> <p>10</p> <p>7</p> <p>8</p> <p>9</p> <p>6</p>

Appendix 3 – Participant information sheet

PARTICIPANT INFORMATION SHEET

An phenomenological investigation into the lived experiences of trans-males regarding discrimination in medical settings, and the impacts it has on healthcare decision-making, outside of specialised gender clinics.

Researcher: Ellis Hobson (ellis.hobson@hud.ac.uk)

You are being invited to take part in this study as you have come forward as a self-identifying transgender man and have experiences accessing health care not regarding your transition. Before you decide to take part it is important that you understand why the research is being done, what it will involve and what will happen to data you provide.

Please take time to read the following information carefully and discuss it with me if you wish.

Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

WHAT IS THE STUDY ABOUT?

The present study aims to explore the lived experiences of self-identifying transgender men accessing health care that is unrelated to their transition. Examples could include going to your GP for a routine appointment or an experience going to A&E for a un-transition related reason. The study is interested in looking to see what sorts of discrimination transgender men face, if any, from health care providers and how these experiences impact decision-making regarding health care following these experiences.

WHO IS THE TARGET AUDIENCE?

This is my MSc Psychology thesis and would be only be read by the two supervisors and two examiners. Though I may wish to write the thesis up for publication in a journal, all participants will be anonymised.

WHAT WILL I NEED TO DO?

You will have the opportunity to participate in the research via a video call interview on Teams, to talk about your experiences with accessing health care unrelated to your medical transition. This should take no longer than an hour, however will vary from participant to participant. Various questions will be pre-determined, although other questions can be asked depending what is being discussed and what you feel is important to expand on. You have the right to not answer certain questions you do not feel comfortable with.

DO I HAVE TO TAKE PART?

You decide if you wish to take part. If you decide to participate, you will be asked to sign a consent form. A decision not to take part will not affect you in any way. You are free to withdraw from the research at any time without giving a reason. You can withdraw your data any time until **30/06/22** without giving a reason. A decision to withdraw will not affect you in any way.

Issues of discrimination will be asked about, although this can be an empowering conversation, please be aware this may be an upsetting conversation for some participants.

WHO IS CONDUCTING THE RESEARCH?

The main researcher (Ellis Hobson) is conducting the research; I am a Masters student at The University of Huddersfield being supervised by Surya Monro (S.Monro@hud.ac.uk) and Alex Bridger (A.J.Bridger@hud.ac.uk), who are overseeing the research.

WHO WILL HAVE ACCESS TO THE DATA?

The only person who will have access to the data is myself, the main researcher. Nobody outside the research team will have access to the data.

WHAT WILL HAPPEN THE DATA COLLECTED?

Personal data shared by participants in this research will be held confidentially by the University of Huddersfield in accordance with the requirements of the General Data Protection Regulation (GDPR) and Data Protection Act 2018.

The University is the Data Controller and is responsible for its secure management. The research team and transcribers are the data processors.

Complaints should be addressed to the University Solicitor (the Data Protection Officer- data.protection@hud.ac.uk). Appeals can be made to the Information Commissioner's Office if a participant is not satisfied with the response from the University.

No information provided will be shared in a way that would allow participants to be personally identified (*except where legal obligations would necessitate disclosure by the researchers to appropriate personnel*).

The data will be securely stored for 10 years; it will then be safely destroyed. This is part of the GDPR regulations.

Quotes used in any resulting book/article/report or other publication will be anonymised or pseudonymised.

ETHICAL APPROVAL

Ethical approval from the relevant School Research Ethics Committee at the University of Huddersfield has been obtained.

Appendix 4 – Participant consent form

PARTICIPANT CONSENT FORM

An investigation into the lived experiences of trans-males regarding discrimination in medical settings, and the impacts it has on healthcare decision-making, outside of specialised gender clinics.

Researcher: Ellis Hobson (ellis.hobson@hud.ac.uk)

UNIVERSITY OF HUDDERSFIELD

I agree that (please tick):

Thank you for your interest in this project. Before agreeing to participate, please read the information sheet. If you have any questions, please ask a researcher. You will be given a copy of this consent form, and one will be retained by the researcher.

- I have read the information sheet and understand the purpose of the research.
- I understand that if I decide to no longer take part in this research I can leave the study at any time.
- I am aware that topics may arise that may be potentially upsetting and emotional.
- I understand that I can withdraw my data any time **up until 30/06/22**.
- I understand that should I wish to withdraw my contribution I can contact Ellis Hobson (ellis.hobson@hud.ac.uk) before **30/06/22** without giving a reason and all data will be destroyed.
- I understand that my personal information will be processed only for the purposes of this research.
- I understand that such information will be treated as confidential, except where legal obligations require information to be shared with relevant personnel, and handled in accordance with the provisions of the General Data Protection Regulation (GDPR) and UK Data Protection Act 2018. This includes any risks identified to the safety of yourself or others.
- I understand that the information I share, including anonymised direct quotes, may be included in any resulting report.
- I understand that any identifying information would be kept confidential (except where legal obligations require information to be shared with relevant personnel), and access limited strictly to the original study team and database team.
- I understand that my participation will be audio recorded for accuracy.
- I understand that the information I provide will be retained for 10 YEARS and destroyed after this time.
- I agree that the project named above has been explained to me to my satisfaction and I agree to take part in this research.

- I have read and understood the institution's Privacy Statement (<https://www.hud.ac.uk/media/policydocuments/Data-Protection-Policy.pdf>) and consent to the researchers processing my personal data accordingly.

Signed (Print Name):

Date (00/00/00):

Appendix 5 – N transcript

Researcher

Thank you for agreeing and taking the time to participate in this interview. The purpose of the interview is to explore transgender men's' first account experiences in accessing health care that is not directly related to the gender transition in order to understand how discrimination presents itself in these circumstances and how trans men cope with these experiences. So there are no right or wrong answers, I am just interested in your experiences. Participation in this study is voluntary and your decision to participate, or not participate, will not affect you in anyway if you wish to withdraw. The interview should take approximately one hour depending on how much information you would like to share. With your permission, I would like to audio record the interview because I don't want to miss any of your comments. All responses will be kept confidential. This means that your de-identified interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. You may decline to answer any question or stop the interview at any time and for any reason. Are there any questions about what I have just explained? May I turn on the digital recorder? And if you wish to turn off your camera feel free to do so now. ***Recording stated***

Researcher

So this is the stuff about general care to get us started, do you have a general GP that you've been going to for a set time?

Participant

Yeah, like 15 years.

Researcher

Do you see the same person every time?

Participant

It's sort of mixed I think, but like I know that if I'm having an appointment at my GP with anything that's important, I have to see one of the senior partners.

Researcher

Alright.

Participant

Say about it life is to do with hormones than they have to yeah, go through them.

Researcher

And so this is going to be more about you GP, but have you been to your fairly often about things that aren't to do with trans issues. Is that something you do go to or?

Participant

Generally like I've been about mental health or like the occasional physical health thing.

Researcher

Yeah, alright, that's good. Because that's kind of what I'm asking about rather than. So I'm assuming GP is aware that you trans, yeah?

Participant

Yeah.

Researcher

One thing I want to ask about is, do you feel like you GP is very educated on trans issues. Or do you feel like that's something?

Participant

And I think my GP practice in general isn't. My GP practice have been really bad with it, but so I went to change my name at, took my deed poll when I was 16 and then like they gave me the form to change my name and my title like because I have this deed poll. I gave them back and then they changed my preferred name on the system rather than my actual name. So everything like letters and stuff came through was *name*. So I didn't really know that anything was like a miss, but.

Researcher

Yeah.

Participant

And when I tried to get a COVID passport, it was wrong. Any like prescription I'd get would be wrong. And it gets to a point where like you and your transition and you're old name you can't really pass as your old name or like it get questioned. I can't walk in and be like hello my name is girl name because like no because you're not a girl.

Researcher

Yeah. What did you do in that situation? Did you tell them over and over or?

Participant

It was fucking years later that I actually like found out because I rang up and I was like, oh, this is wrong. And also the same thing happened at the hospital where basically like my preferred name and everything has changed. So I had a situation where I've been in for my eyes at the hospital and I got all being like blah blah blah. About *name* and then was calling me young lady, she her. It was horrible like it literally said, things like young lady.

Researcher

Oh god.

Participant

After literally being like hello *name* on the letter and like using *name*.

Researcher

How did they even do that?

Participant

Well, I put a complaint in with the hospital cause like who wrote the letter was the one who saw me. The doctor had seen me in person as well that wrote the letter.

Researcher

Right.

Participant

So looked at me and then like, Oh yeah. So I rang out hospital complained about it and then I had a really nice woman called me back basically saying that it's, I'm still like female and everything in the system and that's why the mistake has been made and I'm like but my name is and apparently my name was only my preferred name as well, so they rectified it for me. But I also had to do with my GP. So took my deed poll back into the GP, literally like 2 odds and a bit years after I thought I'd already changed it. And had a bit of a go at them obviously because I was like this fucking unacceptable. Like, you can't do this to people, you can't act like. I've come in, change my name. This is a legal document and a legal change and you have failed to put the correct name in the system. Also there have been times where I've gone to A&E and they've not been able to find me because I'm like because

they've changed my name weird or I've given a name that's not on the system because that's what I think my name is. But they have it as like, they have my name as something else. Yeah, like so many problems just because they couldn't be bothered to change my name properly the first time.

Researcher

Yeah. Yeah, that's not good but at least you said something, a lot of people won't be so-called aggressive, and saying like why aren't you sorting this out.

Participant

I went in I was like, yeah, I'm not very happy. It's unacceptable really. Like this this and this being a bit of a Karen. But I was fucking angry like.

Researcher

Good for you. Alright. I don't know how to start going into it without just saying direct. Would you say overall your experiences of overall types of healthcare? It doesn't necessarily have to be GP as you said you've been to the hospital and stuff. Would you say they have been positive or negative and would you like to elaborate?

Participant

I'd say negative. Especially if we're like in, it's just me being trans and trying to get normal healthcare. I just, where do I where to even start? Because I could think of like, I can literally think of a situation in every single healthcare setting that I've been in where it has been a problem that I have been trans for some reason, like it has caused by me being trans.

Researcher

Well, you can just list them off haha.

Participant

Yeah. And so obviously like an example you gave was like going to a sexual health clinic. I filled in the form cause obviously there's, like what you're in there for and stuff. And like they ask you questions on the form to organize themselves better. So that I was in for a screening but on the back there's like a symptoms column and it's like, oh, do you have any of these symptoms? But there's like a penis column and a vagina column. Obviously I'm not going to tick the dick symptoms because that would cause me problems getting healthcare because, but yeah. And anyway so give it to her and then she like a few minutes later calls me from across the room and, like, holds the sheet up. And she was like, "did you fill in the right side?" like pointing at it. And I was like, "yeah I did" I was like "if you read the other side of the form, you'll find out why". It literally says, like, I'm trans on it because it asks you. And she's like "oh sorry". So that was first point of like Umm, if their genitals are different to their name so then they check to see is they are trans before shouting across the waiting room.

Researcher

Yeah how did that make you feel? Well, I'm assuming was there other people there?

Participant

Yeah, it was full, and luckily I'm like not in a place where that would really like cause issues because I don't care enough, in that situation anyway. It's just like random girls of Blackpool. But like, I feel like many, many people that could be dangerous for especially like. Put you in a literal public setting in a waiting room with any fucker, and that's a very, very big bit of information they've just sort of like outed you over.

Researcher

Yeah.

Participant

So yeah, it was a bit like, hmm about that. Get into the appointment and everything is fine. To be honest, the sexual health clinic is probably the best experience I've had NHS wise to do with me being trans like. And that is saying something. And it was at like the nurse was dead respectful and everything. But again, like he asked me if I was like having bottom surgery or like, what my sort of plans for surgery was, which isn't relevant to me getting an STD screening.

Researcher

Yeah, literally. Did you feel like you needed to answer that?

Participant

I did. I did answer it. Yeah, because I was like I don't know. I was basically just, because he asked me about bottom surgery and I'm saying it's not something I really plan on doing because of the risks associated with it and the money and everything and like just everything. And then he said, like, pretty much said that like is probably a good idea to be thinking that way. But at the same time, like is it his business? But would it affect my care either way in that situation if I was or wasn't getting bottom surgery? But I'm told in my job that like personal information is a needs to know basis. You need to know something if it affects someone's care. It did not affect my care.

Researcher

Do you think that's like cause one thing a lot of people have said to me is it's like a power thing because they're like in power in that situation, do you feel like it was that kind of?

Participant

Yeah, I think a lot of the time it is just curiosity though.

Researcher

Yeah, but like you answered it?

Participant

Yeah. I didn't even think to like refuse to be honest.

Yeah, it's just like one of them things where I didn't. When you're in like a healthcare setting, the rest of your question want to be like Oh. Because I also like didn't realize until sort of later on that it was like a problem because I was like wait, why did they ask me that? But it's just so normal to me that like I would get asked things like that.

Researcher

Yeah. It just becomes more annoying than anything. As you become so desensitized to it, but they would never, ever ask someone else that question.

Participant

Yeah. No, exactly.

Researcher

If you've got any more just as real them off haha.

Participant

Boy do I have more, we are getting to the big stuff. So about 20 months ago, I started seeing a mental health nurse with like, a community mental health nurse for like, a few issues not relating to me being trans and just mental health problems, yeah, yeah life. And from the beginning, he's been like just weird about the fact I'm trans. When I first started, like being under his sort of care, because he is my care coordinator as well. He would like constantly bring up or needing like the fact that I'm trans. One time he asked me the exact question because I remember being like, why is he phrased it this way? He was like in terms of you being like in terms of your gender and stuff and you being trans meaning like my transition and then he was like, what's your sexuality being like curious about who I'm sexually attracted to and how that works? So yeah, I think I've had to re explain the fact that I am gay to this man on at least 20 different occasions. He's brought it up in the middle of appointments, about like how I'm doing and how my mental health is just will start talking about my transition when it's not something I've mentioned. When I was like, he always knew that I was planning on starting testosterone and he, It's fair enough to say that he discouraged it. He'd just be like, say, all the risks associated with it, like not being encouraging at all of it. So it's saying things like, just giving off the impression that he thought it was a bad idea or that I'd changed my mind, not that it's his business. So a big thing for him was like "oh what if you want kids one day". I've had a massive conversation with him before about like if I want kids I can still have kids. It's just not, I wouldn't be giving birth to a child and like even then if I really wanted to I probably could just like after a certain amount of time. And he was just like, Oh well, you know basically telling me that I shouldn't go on testosterone in case the specific circumstance where I want to give birth to my own baby comes along. Like he thought what was a legitimate thing that will happen and I will want children and I will want my own and I will really regret going on testosterone for that exact reason. Uh, is, you know, the whole point of. It's actually like he's valuing women as having children at that point. It's so odd. So yeah. Had that falling out with him more times than I can even recollect. There was also I was getting like sexually harassed by a manager at the end of 2020 and this manager said he was straight and obviously like, so that was the thing that I like mentioned.

Researcher

Yeah.

Participant

And he was like, Oh well, he is straight like. Say it like wouldn't, he couldn't get his head around the fact that because I identify as male, anyone who is attracted to me and is male is therefore not straight because they are a man. I like it, doesn't. It doesn't matter what genitals I have, like It's Yeah. This is a big, big argument with people in general, but not an argument I should be having with someone who is my mental health nurse. And to be improving my mental health or helping me in any way. He also told me that I must have been doing something for this manager to be harassing me. Uh, which is, you know, classic. But yeah, just insisted that all you know, like he's not gay because of that like etcetera. Making me feel like shit and then again since then it's been literally a cycle of conversation of like me explaining that because if a man is attracted to a man that makes them homosexual. I've like had to break it down so many times I've been like if you saw me in public and thought that is a boy. You don't know what genitals I have. If you look at me in public and think that is a boy, I want to shag that boy. You are wanting to shag someone you're perceiving as male. If I looked at a butch lesbian in the street and thought it was a man and then and was like, oh, nice, that wouldn't make me straight because I've perceived that person as like male.

Researcher

Yeah, literally.

Participant

It's all on your perception of person. It doesn't matter about genitals.

Researcher

Yeah. Well, then that's obviously that's going to be affecting your appointments as well because you're missing out on valuable time.

Participant

Literally like he's meant to be sorting out my care or talking to me about like things I can be doing in my actual life. Everything's just arguing about me being trans or my transition. Really, really discouraging of me going on T. When I went on T, he like obviously sort of shut up about it because the deed is done. But even then he is very, he'd be the last to admit that it's done me any good. You know what I mean? Like. Bitter about things in appointments now. The other week he was like, are you ill or like basically saying like you sound ill and that's why your voice is deep, was like your voice is deep because you're all that like, my voice is deep because I'm five months on testosterone. Why is man's in denial?

Researcher

Yeah. Is there anything you can do about that?

Participant

Well I have emailed the centre, the in Mount Cross Centre where Basically where he works. And like his managers being like, please can I have a new mental health nurse due to lack of chemistry, which is, we shouldn't have to give more detail than that really. If it's like a chemistry and a mental health setting, then it should be fine. No, It was, I didn't get a response to my email that I like about that complain. And then in my next mental health appointment, I was confronted by my Mental health nurse about it being like I know, I know you tried to get a new mental health nurse. Essentially no you can't have a new one. Lack of chemistry is not a good enough reason. You'd have to be a bit more detailed than that. And I'm like, right. OK. So you obviously tell you, tell them you are trans phobic then alright.

Researcher

Is something you're going to like call them out?

Participant

Well, I will. I want to pursue it again because I'm just fucking like not getting help from this man for like ages and ages and ages and ages and ages and he was saying some pretty horrific shit. So like, have you told him that you're trans? So back to that whole like me being gay thing and him being like you cant be trans and gay. He found out about my boyfriend, who had specifically didn't tell him about. I just told someone else who I see about, like my therapist for, like trauma and stuff. But obviously, like, she makes notes and he can see them as at my

care coordinator. So he found out had a boyfriend through her. Asked about him and I was like, yeah, well I used to work with him. And then he was like, so is he like gay or, like, asking that sort of like, what what's his sexuality? And I was like he is a gay man while he was so confused by that and he was bamboozled, despite me like explaining it to him like a baby over and over and over again. And then he said does he know you're trans after I've been like we've been together for a few months blah blah. Oh yeah. Like, yeah, he's gay. His first response to like him being gay was does he know you're trans like accusing me a trans person instantly just assuming that I've deceived someone because someone is attracted to me or that I've lied or that I'm being a perpetrator in some way. So my response was well I fucking hope so because we shag quite a bit.

Researcher

Yeah. Good response. It's probably the best way you could have gone around it.

Participant

All that well I'm not being funny I'm telling you that I'm 19 years old and I've been in a relationship for a few months. You think my partner's not going to have once that like it's 2022 I'm not going to wait till marriage like.

Researcher

Yeah. As you said, you tried educating him a lot.

Participant

Yeah like so many times we've had that conversation where I have like, like said I'm gay and men who are attracted to me are gay. Right. So have you ever heard of the book trans?

Researcher

I think so.

Participant

It's a very critical view of trans activism, and by a woman who is sort of like in the same sort of vein as JK Rowling, with the sort of content. Like those sorts of books that say things like the whole, you know that whole like theory that was a few years ago where people were thinking trans people have been influenced into being trans by things they are viewing on the Internet.

Researcher

Yep.

Participant

Shit like that in in this book that he recommended that I read, like he told me to read it. He said I can educate myself and be better equipped to, you know, like respond to things or like, have arguments with people when I actually know what I'm talking about.

Researcher

That he's telling a trans person to...

Participant

Yeah. Yeah to educate like on a book written by a cis terf woman. That book is a very feminist book. I'll try find it and like get you some of the shit from it so you can compare it to. Cause also if you if you're looking for it on like Amazon and stuff it's like books you also might like and it is literally shit like trans people in the bathroom and shit like that. Or like.

Researcher

Yeah, that's horrendous.

Participant

Yeah, like telling me to read this book. Like he's insinuated to me before that like I'm only trans cause I hate being a woman or that I hate women in general, and that's why I'm trans. All that I just don't want to be oppressed as a woman and that whole argument.

Researcher

I do want to ask I know you said you've complained about him already, but like, what's stopping you from saying all this stuff that he has done? Is there anything in stopping you from?

Participant

Well to be honest, it's just like but there's only so many times you can fight against something and be knocked back before you give up, it's literally a case of that. Like it feels like so much effort but I'm definitely planning on raising it again because it's got to a point where I've actually stopped really having appointments with him. So if I have an appointment with him, I miss it a lot of the time and then it'll get rearranged. So like a phone appointment or something. So I'm meant to be seeing him once a month, well, to be fair with like sort of mental health state probably like every three weeks because it varies depending on how I'm doing. But I literally see him like, there was a period of time recently where I didn't see him for three months.

Researcher

Was on purpose because you just didn't want to?

Participant

It was literally like Well, I like got with my boyfriend. Didn't want to have the conversation about my boyfriend. Didn't want to have to re explain to him that with a gay man and how that works and makes sense. Like it affects my care massively because I can't tell him how I'm feeling about anything. I can't tell him how I'm doing mentally honestly because he's not making a safe space for me to open up about anything. Anytime I do come forward for something it feels like I'm argued at and made to feel like it's completely my fault I've got myself in that situation. Ohm, which I feel like he probably, I mean, I hope he's not like this with other patients, but everything feels like it's my fault. I know he goes back into the office and he's like oh he doesn't help himself like blah blah blah blah. Like no doubt in my mind that he said shit like that about me because he just, yeah he is fucking useless.

Researcher

And you feel like that is because you are trans, I mean it is pretty evident.

Participant

Yeah. Yeah, I wanted to ask as well, how come you didn't tell him about you having a boyfriend, Someone else told him. Was it purely for the matter that you didn't want to explain yourself constantly?

Participant

Yeah. Obviously you're getting into relationship especially with like what I'm seeing mental health help for, me getting to relationship is a very big deal and especially we having like a sexual relationship is a very big deal. So it's something I should really be able to tell my mental health nurse who is coordinating my care because you know like it is a big deal. Things can come along with it that can be good or bad that could affect me mentally. And I yeah. So like as soon as I started talking romantically to someone I decided I didn't really want to tell My mental health nurse about it because he is going to take every opportunity he can to like I don't know. Almost put me down about it. He speaks down to me a lot and I didn't want to have a full conversation with him that can take up to my whole hour like literally can take so, so much time out of my day.

Researcher

Yeah.

Participant

I'm pretty sure at one point a few months ago, like months and months ago, I recorded a fair chunk of this conversation, one of these conversations as well to playback for grace cause that was like, so fucking angry about it. But yeah, no, I didn't. I didn't tell him because I didn't want to be questioned on it or to have insecurities be put back into my head that I just tried to get out of. So I'm trying to help myself and, you know, tell myself that obviously my boyfriend is attracted to me, sees me as a male. He is gay. He does not like women. That must say a lot about, like, how he views me etcetera. And I just know that the sooner I say that to my mental health nurse, he's just going to try and undo all that because he feels like he doesn't want me to have confidence in myself or my identity. It doesn't, like, want me to be happy on testosterone. He seemed really salty when I was like, telling him that I was doing well once I got on testosterone. And in fact, like I've been seeing him pretty intensely for a while, because I've been doing really mentally horribly like just before I got on T. And then so I've been seen him like every two weeks and then was happy one day when I answered the phone to him because it was phone appointment, I was in a in a good mood because like someone who assaulted me had just gone to prison and I just started testosterone. And he saw me being in a good mood as that one phone call as on that one, one phone call as an excuse to withdraw the intensity of care that I was getting and go back to like it was like, so I'll see you in like 5 weeks or something. I was thinking like what, I was trying to explain to him on the phone. I was like, just cause I'm going to in a good mood now doesn't mean I'm stable or I'm doing well.

Researcher

As a healthcare professional, he should know that.

Participant

Yeah. he doesn't care like it's evident that he doesn't care.

Researcher

Yeah, that's really bad. So like in the, obviously this is a really big situation like how do you obviously cope with that? As you said, you speak to your friend and you recorded the call.

Participant

Yeah. So if I'm if I'm answering the phone, it'll be likely that I'll have a friend here ready with like, my friend is here anyway. She lives with me, and she's always like she seems more horrified by the phone conversations than I do 9 times out of 10 because I'm so used to how I am being treated by this guy and she's like this is so bad like blah blah blah. Because I just forget because it's literally become normalized to me that I'm literally like having trans phobic shit just put in my face and I'm just like, Umm. I like I used to argue back and I used to get really angry and obviously not like lash out at a professional but like it would just ruin my day if I'd have to see him. It would literally ruin my day. And I've got to a point where I'm just really passive with him and I was like, yeah, whatever. And I just like nod my head and zone out for my appointment cause I'm never going to change his mind, he's never going to change mine. Like while it would be nice to be in an appointment and talk about my mental health in a mental health appointment instead I have to justify the fact that I am trans to someone over and over and over and over again.

Researcher

Yeah..

Participant

Explained also to him, like how being trans works like scientifically, and how it is a medical condition and not a choice, and he's still like, doesn't get it.

Researcher

So ridiculous. Yeah, because I've noticed that with a lot of people and myself, you don't realize how bad it is until someone from the outside validates it for you.

Participant

Yeah.

Researcher

Like even you telling me this, I'm like, ah, I'm not surprised.

Do you ever turn to trans people like maybe trans groups or trans friends about stuff like this?

Participant

Trans friends rather than trans groups because I don't know I feel like in groups is too, like broad and very, very few people, I think have had my specific experience. Because like there's a lot that comes into my situation other than me being trans, obviously like with my mental health support and stuff. A lot more like outside stuff so it's very specific to me. However, like if it's like my friend is probably my go to cause it's just elder like he knows more and trans and like diplomatic. But if I didn't have that, yeah, be. I'd probably turn to trans groups if I didn't have like, close trans mates.

Researcher

Yeah, yeah, I get that cause it's just you don't have to explain yourself.

Participant

I'd have to like go on a full like, you know, like 10 minute conversation about what's going on to make any sense yeah.

Researcher

Would say that it is mainly outside support that you seek when you're doing that.

I think if you if you've got another instance in mind, it can be different for your mental health one.

Participant

There just like, obviously, it goes without saying. I've like been misgendered by like healthcare professionals a lot from an experience as a trans person and trying to think.

Researcher

Did you ever correct them?

Participant

Right. So recently. Yeah like over the last like year or so I'm quite like honest because no point being the passive about it, because they're not going to learn. It's like when I rang the hospital about being misgendered in that letter, I went sick in a very respectful way. Because I wanted like I wanted them to actually help me and not just like hear blah blah blah. I was very, very, very stern and I said that I was happy to take it further and shit like that, you know, scary shit. Like, you're not actually happy to take it further. But if they think you are, that'll do something.

Researcher

Yeah. I also want to talk about as well because I'm looking into because if you if something comes up, you can just start talking about it and I'm looking into like future healthcare experiences. And one thing I've learnt now is I go into appointments now, hiding the fact that I'm trans just because past experience is everything comes about being trans.

Participant

Oh yeah, if I can avoid mentioning it I'll will. But it just it's difficult now as well because it comes up so much and I feel like any interaction with any healthcare professional I have, I'm under the impression that they know because they've got my medication list up in front of them that I'm on and Alright, just my medical history is probably found out pretty easily. So I'm I am always conscious of that. I'm always like oh my gosh, I've got another. I've got another experience I'm going to say, not sure if this is cause I'm trans or if this woman is just fucking stupid on how to treat patients.

Researcher

He gone.

Participant

So I had a thing happened with the heart last year, cause was really stressed at work. Basically my, I needed like medical attention it would seem because I'd really, really bad chest pain and my arm and leg left side numb and like pins and needles all day and stuff like that. And like I was really stressed getting like really short of breath and like I think I collapsed, anyway after that I was in the hospital. Hospital experience itself as far as Blackpool Victoria was like fine. Like nothing's to really know other than me waiting 10 hours to get seen for something that could have been a heart attack but we move. It was however a follow up appointment from this at my GP where it was like I don't know like a nurse type woman, not a doctor but she would like I've had doctor's appointment with her before. So she obviously had to do my blood pressure and do an ECG which will you know, with all the stickers. She did not ask I, right? So I'm pretty understanding of procedures when it comes to or like just things you do in terms of policy with how you're treating people you're supporting or patients. Everything needs to be consented if they have mental capacity and therefore I need to give consent for you to touch me Misses. So but like, not even asking me what they could with this ECG like just starts like lifting my top up and stuff as I'm like obviously very uncomfortable.

Researcher

Yeah.

Participant

But she was like, she knows I'm trans because she's, *inaudible* unless she's got two brains, she knows I'm trans. Though she was like, I'm not sure what she was expecting to find chest wise, but like she literally like was like right in there like being really, really invasive, my personal space like touching me, being quite forceful about, like lifting my top up and stuff without asking me first or saying like I'm about to do this by the way, very brisk. I'm also made to feel a lot of the time that well, I'm not sure, maybe it's everyone, but I think it's because I'm trans. If I have a health problem, I don't have a health problem. If that makes sense. They almost gas light me a lot of the time into thinking that I'm like, I'm overreacting, I get told that I'm overreacting to things a lot. They wouldn't tell me that right out, but it's obvious It's like what they're trying to insinuate. Or like I've had it where they don't want to run like proper tests or something when I've had really extreme symptoms of something and I felt that it's

because I'm trans because own of people in the exact same situation have been taken seriously. Just don't feel like I've been taken seriously by a lot of like healthcare professionals based on the fact that I'm trans, because if I was a cis man going into that situation especially like in the hospital for example I would have been like more seriously definitely.

Researcher

Yeah. Yeah, there's actually a thing. It's like literal thing in a trans research, it's called trans Broken Arm syndrome, and it's where a trans person will go in for a broken arm, and that will get blamed on being trans.

Participant

Umm.

Researcher

Yeah, like it gets blamed on being trans, and I guess that's kind of what's happening with your mental health nurse.

Participant

Yeah. And he's also very much like oh well testosterone isn't going to solve all your problems like it would not improve my mental health. And things in like completely negate in the fact that my transition would do me good mentally or like be positive for my mental well-being. Literally denied that all that all that to my face pretty much saying like transitioning wasn't going to help me mentally. Like it wasn't going to like it, I know it's not a fix all to all my problems, but he was just like really drilling that into me being like you know it's like it's not going to sort you out like this is this. Being so discouraging to me about starting T but the thing is why does it matter to him or change his life at all whether or not I'm on testosterone.

Researcher

Yeah.

Participant

Unless that he wants to have babies with me, like.

Researcher

I do want to go back on what you said about not being taken seriously and saying that that's because you're trans. Is there any indicators or pointers from the people treating you that makes you think that? Or that just something that like they're like hostile with you or?

Participant

I was so the start of 2020 I was in hospital for trying to unalive myself and obviously, like everything down as *N*, I'm quite clearly presented as male at that time I was pretty well passing as well because was 17. I didn't really get misgendered that much. The nurses that, like, took me through to my bed in the AMU were like nice to meet you my face. And then second I had a panic attack. I was getting literally laughed at by them, by all these nurses having a panic attack in my room. You know, I was getting threatened with a section just because I wanted to go outside, so if I was not having a good time as you wouldn't. Been so depressed that you want to die. And then my dad, like, came into the hospital at some point and was chatting away to the nurse and I overheard this. Like, I wasn't even told this by him. Oh, because he doesn't fucking respect me either, but him and the nurse will actually talking about how I have probably just been watching too much stuff on the Internet. Called me she/her on the other side of the door. Like I heard the words like young lady come out of this nurse's mouth and then they were both just having a conversation about how I must be like, susceptible to things on the Internet because I'm both trans and I've tried to kill myself.

Researcher

So I just don't get it. Because how do you even say something about that?

Participant

That was said behind my back.

Researcher

Yeah, like it's difficult.

Participant

It's just so many occasions where, like, just like I know it's a problem with staff at Blackpool Victoria Hospital

like they're known for being horrible people, just as far as hospital staff go, they don't need to be very nice. But like even then, like literally, you're laughing at a patient who is in there for mental health. And I don't think I would have been laughed at if I was a girl having a panic attack.

Researcher

Yeah, yeah, yeah, definitely.

Participant

So I often think like is this happening because I'm trans or like because I never want to put it to that because obviously that's quite a like a snowflakey quote UN quote thing to do. Like, uh, it doesn't trans, isn't it? But then I have to compare the situation to if I was a cis person in this situation, would this have gone this way? And the answer is never yeah. It's just normalized to me that I'm going to be treated differently because I'm trans that it doesn't even like, like it goes over my head. That's why it's so hard to like, remember things because it's everything, every experience is like that to some degree.

Researcher

Yeah. Yeah. So you go in expecting me treated badly?

Participant

Yeah, literally.

Researcher

Like, that's just how you expect things to go.

Participant

Yeah. Like honestly, like I was coming out of my sexual health appointment buzzing because I hadn't been like flat out disrespected or told that like my choices were bad and despite the fact that I'd been asked inappropriate questions like that was still a good experience for me. That should have been a negative experience.

Researcher

Yeah. And so how do you obviously all the have had really bad effects on you, but when you go in say you go into a general appointment, doesn't have to be anything specific, it can be mental health. I'll just GP for a cold, how do you feel going in before you even go in?

Participant

Well, uh, I have pre-expectations every time of that I'll be asked about my future with my transition. Umm, it could actually be appointment about fucking foot and id be asked that though. Like I literally feel like I could go in say like, oh, I've got a problem with my toenail, and they'll be like well, you're on testosterone, so. Stuff like that or like I had just, yeah, everything. Everything is pulled down to being trans it feels like. Anything and everything: mental health, you name it.

Researcher

So, has any of this changed how you go about seeking your healthcare now?

Participant

If I'm going into like, obviously with, like sexual health stuff, I need to be like very crystal clear. But if it's just a general appointment for any, any degree, I will like try and avoid mentioning, unless it's brought up to me by then. Which you know it can do. I've gone in for blood tests about vitamin D and had questions asked to me about my transition for like completely unrelated stuff and.

Researcher

Did you get the care you needed out of that?

Participant

Well, I definitely feel like there's sometimes I feel like I've been still given like it in like an entry-level amount of care that has been acceptable that situation. However, there are sometimes, like with my mental health nurse, I'm not receiving care from that man. He's probably paid for that however fucking probably that £40 for that hour that he sees me. And then the hours after where he's writing up about it or whatever, like, he's getting paid for, like quite a bit of money to just have me as a patient. And I'm not receiving care of him and he has even said to me that he doesn't feel like he helps me and he doesn't feel like I get anything out or a benefit from seeing him he's

said that to me. So he like he's under the understanding himself that it's not a good dynamic and he could see that and do the responsible thing and pass my care on to another nurse. It literally feels like he's keeping me, as is keeping me as his little pet to be able to have someone to fucking belittle about their identity all the time.

Researcher

That's one thing I found as well. Is like, people get treated as like a spectacle, like a circus animal because no one comes across trans people that often, so it's like uh, here's a person. Let's ask them everything we can.

Participant

Well, yeah I got asked if some random like junior doctor could come in to my GP office to watch me have my T shot done and I was like no.

Researcher

Cause that is literally they know what an injection is.

Participant

Yeah, its intramuscular. You can do that, go watch that at the hospital like a million times.

Researcher

Yeah, that's very, that's yeah.

Participant

Why me in a GP practice. Why would you need to observe that in a GP practice? Very weird.

Researcher

Yeah. Do you think, do you think they would have asked anyone else or do you think it was literally because?

Participant

I feel like they would have probably asked people like that day just with him being around about like stuff but It was very like it seemed like a fully qualified doctor geezer as well. Like, he was, like, late 30s, wearing things that doctors do, like, you know like shirt and pants that are a bit too tight and the lanyard and everything. And I was, yeah, I'm really sorry, but now I'm not getting my arse out in front of you.

Researcher

But yeah, to you, it felt like it was very much because you were trans

Participant

Like a deep intramuscular injection is incredibly common. People that get their arse injected every single day. Its basic to the point where like cis people on T, never ever go to a GP to have it injected cause it's just self admin. They don't let trans people self admin, which is a whole another thing as well that like I think is really shit because I could get a way better, I could get way better levels, way better, like steady dosage If I was able to self-administer once a week on like a low dose and I will have such a better time and they know that. But and like if I was a cis man and they were describing me sustanon, it would not be an issue for me to self admin. It's just. Why? How's it different to insulin you know what I mean? Like any diabetic person can inject themselves. Loads of people inject themselves all the time. Like, why is it different.

Researcher

Because in America, you see trans guys injecting themselves every week.

Participant

It's not a dangerous injection to do. It's a very, very easy injection. I know a senior looking doctor guy should not have had to watch that to, look it up on YouTube.

Researcher

Yeah, that is, that is ridiculous. And so one other thing I wanted to ask about, like, say, for example, you might not have done, but for when you got your referral to the gender clinic, you got to go through GP first. Did you actively look out for GP you knew had done before or you knew had encountered trans patients. So was that something you looked up?

Participant

Not like my local GP and hope for the best and like he was good with it and put on put the referral through, but he did the referral wrong the first time, so that's to ring me up again and ask me loads more questions and they did the referral wrong again. And then he did the referral right and then I got like a call maybe a year later from the gender clinic basically being like which adult service do you want to go into because I was going on a wait list for TAVI when I was too old for it. Got as fresh waiting list for like Newcastle or something. This is gone like nearly three years ago I got on this waiting list now, never heard anything back so went private for my trans care.

Researcher

Yeah.

Participant

I'm getting like shared care with my GP now.

Researcher

Were they okay with shared care?

Participant

Yeah. So like I was so lucky really because I'm pretty sure like I can't think of anyone else in my area who's been able to get shared care. Like I literally can't think of anyone, and I also can't think of anyone who's been able to get on injections like Privately.

Researcher

Yeah.

Participant

Umm, so yeah, like I'm definitely what I think I'm one of two people that I know that is private and on sustanon like it's everyone that I know who's private is on gel which is not a good way to administer T at all.

Researcher

I didn't do anything for me.

Participant

Yeah, exactly like it's not good.

Researcher

Yeah. Well, and so back on the have you ever actively sought out research or ask trans group of trans friendly places?

Participant

I've asked trans friends about like the bridging prescriptions etcetera. Or like asked a trans friend about what he knows and stuff. And also like looked online of like trans friendly sort of endocrinologists but at the end of the day I think I'll just like, when I was actually going through it privately cause my endocrinologist is a registered NHS endocrinologist and he does do it, like he works for the NHS primarily. He just does some stuff on the side. And it was just yeah, I had to research about, like, who would be cool and also who wouldn't like because there's a few things you've got a balance. It's like, am I going to be respected by this medical professional? Is this medical called professional going to drain my bank account? and also will I have to wait for four more years to get seen by this medical professional? You've got a got a tally up those things because you can never have it all. My endocrinologist was lovely, no problems there. Obviously I'm paying him so if he was weird with me we'd have issues. But like yeah, it cost me like over half a grand to get on T like £800 or something just to like get a prescription through for T. And he made me wait so there was really, really bad issues in terms of correspondence between my endocrinologist and my GP. In terms of like it was all my GP's fault, when I went to get a blood test at my GP, they didn't send it to my endocrinologist, my results and didn't tell me that they hadn't sent it. So the day before my appointment and my endo was like where your results. So then I have to go back to the GP and be like send the results over now. Then they didn't do it and I had to ring up again and then they did do it.

Researcher

And do you think that would have been because it was a trans related matter?

Participant

Yeah. It was if it was anything else to do with endocrinology I feel like it would be taken pretty seriously because

if your hormones are wrong, you can die because basic body functions, everything. Everything depends on hormones. Obviously like if you're low key, you can't really bad like bone density. This this this like, there's so many problems that are affiliated with having the hormones that aren't right. So yeah, that was the first issue, and then after I'd had my appointment, had an approval for a prescription, I rang the GP again and was like, yeah, I've got this letter from my endocrinologist for this thing. And they were like, yeah. So I got my endocrinologist to give the GP the letter directly. And then the GP said that like never happened when it definitely did. They couldn't find it or something. So then I also got the letter off my endocrinologist and sent it directly to the GP practice.

Researcher

That's not something you should have to do though.

Participant

No, it's not. It's not. Yeah. So I had to get all the information myself off like both parties do the correspondence for my medical care myself with the GP. And then finally got an appointment to be approved for this, which literally was a 10-minute phone call of him reading the letter out loud and then being like, yeah, sure, like I'll prescribe it. And prescribed it. They then were lacking for weeks on getting their prescription sent out to me. Like lacking for weeks. Finally I got a prescription through for it. And then my pharmacy obviously didn't stock it straight away. So then I went in every single day for two weeks trying to get my T because I wasn't even allowed to book in with the GP to get it injected yet until I'd got it from the pharmacy. So I finally got the T from the pharmacy after literally like weeks and weeks of things just like being bounced around or like I'd have someone be like all like I thought like it should have been ordered, but it hasn't been or something like that, just like loads of things going wrong where I felt like if it was another sort of medication, it would have been taken more seriously.

Researcher

Yeah.

Participant

This is like, with like hormones and stuff, specifically testosterone, they don't even like giving it out to cis man either. Like. They're just the really weird about testosterone in particular for some reason and like really precautionous with the prescribing and stuff like.

Researcher

Yeah.

Participant

Anyway finally, get my fucking Sustanon after waiting months after my endocrinology appointment where I was like, approved. You know you're all healthy. You can go on T and then three months after that, I finally have my boxes of testosterone, you know ready. Went to the GP and was like can I book an appointment to get this medication injected. It's actually just an injection for a prescription. And they're like, when's it due? When I was like it's my first one. And then the receptionist made me wait a month for the first time an appointment. It literally took 10 minutes to stab me in the bum with the needle.

Researcher

It's ridiculous.

Participant

Especially as they are like, feel like GPS and stuff they're offering like same day appointment only. But if I want a medication injecting that I've been prescribed I had to wait another fucking month. I was like you.

Researcher

Yeah, they just don't deem it is important and life threatening, but mentally it can be life threatening.

Participant

And especially as like the date that it got moved to was like a really, really, really bad date for me. Like in terms of just life significance so my T start date will always be that day and it's fucked up but. But yeah, so I had to just wait and wait endlessly for no reason. I could have been on testosterone at the start of September and I got on the 17th of November.

Researcher

And that's on your GP's behalf just being...

Participant

Along like lack of, like just dragging their feet with everything. But its run by old ladies so...

Researcher

Yeah. That's sucks. So another thing I'm looking into as well is obviously as a result of negative experiences. Have you ever avoided seeking healthcare altogether?

Participant

Yeah when I was sexually assaulted a main reason I didn't report it is because the idea of getting like a swab at the hospital and having DNA evidence taken for it was so horrifying and I genuinely believe that it would have been genuinely as, if not more, traumatic as the event itself, especially as a trans person like I just couldn't face it and I think it's a big reason why a lot of people don't.

Oh yeah, on a regular basis like I was prescribed a medication that I needed to have like regular ECG's for because it was dangerous not to, just because it could be toxic to your heart, etcetera. And I just didn't go for my ECGs cause of me being trans and the way I've been treated in the past and yeah, because every single time I've ever been for any ECG as well, because I've obviously had to go for a few my lifetime. I've had to like, It's just been so awkward with me being trans. Like a lot of the time they are OK with it because they can't really not be and they're not like especially rude. I just definitely don't feel like it's treated with enough sensitivity sometimes and as it's quite obvious that there's no training put in place for like what to do if you come into contact with a trans person in the healthcare scenario. But when you're doing ECG's all day, every day, I feel like you need that sort of training because you're getting everyone taking their chest out in front of you. And it's not exactly like trans people don't exist, Obviously like when you're a teenager and everyone's like oh, loads of trans people exist nowadays and they don't actually cause like. But I thought to cis people, they know of like 2 trans people in their lives out of all the people that they know. But like trans, people aren't uncommon. Like you're seeing thousands of patients a day, you're going to see at least one trans person a day statistically so, like, but where's the training? Well, it's the same across the board like there obviously is no training and it's ironic because trans people are more likely to be seeking mental health help, more likely to be seeking physical health help because you have to medically transition. And also being trans just on its own, without any like you could be accepted by your parents as a trans person, everyone be accepting, never have a bad experience with another person. It's still one of the most traumatic things you can go through just like as a human is, is being trans like it's just like it's, there's no thought. But like the, the fact that if I'm coming out of a situation like healthcare situation, I'm over the moon, if I've been respected as a human being, like that's how bad it is.

Researcher

Well, that's what I wanted to ask, how would you define a positive experience?

Participant

When I have been seen as a person or like felt respected as a person and not just like I don't know been made to feel like either a joke or like afraid, like I don't. I don't want to use the word freak because it's not like, oh, you're a freak. But at the end of the day like you're not treated like a human, like you're not treated like everyone else. You'd like, trans people are subhuman, like they are not seen the same.

Researcher

Yeah.

Participant

I also like have anxiety every time, every single time I'm seeking help for anything about, like am I going to be respected? Am I literally going to get hate crimed while receiving care? Especially as like well, you know, like at the hospital you've got big wide range of sort of staff body. All sorts of cultural backgrounds, I don't know what bias' they have, and I know they've not had specific training about how to deal with me, so I'm going to have like whatever experience, obviously. So like with my eye appointment. He'd clearly never had training on talking to anyone ever. But like, he wasn't white and like a lot of the experiences, unfortunately, I've had other. My mental health person is white, It's not a race thing, but I think it's a lack of understanding as well. Certain cultures who have like, you know, coming into the country for NHS jobs.

Researcher

Yeah, yeah.

Participant

If they haven't been exposed to that at home and now they're been exposed to that here with no training. Then it's a recipe for disaster.

I don't know how to word it cause it's very sensitive issue and I'm not being, yeah, like immigrants are bad with trans people because it's not about that. It's just I especially feel like more anxious and nervous knowing that they probably have very little knowledge of what I'm going through and stuff. But I think that's fair enough. And with any situation like if you were a cancer patient, being treated for cancer and everyone who was treating you for cancer had no idea what cancer even was. You would be nervous like. That's how I feel with healthcare. I'm like, well they don't actually know what's going on with my body. Trans bodies are also very different and work differently to cis people for a multitude of different reasons and trans people need like specialist care with the bodies.

Researcher

Yeah. I used to have to go to when I was on blockers I had to have my bone density scans and all this stuff.

Participant

Yeah, but.

Researcher

Which I also think I know it was for my care, but for me personally it felt very pointless but I know, it's probably not and there is a reason behind it, but I'm like there's that fine line of feeling medicalized as well.

Participant

Yeah.

Researcher

That's and that's a whole other issue in itself. Trans people being medicalised and being reduced to their medical bodies and stuff. That's a whole other issue.

Participant

Oh yeah. Healthcare professionals sort of like treat me as if I will be a boy in the future. You know that sort of like it's just you want to be a male. And then the second I'm like, yeah, I'm not going to get bottom surgery. They're like, also, what's the point of being trans then.

Researcher

Yeah.

Participant

It's like, yeah, it's almost like everything about being trans to them is wanting a male body when it's like not.

Researcher

It would just take one staff meeting, half an hour just to that's all it would take.

Participant

Honestly, Take a 5 minute like run through a slide on a PowerPoint and then like. My boyfriend just gone into the NHS obviously to work at the Mental Health Hospital and he's like had to do training on discrimination and stuff. But I don't think there's been anything about how to deal with trans people at all. Like he's got own induction training today and he's learnt this that and the other, knows how to like not be biased against black patients specifically. Like all the training is based on race.

Researcher

Yeah. Which is obviously important, but.

Participant

Very important, but there's a lot more to. And also when you've got a lot of like a lot of the NHS aren't white

anyway, so if you if you're doing racial discrimination training, it is geared towards white people because they are most likely going to be the oppressor. Whereas trans training they would be geared towards everyone.

Researcher

Literally, people don't realize and like they don't realize that it is on par with racism, but they don't want to have that conversation.

Participant

No.

Researcher

Like I use that as a comparison quite a lot because it's like people, you need to compare it to something serious because it is serious.

Participant

Yeah, it's not seen that way though is it. I like to point out is like any race that gets discriminated against has a home country. Where is the? Where is the like trans people come in any shape, size, colour like any race can also be trans. You can be a person of colour who is also trans. You can be both types of things. So like It's a universal issue not that it makes it more important, but it makes the training very important because that you're training is for everyone, not just.

That is also going to cover a lot. Oh yeah.

Researcher

It's a lot. Yeah, I could keep you here all day and I would, but if anything else has popped up that you can think of.

Participant

Just you know, getting borderline sexually assaulted by nurses and. Well, when I was at staying in the hospital I'm not sure if it was me being trans or me being a mental health patient. They don't treat either very nicely. But I was like, borderline, like, abused. When they were moving me wards for example, they did it in the middle of the night 1 AM team of like, I wasn't a difficult patient I was in there for like an OD I'd been just vibing in my little room. Was asleep woken up in the middle of the night? They were like 6 or 7 HCA's around my bed, like healthcare assistants around my bed. At the hospital they're not allowed to restrain you and therefore they shouldn't really be touching you either. And but like I was sort of like almost physically moved from my bed to a wheelchair and they put a new drip in a cannula that had been in my arm for four days, which is too long. You've gotta change after three. Put a fresh drip in that and then instead of putting it on a stand, dumped it in my lap on my wheelchair and then put all my stuff on top of me, just like piled it on top of me and this wheelchair. I was half asleep. Umm, asking me about like if I was on any medication, if it was in the room or whatever. And then this, HCA took me across the hospital, was like borderline running down the corridor with me in my wheelchair. Got the end of the corridor like stopped so I nearly flew out of that said chair. And then like I was, I was just, like, sat in this chair. Like, what the fuck is going? Well, I had blood flowing into this RV tube because it wasn't attached to a pump, and they decided to put me on it before moving me wards. And also like, none of this was consented. I was not asked about putting medication into my body. Wasn't asked about being moved like, none of it, not a word was said to me the whole the whole procedure that was going on. I felt like a caged animal, I don't even want to say a child because they would offer more respect to a child. Before they started, like Wheeling me away, I went to like I think I moved my hand like out of my chair to like grab something or give myself a bit better support the things I was holding. And then second, I move my hand like out of my own perimeter. I had literally like my I felt someone be like but back on my lap with my hand with force.

Yeah. And this HA was just like taking the absolute piss. We would get the end of the corridor. Like, swivel me around that fast and they go completely different way. I am convinced like, so I had to go from this place, called the AMU to Ward C, which are very, very close in terms of like hospital, it should have taken 2 minutes. It took like 10 with him just having a joy ride with me down all these corridors, unless he was shit and didn't know where it was going. But like.

Yeah, that was another experience I had while staying at the hospital and.

Researcher

That so bad.

Participant

Any time that I've had to, like, have intense sort of healthcare has been unnecessarily traumatic, I'd definitely say,

and it's either because I'm mental health in a general health hospital, which is a big thing. Like, I know they mistreat mental health patients there or whether it's I'm trans or both. But seven men to get me out of bed was not needed, I am a small individual especially then like. Recovering from an overdose I cannot going to put up a fight.

Researcher

Let's say in your opinion, what do you genuinely feel? It was mental health or trans or?

Participant

Given the fact that I was not displaying mental health behaviours the whole time I was in hospital and I was literally just receiving treatment for my liver and I literally wasn't displaying behaviours, wasn't being difficult. Wasn't self-harming, wasn't doing anything, and that would have been my notes like it would have been notes what I was in there for sure, but it actually would have just said like blah blah OD. I'm so I feel like it was probably because I am trans because like even for like mental health, had they treated like any old person like that, they would expect to get complained about.

Researcher

Yeah.

Participant

And I'm like, got information from the inside as well that trans people aren't, like, respected behind the backs by healthcare professionals. So like my boyfriend working in the hospital had a situation where like an FTM came onto a male acute ward but wouldn't they wouldn't put him on a female ward, obviously because I'd be like really traumatizing for him. But they didn't want to put him on the male ward because they'd have to move someone else and like they're all having this bickering argument about whether to put this female to male trans man on this ward or not. But apparently when they were talking about it, like sort of hand over situation like it wouldn't, there was no he/him 'ing about it. Apparently like upset my boyfriend because he knows me now and like probably would not have upset him before. But I'm not funny as well when cis people are like oh like I didn't care about trans people then you know one trans person they know and they now care. But before I knew I was trans, I still gave a shit. People will not care unless they know someone personally who is. The assumption is that you're not even a proper person.

Researcher

Yeah, that's that is very, very true. What a lovely existence.

Participant

You've got to change everything about yourself, and then there's everyone else.

Researcher

So do you have any comments or questions for me or anything you would like to elaborate on is? And so that concludes the interview. And thank you for your time. I will email you with provide you with some resources in the event you feel you need them. Don't be afraid to email me if there's anything you need to know further about this today. And I'm also happy to arrange a further online meeting by email if that's something you feel like you'd want. And I'll turn off the recording now.

Appendix 6 - A reflexive account of the methodological process of analysis

IPAs analytical procedure was implemented on the data. The first stage comprised of the researcher familiarising themselves with the data through repeatedly listening to the recordings, this involved making initial notes of anything that felt important. Once familiarised, the interviews were transcribed. Step two involved systematically going through the transcripts and examining them for meaning, this was done vigorously and line-by-line to ensure nothing was missed. Notes were made in the right-hand margin (these are brief although descriptive). The third stage included re-reading the transcripts systematically and identifying statements relevant to the phenomenon and begins to piece together any emerging themes. Further comments were added, and these initial comments came in the form of: initial themes, summaries, associations or connections, key words, metaphors and some initial interpretations (i.e. interpretations based on the features of the life-world). Step four formed connections and links between themes and were clustered together if an overarching theme was presented. Stage five consisted of finalising the themes through creating a table to visualise the themes with all the supporting evidence from the transcript. This allowed themes to be removed if there was lack of supporting statements or did not fit into the main overarching themes. The second to final stage used the themes identified in the previous stage, however returning to the transcripts to use the features of the lifeworld as a heuristic. The very final stage involved the final list of emergent themes from each participant's transcripts, and deciphering which ones were of most importance, determined by which themes were spoken of most often and the level of evidence from the accounts, and were put into superordinate themes which encompassed the evidence from the whole dataset. The write up was then produced.

It is also worth discussing that my ontological position when conducting this research is stemming from a relativist ontological background, which is the belief that reality is a finite subjective experience (Denzin & Lincoln, 2005) and nothing exists outside of our thoughts (Levers, 2013). It claims that reality is human experience and therefore human experience is reality, meaning there are multiple constructed realities rather than a single knowable reality. In other words, two separate individuals are not experiencing the world differently; their worlds are completely different (Stajduhar, Balneaves, & Thorne, 2001). Phenomenology informs my ontological position and how as a researcher I am interested in getting to the essence of peoples' experiences, hence why IPA was the chosen methodology over any other forms as it encompasses these standpoints.

Appendix 7 – Approved ethical review

THE UNIVERSITY OF HUDDERSFIELD
School of Human and Health Sciences – School Research Ethics and Integrity Committee

APPLICATION FORM

Please complete and return via email to:

SREIC Administrator: hhs_srep@hud.ac.uk

Name of Applicant: Ellis Hobson

Title of study: A phenomenological investigation into the lived experiences of trans-males regarding discrimination in medical settings, and the impacts it has on healthcare decision-making, outside of specialised gender clinics.

Department: Psychology / Human and Health Sciences Date sent: 22/02/22

Please provide sufficient detail below for SREIC to assess the ethical conduct of your research. You should consult the guidance on filling out this form and applying to SREIC at <https://research.hud.ac.uk/strategy/concordat-research-integrity/hhs-ethics/>

Researcher(s) details	Ellis Hobson – Masters by Research (psychology) student.
Supervisor(s) details	Surya Monro Alex Bridger
All documentation has been read by supervisor (where applicable) and Supervisor Report Form attached	YES
Aim / objectives	The aims of the present study are: to explore the lived experiences of transgender men in relation to the health care system, specifically when accessing health care that is not directly related to their medical transition. How this impacts the men's decisions regarding accessing health care will be explored. Research questions are as follows: <ul style="list-style-type: none">• What are trans men's experiences of accessing general healthcare services and healthcare providers?• What sorts of discrimination do trans men face, if any, from providers?• How do trans men's experiences impact their decision making regarding health care?

Brief overview of research methods	<p>Prior to any data collection, contact will be made via email on the participant’s behalf and relevant documents (information sheet and consent form, attached to this document) will be provided to participants and must be signed before the data collection even gets arranged. A draft email reply is attached below.</p> <p>Arrangements for interviews will be made via the main researcher’s university email address.</p> <p>Data collection in the present study will take the form of a single open-ended semi-structured interview per participant (interview schedule attached below). This provides rich data sets and allows participants to expand on elements they feel are important in their experience. It provides a more natural flow of conversation, putting participants at ease, as the loosely structured questions gives interviewees more opportunities to fully express themselves and it provides a relatively warm and friendly atmosphere. There is also more space to ask for clarification on answers and to express a free flow of thoughts through back and forth talk, rather than rigid questions only allowing one answer. Interviews will be conducted online via a video call application, such as Teams; these will be recorded to allow for transcription ready for analysis. Conducting the interviews online allows participants to choose a time and location that best suits their needs and eliminates travel risks/costs. Once the interview is concluded participants will be debriefed on what happens next and how their data will be used. Withdrawal of data sets will be discussed on the information sheet and consent form and the time limit to do so will be disclosed, 30th of June 2022.</p> <p>For analysis of the data, the process of IPA analysis will be taken as this enables a focus on studying the lived experiences of the participants.</p>
Project start date	01/10/21
Project completion date	01/10/22
Permissions for study	The organisation (Facebook group moderators) will only be asked if I can post an advert for the research within the group myself and will take no other part in data collection or recruitment, therefore a letter of permission is not deemed necessary.
Access to participants	Snowball sampling will be used to recruit self-identifying transgender men from community forums on Facebook, specifically trans masculine support groups. The Facebook group I will be recruiting from is not a public group and requires permission to be a part of prior to joining. Access will be granted to such platforms as an emic researcher; therefore access will not need to be granted by group moderators, however permission will be obtained prior to posting the advertisement. The only way participants will be able to sign up and take part in the study is through the provision of the researcher’s email address where they have to email voluntarily and initiate contact. From initial contact, via email, more information will be given surrounding the study through an information sheet (see attached file to this submission) so participants can ensure they definitely want to participate.

Confidentiality	<p>To ensure confidentiality and anonymity within the recruitment process comments and any other form of interaction with the post will be disabled as a means to hide names and picture from other people within the forum. This can be done through the post options when uploading the advertisement; settings will be set to “comments disabled”.</p> <p>There are issues of ensuring confidentiality when conducting online interviews, for example securing a physical space for privacy for participants; the online format means the researcher can’t always control the participant’s environment to ensure confidentiality. Participants involved in the online interview process can choose where they want to do the interview - considering their own needs regarding confidentiality. To prevent confidentiality being compromised while data is collected from the researcher’s perspective, a sound proof room, which is a private and bookable room available in the University of Huddersfield’s Library, will be utilized.</p> <p>In terms of the software used to conduct interviews, there could be potential confidentiality issues over the way internet platforms retain information. Teams will be used; as this is the University approved meeting system in relation to GDPR and links with MS Office software.</p> <p>All personal information will be kept confidential though the use of the University’s Onedrive, unless in a situation where participants reveal that they or anyone else is at risk of serious harm. This will be made clear in the information given to participants via the information sheet and consent form. In this situation the information would be passed on to my supervisor team to which we will discuss the correct course of action. This will depend on the context of the situation however relevant organisations could be: Samaritans and NHS.</p>
Anonymity	<p>Participant names will be removed and replaced with a unique identifier (a number) as soon as the interview has been conducted and before transcription, and will remain throughout the whole research project, this includes the initial data and any analysis following. This will be on a completely separate document, away from any of the collected data behind a password-protected software (the University’s Onedrive). This also allows me to regain access to the participant’s corresponding original data if needed, for reasons such as withdrawal or any safety concerns. Personal data shall be kept in a form which permits identification of the data subject for no longer than is necessary, meaning once the project is completed and submitted/and if published, the personal data of all participants will be destroyed.</p> <p>Participants will only be in contact with myself as the researcher via video call (Teams) for the interview, this also gives the participants control over whether on not they want their camera on to further protect their anonymity. Letting participants decide if they would like their camera on will be stated before the interview takes place.</p>

Right to withdraw	<p>Participants will be offered the right to withdrawal at any point throughout the study until 30/06/22. This will be stated in the consent form. This can be clarified by continued informed consent, where I the researcher, throughout the interview will check in with the participants and ask if they are okay to carry on. Participants will also have the right to not answer certain questions in the interview if they feel uncomfortable doing so. This will be made clear at the start of the interview when the brief is given, as well as being on the information sheet.</p> <p>In regards to withdrawing their data after the data collection has taken place, due to the anonymising of the data the corresponding number to their identity, hidden away on the separate document, will allow me to re-link the participants to their data and destroy it immediately. This will be done by participants emailing the researchers university email address, to which they already have, but will be re-given in the debrief to state they wish to withdraw.</p> <p>The cut of point for withdrawing data after the data collection will be 30/06/22. Again participants will be told about this in the debrief.</p>
Data Storage	<p>In regards to data confidentiality and anonymity, all participants' confidential data will be stored on a password-protected software (Onedrive) and only myself, the main researcher, will be able to access these. Any personal data collected will be limited to what is necessary and relevant to the purpose of the study and all personal data shall be accurate and, where necessary, kept up to date.</p> <p>Any physical data, which will be unlikely, will be kept in a locked draw/locker away from computers that contain the online data. Data will not enter transit, as there is no travelling involved.</p> <p>As recommended by the University data will be stored for 10 years as recommended part of GDPR regulations, after the time period is over, data will be safely destroyed.</p>
Psychological support for participants	<p>Research involving potentially sensitive topics (such as participants' sexual behaviour; their legal or political behaviour; their experience of violence; their gender or ethnic status) can create risk that can be defined as the potential for psychological harm.</p> <p>Before the interviews take place on Teams, participants will be informed about the possible risks of discussing topics that are private and intense, making them feel distressed or upset in the information sheet. The procedures for seeking consent will be taken after they are aware of this. A debrief will be offered where questions will be asked such as whether participants feel they need any support or information. Details of organisation will be provided, such as: helplines specific for transgender people such as MindLine Trans+ (0300 330 5468), which is a confidential emotional, mental health support helpline for people who identify as Transgender. And mental health services and hotlines such as Samaritans (a volunteer-led national telephone service providing emotional support for those in crisis). Contact details for the researcher (Ellis Hobson: ellis.hobson@hud.ac.uk) will also be provided for future issues that may arise and they will be reassured that is safe to contact the research team.</p> <p>As previously mentioned, participants will be made aware that they can withdraw from the study at any time and all data will be destroyed. This is a measure also taken to help reduce harm and is made clear in the information sheet as well as at the beginning of the interview.</p>
Researcher safety / support	RAM form attached below.

Information sheet	Attached below.
Consent form	Attached below.
Letters / posters / flyers	Sample Facebook post attached below.
Questionnaire / Interview guide	Attached below.
Debrief (if appropriate)	N/A
Dissemination of results	Findings will be presented in my unpublished thesis submitted to The University of Huddersfield, with the possibility of being published in a peer-reviewed journal or in academic reports/conferences. This is of course yet to be determined.
Identify any potential conflicts of interest	There are no conflicts of interest.
Does the research involve accessing data or visiting websites that could constitute a legal and/or reputational risk to yourself or the University if misconstrued? Please state Yes/No If Yes, please explain how you will minimise this risk	No.
The next four questions in the grey boxes relate to Security Sensitive Information – please read the following guidance before completing these questions: https://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2019/Oversight-security-sensitive-research-material-guidance-3.pdf	
Is the research commissioned by, or on behalf of the military or the intelligence services? Please state Yes/No If Yes, please outline the requirements from the funding body regarding the collection and storage of Security Sensitive Data	No.
Is the research commissioned under an EU security call Please state Yes/No If Yes, please outline the requirements from the funding body regarding the collection and storage of Security Sensitive Data	No.

<p>Does the research involve the acquisition of security clearances?</p> <p>Please state Yes/No</p> <p>If Yes, please outline how your data collection and storages complies with the requirements of these clearances</p>	<p>No.</p>
<p>Does the research concern terrorist or extreme groups?</p> <p>Please state Yes/No</p> <p>If Yes, please complete a Security Sensitive Information Declaration Form</p>	<p>No.</p>
<p>Does the research involve covert information gathering or active deception?</p> <p>Please state Yes/No</p>	<p>No.</p>
<p>Does the research involve children under 18 or participants who may be unable to give fully informed consent?</p> <p>Please state Yes/No</p>	<p>No.</p>
<p>Does the research involve prisoners or others in custodial care (e.g. young offenders)?</p> <p>Please state Yes/No</p>	<p>No.</p>

<p>Does the research involve significantly increased danger of physical or psychological harm or risk of significant discomfort for the researcher(s) and/or the participant(s), either from the research process or from the publication of findings?</p> <p>Please state Yes/No</p>	<p>Due to the sensitive nature of the topic being discussed there is risk of psychological harm or discomfort for the participants as it is a very personal area of their lives that they will be discussing. However, participants do have the choice to not answer and talk about certain questions as well as stopping the interview at any time.</p> <p>Furthermore, from my perspective as a researcher and my own transgender status, there could be potential risk of my own psychological wellbeing being compromised from how participants discuss their experiences. In this case I would approach my supervisors to discuss my situation and how we can go forward to ensure my wellbeing is not compromised in the research process. I also have the option of accessing other services and organisations as and where needed, i.e. transgender social contacts and other researchers.</p> <p>In terms of the writing up and publishing of research findings I am consciously aware of the sensitive nature of the topic at hand and know it has to be approached with caution and show the findings to be an accurate reflection of the issues related to healthcare discrimination towards transgender men.</p> <p>The process of IPA reflects true and accurate findings and involves not implementing the researcher's own standpoint into the research. Within IPA there is a lot of reflecting on the researcher's behalf to make sure they reflect upon their own preconceptions about the data, and attempt to suspend these in order to focus on getting a true representation of the participants experiences and make sure there is no bias in the analysis process.</p> <p>Also the principles of the BPS Code of Human Research Ethics: Respect for the autonomy, privacy and dignity of individuals, groups and communities, Scientific integrity, Social responsibility and Maximising benefit and minimising harm. The research should focus on generating psychological knowledge to support beneficial outcomes and I am aware, being the researcher, the importance of its scientific integrity and that I am accountable for ensuring that the scientific and scholarly standards of this research are of high quality</p>
<p>Does the research involve risk of unplanned disclosure of information you would be obliged to act on?</p> <p>Please state Yes/No</p>	<p>There is a possibility of causing distress to participants and them disclosing issues of mental health concerns, for example feelings of suicide. Although unlikely, I am aware that the interviews are not a form of therapy but I would of course listen to my participants and have a kind approach with them however I would refer them onto other services as and where needed. I would also seek guidance from the supervisor team, and if deemed necessary we have the option to contact 999 or other relevant services.</p>

<p>Will your research involve NHS patients?</p> <p>Please state Yes*/No</p> <p>*If Yes, please follow the HRA Decision Algorithm (http://www.hra-decisiontools.org.uk/ethics/) and indicate the outcome.</p> <p>If the algorithm indicates that an application will be required through the IRAS system please append your draft IRAS application and all accompanying documents to this form.</p> <p>NB: Do not submit your IRAS Application until full approval has been granted at School level.</p>	<p>No.</p>
<p>Will your research involve NHS staff?</p> <p>Please state Yes*/No</p> <p>*If Yes, please follow the HRA Decision Algorithm (http://www.hra-decisiontools.org.uk/ethics/) and indicate the outcome.</p> <p>If the algorithm indicates that an application will be required through the IRAS system please append your draft IRAS application and all accompanying documents to this form.</p> <p>NB: Do not submit your IRAS Application until full approval has been granted at School level.</p>	<p>No.</p>
<p>Where application is to be made to any other External Agencies</p>	
<p>Other issues</p>	
<p>Please supply copies of all relevant supporting documentation electronically. If this is not available electronically, please provide explanation and supply hard copy</p>	

All documentation must be submitted to the SREIC Administrator. All proposals will be reviewed by two members of SREIC.

If you have any queries relating to the completion of this form or any other queries relating to SREIC's consideration of this proposal, please contact the SREIC Administrator in the first instance – hhs_srep@hud.ac.uk

THE UNIVERSITY OF HUDDERSFIELD: RISK ANALYSIS & MANAGEMENT

ACTIVITY: Online Interviews			Name: Ellis Hobson	
LOCATION: Sound proof room available in the University of			Date:	Review Date:
Hazard(s)	Details of Risk(s)	People at Risk	Risk management measures	Other comments
Loss/Theft of Data	Security of data	Interviewees	Password protected software such as the university Onedrive account and own computer will be used to store electronic data. Audio recordings will be, if transported, in a lockable case and kept on my person at all times in transportation.	
Breach of confidentiality.	Researcher has no control over where participants decide to conduct their interview due to being online.	Interviewee	Make sure participants are aware of this issue and it is their choice as to how to control their environment to make sure they are comfortable with the risk of confidentiality. Let them know the risks such as people overhearing the conversation and knowing who they are as a result if they choose to do it in a public place.	
Electronic equipment failing.	Risk of recording not working. Issues of internet connection issues.	Researcher	Ensure recording device works multiple times prior to conduction of interview. Have a faux interview with a colleague to ensure recording is clear. Establish a reliable and secure internet connection a few days prior and the day of.	
Falls/Trips	The university campus and general everyday obstructions ie cables.	Researcher	Be aware of surroundings in public areas and always make sure work environment is safe.	
Display screen equipment	Prolonged period of sat down working, resulting in bad posture or visual fatigue.	Researcher	Take regular breaks and walk around. All workstations subject to DSE assessment process.	
Psychological Distress	Interview questions/conversation that may provoke distressing details.	Interviewees	Provision of contacts to wellbeing organisations and charities. Continued informed consent throughout the interview to ensure participant's wellbeing is okay.	