Expectations and Experiences of Gender Affirming Healthcare in Transgender Individuals

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Abstract

Gender affirming healthcare refers to a range of treatments and procedures which aim to alleviate gender dysphoria in transgender patients by bringing their bodies into alignment with their gender identities. These treatments can include gender affirming hormone therapy (GAHT) and various surgeries. This research, which was influenced by PPI (patient and public involvement) , aimed to explore the factors associated with experiences of gender affirming healthcare through two studies: (i) a systematic review of factors associated with gender affirming healthcare in existing literature, and (ii) a qualitative study consisting of interviews with ten transgender people (four males, four females, two non-binary) living in Ireland which explored expectations and experiences of gender affirming healthcare. The findings of these two studies suggest that a range of factors are associated with experiences. The systematic review included 38 studies from 13 different countries and found that factors associated with experiences broadly fell into the categories of sociodemographic factors, treatment-related factors, and psychosocial factors, such as interactions with healthcare professionals (HCPs). The qualitative study found that experiences of transgender people seeking treatment in Ireland were mixed, with positive experiences generally relating to treatments themselves and negative experiences generally relating to interactions with HCPs and barriers to care. Common barriers included waiting times, cost, and distance to gender clinics. Social support was frequently reported as an important factor in seeking care.

Participants often sought information online and from other transgender people due to a lack of available information and lack of knowledge among HCPs. Information from these sources often shaped participant expectations which in turn shaped experiences. A list of recommendations for those involved in supporting patients undergoing gender affirming healthcare has been developed based on the findings of these studies. This suggests a

number of ways in which transgender patients could be better supported through the transition process.

Chapter 1: Introduction

1.1 Transgender Healthcare

Transgender is an umbrella term used to describe any individual whose gender identity differs from that which is typically associated with the sex they were assigned at birth (American Psychiatric Association, 2015). For example, a transgender man is someone who was assigned a female sex at birth but who now identifies as a man. Conversely, a non-transgender person is referred to as a cisgender individual (APA, 2015). Although prevalence estimates vary depending on how the term transgender is defined, Collin et al. (2016) found that the meta- prevalence estimates for those that had undergone gender affirming healthcare was 9.2 out of 100,000 of the population, while self-reported transgender identity was 355 out of 100,000 of the population. In each case, male-to-female (MtF) self-reported transgender individuals were more prevalent (521.5 out of 100,000) than female-to-male (FtM) transgender individuals (256.2 out of 100,000).

The misalignment with one's birth sex causes transgender people to experience a specific type of distress known as gender dysphoria, which often leads them to seek gender affirming healthcare (APA, 2015). This healthcare involves a range of treatments such as counselling, gender affirming hormone therapy (GAHT), various surgeries and speech therapy, and is designed to alleviate gender dysphoria by bringing one's body into alignment with one's gender identity (Selvaggi et al., 2018). Many transgender individuals disagree that these treatments are purely cosmetic and feel that they are necessary to manage their gender dysphoria (Sheehan & Collins, 2004). Benefits of gender affirming healthcare have been widely reported (Newfield et al., 2006; Papadopulos et al., 2017; Zagami et al.2019; Gorin-Lazard et al., 2012), however, patient experiences of healthcare may be influenced by a variety of different factors.

It is well established that transgender individuals often experience poorer mental health than their cisgender counterparts, with higher rates of anxiety, depression, and suicidal ideation reported (James et al., 2016; Carroll-Beight & Larrson, 2018). However, being transgender in and of itself does not predispose one to mental illness. The social implications of being transgender- such as discrimination, stigma, abuse, and lack of support contribute to a lower quality of life, resilience, and general mental health (James et al., 2016; Reisner et al., 2016; Robles et al., 2016). These implications also sometimes affect how transgender patients experience healthcare, which will be discussed in the next section.

1.2 Experiences of Healthcare

While undergoing gender affirming healthcare generally leads to positive outcomes for patients, such as increased body satisfaction and less gender dysphoria, patients can encounter a variety of experiences during the process of seeking or receiving treatment, with potentially negative consequences (Newfield et al., 2006; Papadopulos et al., 2017; Zagami et al., 2019; Gorin-Lazard et al., 2012). This can be captured by examining patient reported experience measures (PREMs), defined as "a measure of a patient's perception of their personal experience of the healthcare they have received" (Male et al. 2017, p. 315).

While previous research in the area of transgender healthcare has found mixed experiences among patients during the process of treatment, it would appear that negative experiences are common (Carroll-Beight & Larrson, 2018; McNeil et al., 2013; Heng et al.2018).

A systematic review exploring transgender peoples' experiences of healthcare found that while there was generally a lack of knowledge among HCPs, patients commonly reported feeling dependent on HCPs as well as viewing them as gatekeepers to medical transition (Heng et al., 2018). Other studies also noted this lack of knowledge among HCPs, which can result in negative interactions with patients, such as HCPs asking inappropriate questions (Poteat et al., 2013; Sheehan & Collins, 2004;). There are, however, likely to be a variety of factors that impact on experiences with gender affirming healthcare which may extend beyond HCP interactions. These could include demographic factors, such as one's own gender identity. For example, Jones et al. (2017) found that significantly more assigned male at birth (AMAB) patients were referred for gender affirming care immediately after assessment than assigned female at birth (AFAB) patients, however the reasons for this were not discussed.

The experiences discussed above also appear to be prevalent within an Irish context, with a study by Sheehan and Collins (2004) finding that there was a lack of knowledge about transgender healthcare among Irish GPs. The authors of this study also found that transgender patients reported negative experiences such as being asked irrelevant questions and being asked to remove their clothing for unnecessary examinations (Sheehan & Collins, 2004). More recently, it was found that transgender people living in Ireland were less likely to seek help for a physical illness when compared to those who are cisgender (Howell & Maguire, 2019). This implies that further supports are needed to facilitate transgender people engaging with healthcare services.

1.3 The Role of Expectations

It is clear that HCPs play an important role in determining patient experience. However, there are potentially a range of other psychosocial factors that may impact on this. One of these may be the expectations that patients hold. Broadly speaking, expectations are thoughts or predictions about the future and, in a healthcare context, may relate to expectations about the process or outcomes of treatment (Bowling et al., 2013; Pittet et al., 2018).

Previous research has suggested that expectations can affect one’s recovery and outcomes of a variety of medical treatments. For example, Vos-Vromans et al. (2016) found a significant relationship between expectations of multidisciplinary rehabilitation treatment for chronic fatigue syndrome and patient outcomes. They found that the more positive a patient’s expectations were, the more likely they were to experience a decrease in their fatigue levels. As well as treatment outcomes, expectations also appear to affect other healthcare related experiences. For example, Christiaens et al. (2008). found that women who held negative appraisals of childbirth during pregnancy were more likely to have a negative experience of childbirth. However, more positive expectations may not always result in more positive outcomes. In a study exploring prostate cancer survivors’ prospective and retrospective appraisals of their illness, Maguire et al. (2018) found that survivors who experienced more negative side effects than they expected displayed poorer quality of life scores. In a meta- analysis exploring the relationship between response expectancies and experiences, Devlin et al. (2017) found that patients who expected to experience certain side effects of cancer treatment were more likely to experience those side effects, although this varied depending on the side effect, with the relationship between response expectancies and experience strongest for hair loss. This research suggests that expectations may have a range of different effects on patient outcomes.

Few studies have explored the relationship between expectations and experiences in relation to gender affirming healthcare to date. However, in their systematic review exploring experiences of transgender healthcare, Heng et al. (2018) suggest that the reason negative experiences of healthcare appear to be so common among transgender samples could be attributed to unrealistic expectations, as well as experiences of discrimination in other settings, possibly increasing the risk of transgender patients perceiving an experience as negative. They also note that participants in the studies analysed often changed their expectations and standards of healthcare when presented with HCPs who had little knowledge of transgender issues (Heng et al., 2018). The current research aims to address the gap in the literature exploring expectations and experiences of gender affirming healthcare specifically. As the above studies have illustrated, expectations often play a role in shaping experiences of healthcare and may also illustrate areas where patients have or have not been appropriately prepared for treatments.

1.4 The Irish Context

In addition to a need for a greater understanding of the role of expectations in gender-affirming healthcare in general, it is notable that little research has explored the experiences of transgender people living in Ireland seeking healthcare specifically. One report, published in 2004, explored the experiences of 17 transgender patients in Ireland, and noted that participants often found it difficult to source information on gender affirming procedures available, even from HCPs, often relying instead on other transgender people (Sheehan & Collins, 2004). This report also found that patients living outside of Dublin faced additional barriers when attempting to access gender affirming healthcare, such as the cost of travel, having to take time off work and having to arrange childminding (Sheehan & Collins, 2004). These findings were echoed in a later study which briefly explored experiences of accessing gender affirming healthcare among Irish transgender people (McNeil et al., 2013). The 2004 report also noted that all gender affirming surgeries, with the exception of hysterectomies, were performed abroad, and that all genital surgeries were funded by the patients themselves (Sheehan & Collins, 2004). This was due to being refused funding from health boards and insurance companies (Sheehan & Collins, 2004).

It is important to note that the Sheehan and Collins (2004) report was written before the Health Service Executive (HSE) came into effect, and that this, as well as the McNeil et al (2013) study were both written before the Gender Recognition Act was passed in Ireland (Szydlowski, 2016). The Gender Recognition Act allows Irish transgender individuals to be legally recognized as the gender they identify as (provided they identify as male or female), and does not require individuals to submit medical evidence of surgeries or diagnoses (Szydlowski, 2016). The health seeking experiences of transgender people living in Ireland may therefore differ considerably in the current context when compared to research predating this act.

However, Szydlowski (2016) noted that despite the HSE pledging to reform gender affirming healthcare in Ireland, no changes had been made between 2004 and 2016, meaning that transgender patients in Ireland today may face similar struggles to those who were involved in the Sheehan and Collins (2004) report.

Also, despite gender affirming healthcare now being more widely available in Ireland, with endocrinologists in three separate clinics in the Republic of Ireland now administering GAHT to transgender patients, waiting times have increased, with reports of patients waiting three and a half years for an appointment at a Dublin-based gender clinic as of 2019, leading a number of people seeking gender affirming healthcare to self-medicate and seek care abroad (Gallagher, 2019). While the HSE will cover some treatments abroad in EU or EEA countries via the Cross Border Directive and Treatment Abroad schemes, patients must be referred by a hospital consultant in most cases, meaning that patients seeking surgery will have to have been seen by an Irish gender identity clinic in order to access further treatments (HSE, 2018). These treatments are also available through health insurance, although this can create a barrier to those who cannot afford health insurance (Irish Life Health, 2020; The Health Insurance Authority, 2019).

In Ireland, some treatments, including GAHT, hysterectomies, and orchiectomies are available through the public system (National Gender Service Ireland, 2021). Others, such as fertility preservation, are only available privately in Ireland, while some surgeries are not available in Ireland, meaning patients seeking these treatments are referred to surgeons abroad (National Gender Service Ireland, 2021).

1.5 Study Aims and Objectives

This study aims to explore the expectations and experiences of gender affirming healthcare in the current Irish context, while also exploring factors influencing experiences of this healthcare on a wider scale.

The objectives of the present research are:

(i) To systematically review factors associated with experiences of gender affirming healthcare globally (addressed by Study 1)

(ii) To qualitatively explore expectations and experiences of gender affirming healthcare in a sample of transgender people living in Ireland (addressed by Study 2)

The methodology of both studies will be discussed in detail in Chapter 2. The findings of Study 1, the systematic review, will then be discussed in Chapter 3, while the findings of Study 2, involving semi-structured interviews with 10 transgender people living in Ireland, will be presented in Chapter 4 and discussed in Chapter 5. Finally, an overview of the study findings will be presented and suggestions for improving healthcare experiences among this population will be discussed in Chapter 6.

Chapter 2: Methods

This chapter will discuss the methodology of the two studies that make up this project, which are a systematic review (Howell & Maguire, 2021), and a qualitative interview study. Firstly, the methods for Study 1 (the systematic review) will be discussed.

2.1 Systematic Review Methodology

2.1.1 Protocol and Registration

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement was used as a guideline when reporting this systematic review (Moher et al., 2009). A completed PRISMA checklist can be found in Appendix I. The review was registered on the Open Science Framework (DOI: 10.17605/OSF.IO/J5YSH). As the it did not involve the collection of primary data, it was exempt from ethical review by Maynooth University's ethics committee.

2.1.2 Inclusion and Exclusion Criteria

Publications available in English that reported primary data and that were published from any date up until May 2021 were considered for inclusion in this study. Participants had to be transgender (defined here as having a gender identity differing from one's assigned sex at birth), adults who had accessed some form of gender affirming healthcare such as GAHT or surgeries, or indirect treatments such as counselling and fertility treatments, which are sometimes required in order to access further gender affirming healthcare. Although some identities were classed as transsexual, trans or gender variant, these identities were included as they all encompassed the transgender definition used here. All identities falling under this definition were included such as female to male (FtM), transgender women, non-binary etc. Studies from any country were included as long as they were published in English. The reasons for this were that there is limited research available from Ireland, and also because different healthcare systems and cultural contexts may influence experiences of healthcare.

There were no restrictions on study design, but studies must have collected primary data in order to be included. Studies which involved measures of patient reported experiences with or following gender affirming healthcare, as well as factors influencing these experiences using qualitative, quantitative, and mixed methods data collection tools were included. Studies that did not meet all of the inclusion criteria were excluded, as well as opinion pieces and case studies.

2.1.3 Study Identification

The following databases were searched for relevant articles: PubMed, Embase, PsychInfo, Web of Science. Search terms had to relate to the following factors: (i) transgender identity, AND (ii) gender affirming healthcare, AND (iii) experiences. In order to capture as broad a range of studies as possible, an extensive number of search terms were developed, based on previous literature (Heng et al., 2018; Valentine & Shipherd, 2018). A full list of search terms was used for each database and can be found in Appendix II.

2.1.4 Study Selection and Data Extraction

The results of the database searches were imported into the online systematic review application, Rayaan (Ouzzani et al., 2016). Here, duplicates were removed, and the abstracts were screened by two reviewers (the student and his supervisor). Full text copies of potentially relevant studies were acquired, and these were then also screened by two reviewers. Data extracted from relevant studies included: authors, year published, location, study design, study aims, location, sample size, gender identities of participants, age, treatment undergone, measure of experience, and main findings.

2.1.5 Quality Appraisal

The Mixed Methods Appraisal Tool (MMAT) was used to appraise the methodological quality of included studies (Hong, 2018). As the use of this tool requires one to make subjective judgements about methodological quality, two researchers are advised to conduct an appraisal independently. In this case, the two reviewers conducted appraisals, and were largely in agreement with each other's decisions. Any conflicts were resolved by discussion. 19 studies met all five of the MMAT criteria. However, it is important to note that this is merely a proxy for quality, as the creators of the MMAT advise against calculating overall scores for each study. Some of the main weaknesses observed in the included studies were low or unreported response rates, no discussion of whether the sample was representative of the wider population, and not discussing possible confounding variables.

2.1.6 Analysis

Due to the wide variation of measures used, a meta-analysis was not deemed appropriate to analyse the data. Instead, a narrative synthesis approach was taken. Factors associated with experiences were broadly categorized into sociodemographic factors, psychological factors, healthcare interactions, and treatment related factors. The results of the systematic review will be described in Chapter 3.

2.2 Qualitative Study Methodology

This section will outline the methodology used throughout the qualitative study. Sampling strategies used here will first be discussed, followed by the interview procedure. The qualitative analysis methods will then be discussed. Finally, ethical considerations will be outlined. The methodology is reported in line with COREQ guidelines (Tong et al., 2007).

2.2.1 Objectives

This study addresses objective 2 of the project, which is to qualitatively explore expectations and experiences of gender affirming healthcare in a sample of transgender people living in Ireland.

2.2.2 Participants

The study employed a mixture of convenience, purposive and snowball sampling. The inclusion criteria for this study were: identifying as transgender, living in Ireland, being at least 18 years old, and fitting into one of the following categories: (i) awaiting gender affirming healthcare, (ii) currently receiving gender affirming healthcare, or (iii) having previously received gender affirming healthcare. All participants were aged 18 or older for ethical reasons. In order to be fully inclusive of this population, there was no upper age limit and participants at all stages of transition (so long as they were seeking or undergoing gender affirming care) were included.

Due to the small size of the target population (an estimated 0.0067% of the Irish population; Judge et al., 2014), the study was advertised in transgender spaces specifically. These included: the three gender clinics in the Republic of Ireland that provide gender affirming healthcare, as well as online and offline support groups for transgender people living in Ireland. The Transgender Equality Network of Ireland (TENI) shared details of the study on their social media, and it was also advertised on the researcher's own social media. Participant recruitment took place between February 2019 and February 2020.

Additional calls for participants were put out in August 2019, emphasizing the need for transgender women and transfeminine non- binary individuals to take part, as many of the participants who originally reached out about participating were transgender men and transmasculine non-binary people. In order to avoid bias, individuals who were known to the researcher were excluded from participating in the study.

In total, 18 people got in touch about participating in the study. Of these, three people were excluded as they were known to the researcher, four stopped replying to emails and one did not live in Ireland.

There was not a predetermined sample size. Instead, participant recruitment continued until data saturation was reached. In total, ten people took part in the study. These included four transgender men, four transgender women and two transmasculine non-binary people. Participants ranged in age from 18 to 62 years old, with a mean age of 31.

2.2.3 Interviews

A list of topics was created with guiding questions for participants in each of the following categories: (i) awaiting gender affirming healthcare, (ii) currently receiving gender affirming healthcare, and (iii) having completed gender affirming healthcare. These questions centred around retrospective and current expectations of various types of gender affirming care, experiences of different procedures and general demographic questions. The full interview guide can be found in Appendix III. Questions were not limited to those listed and probing questions were used to encourage participants to expand on their answers.

Ten semi-structured in person interviews were conducted between March 2019 and February 2020. These interviews were conducted in resource centres, the TENI boardroom, the Maynooth University psychology department, and in one case, a café (as per the participant’s request). All interviews were audio-recorded using a mobile phone in order to avoid distracting participants with note taking. Audio recordings were later transcribed and anonymized using

Microsoft Word. During one interview, the audio failed to record. To rectify this, the researcher took notes from memory and arranged a second meeting with the participant to review these notes and clarify points and correct any errors. This second meeting was audio recorded and any quotations from this participant (participant 9) came from this second meeting. Interviews lasted around an hour each but ranged from 22 minutes to one hour and 45 minutes. Although these were the first interviews to be conducted by the researcher, extensive research on interview methods was conducted.

2.2.4 Coding

Once all interviews had been transcribed, the coding process of the content analysis began. The transcripts were coded by the lead researcher using the qualitative analysis software, QDA Miner Lite. Preliminary codes were noted as interviews took place; however, more detailed codes were created as common themes arose during the qualitative analysis phase. The process of reflexive thematic analysis was used. This involves six core stages, including transcription, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report (Braun & Clarke, 2006).

Semantic coding was used when analysing the interview transcripts. This method of coding was chosen over latent coding as it focuses on the explicit content of the data, and provides a more descriptive overview of the data, which is particularly suited to this study and ensuring that the findings are shaped by this minority community.

Codes were not predetermined and were instead created as common themes were identified. After all transcripts had been analysed, a complete list of codes that were identified was used to then recode all transcripts. Once this stage was complete, a second researcher blindly coded a randomly selected portion of the transcripts. These codes were then compared with the originals and discussed until a consensus was reached.

Finally, all coded sections of the transcripts were exported to a word document in order to organize quotes by themes. Following the analysis of findings, the opinions of a number of transgender patients were sought to establish if these findings, and those of the systematic review were reflective of their experiences. Feedback was received from five of the original participants (three transgender women and two transgender men), as well as two individuals who had seen details of the study advertised on social media (one transgender woman and one transgender man).

2.2.5 Ethical Considerations

As this study focuses on what is considered to be a vulnerable population, specific considerations were taken into account in order to ensure the safety of participants. In line with the Maynooth University Research Ethics Committee, exclusion criteria were developed in order to protect the most vulnerable members of the population. These were: (i) having been hospitalized for a mental health issues in the six months prior to participation in the study, (ii) being under 18 years of age, and (iii) having any significant cognitive impairment that may make participation in the study difficult. Participants were supplied with information sheets (see Appendix IV) about the study and were also given a verbal explanation of the aims of the research. Informed consent from those who wished to participate was gathered by asking participants to sign two consent forms- one to be kept by the participant and one to be kept by the researcher (see Appendix V).

Although transcripts were not returned to participants for comments and corrections, they were told that they could end the interview at any time and retract any information they did not want to be included in the study. The audio recordings were stored on a password protected mobile phone and later transferred to a USB memory stick before being transcribed and anonymized. All participants were supplied with contact details for a number of LGBT and mental health related organizations upon completion of the interview. A protocol was also developed to be followed in the case of participant distress (see Appendix VI). In order to protect participant anonymity, pseudonyms were used in place of actual names. Ethical approval was granted on December 13th, 2018 (reference number: SRESC-2018-140; see (see Appendix VII).

Chapter 3: Systematic Review Findings

3.1 Search Results

Search 1 (July 2019) revealed a total of 6,201 results, while search 2 (May 2021) yielded 2,646 results. 177 full text copies of articles that appeared to meet the inclusion criteria were obtained. Articles that did not meet all of the inclusion criteria were then removed, so that the final number of articles to be included in the review was 38. The PRISMA flow diagram (Figure 3.1) illustrates this process.

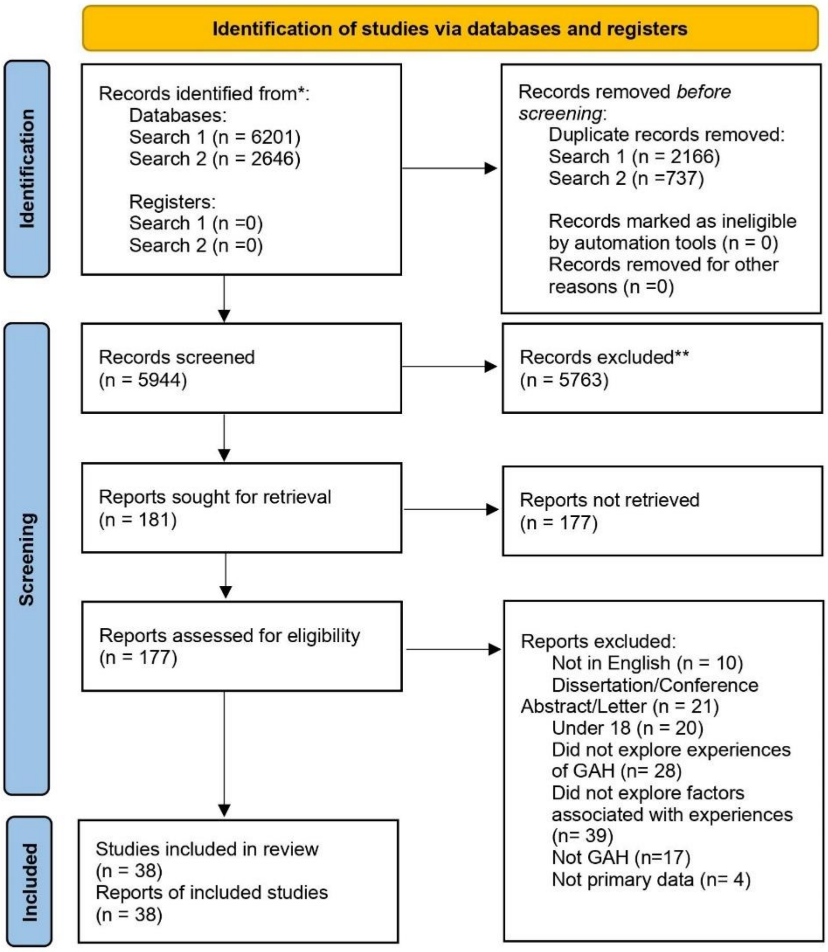

Figure 3.1 PRISMA flowchart

3.2 Description of Included Studies

A total of 38 studies were included in this review. An overview of the included studies can be seen in Table 3.1. Of the included studies, locations included the USA (n = 16), Sweden (n = 3), the UK (n = 5), The Netherlands (n = 2), Australia (n = 2), Canada (n = 5), Iran (n = 1), France (n = 1), Nepal (n = 1) and one study that included participants from The Netherlands, Belgium and Germany. The majority of studies had a sample with various gender identities (n = 20), while other studies focused specifically on transgender men (n = 5), transgender women (n = 6) and non-binary people (n = 1). Some studies did not discuss the specific identities of participants (n= 6). Most of the studies explored experiences of a range of gender affirming procedures (n =22), although some explored specific treatments and procedures, such as mastectomy (n = 5), psychiatry (n = 3) GAHT (n = 4) Sample sizes ranged from 4 to 697, with a total sample size of 4,011participants. Ages ranged from 18-89. Eighteen of the studies used quantitative methods, 17 used qualitative methods, and 3 used mixed methods.

3.3 Methodological Quality

Nineteen studies (16 qualitative, 2 quantitative, and 1 mixed methods) met all five of the MMAT criteria. Some of the main weaknesses observed were low or unreported response rates, no discussion of whether the sample was representative of the wider population, and not discussing possible confounding variables.

Table 3.1 Study Characteristics

Authors (Year)	**Aims**	**Study Design**	**Country**	**Sample Size**	**Gender Identities**	**Age**	**Treatment Undergone**	**Measure of Experience**	**MMAT score**
Agarwal et al., (2018)	To explore changes in body image, wellbeing and satisfaction following mastectomy in transgender men	Quantitative nonrandomized; surveys	USA	42	Transgender men	18-50 (M = 27.7)	Mastectomy	BREAST-Q Reduction/Mastopexy Module, Body Uneasiness Test (BUT-A)	5
Bell & Purkey (2019)	To explore transgender patients' retrospective expectations and experiences of primary care	Qualitative; interviews	Canada	11	Various transgender identities (4 transgender men, 6 transgender women, 1 gender non-conforming)	Not specified (all over 18)	Primary care (for patients who had undergone HRT/surgery)	Self-reported experiences	5
Ho & Mussap (2017)	To assess satisfaction with HCPs and the standards of care among a transgender sample	Quantitative descriptive study; survey	Australia	161	Various transgender identities (3:1 assigned male : assigned female)	18-76 M = 41.15 SD = 15.40	Various Gender Affirming Treatments	Satisfaction with the Standards of Care (Likert), Satisfaction with HCPs (Likert),	3

Hughto et al., (2018)	To explore the healthcare experiences of transgender women who have been incarcerated in sex-segregated prisons	Qualitative; interviews	USA	20	Transgender women	M= 36.9 SD = 10	HRT	Self-reported experiences	5
Khoosal, Grover & Terry (2011)	To review transgender patients' satisfaction with several areas of a gender realignment service*	Quantitative descriptive study; survey	UK	112	Various transgender identities (104 MtF, 8 FtM)	24-75 M = 46.66 SD = 12.43	Surgeries	Likert scales: post-operative satisfaction, complications, support from professionals, user organisations, family and friends, quality of life, relationships, self-esteem, confidence, body image, sexual activity, comfort with new gender	4
Linander et al., (2016)	To examine patients' experiences of seeking gender affirming healthcare in Sweden	Qualitative; interviews	Sweden	14	Various transgender identities (7 women, 4 men, 3 non-binary/intergender)	23-69	Various Gender Affirming Treatments	Self-reported experiences	5
Lykens, LeBlanc & Bockting (2018)	To explore healthcare experiences among a	Qualitative; interviews	USA	10	Genderqueer/Non-binary	23-33	Various Gender Affirming Treatments	Self-reported experiences	5

	sample of non-binary and genderqueer young adults								
Owen-Smith et al., (2018)	To examine how body-gender congruence, body image, satisfaction, depression, and anxiety differed by stage of medical transition in a transgender sample	Quantitative descriptive study; survey	USA	697	Various transgender identities (347 transmasculine, 350 transfeminine*)	Not specified (all over 18)	Various Gender Affirming Treatments	Transgender Congruence Scale, Revised Physical Self-Perception Profile, 10-item Center for Epidemiologic Studies Depression, Beck Anxiety Index	4
Nemoto, Operario & Keatley (2008)	To explore health and social service needs among a sample of transgender women of colour in San Francisco	Quantitative descriptive study; focus groups and survey interviews	USA	380	Transgender women	Not specified	HRT, silicone injections, surgery	Self reported, Likert scales for healthcare engaged with and barriers	4
Radix, Lelutiu-Weinberger & Gamarel (2014)	To assess transgender patients' needs, satisfaction and healthcare	Mixed Methods; survey, focus groups	USA	46	Various transgender identities (5 women, 21 transgender women, 3 men, 8 transgender men, 1 transgender, 8 genderqueer)	18-64	Various gender affirming procedures	Self-reported experiences	5

	utilization in New York City in order to determine points of intervention								
Riggs, Coleman & Due (2014)	To explore transgender patients' healthcare experiences in Australia	Mixed Methods; survey with write in options	Australia	188	Various transgender identities (110 assigned male at birth, 78 assigned female at birth)	M = 44.87 SD = 13.93	Various gender affirming treatments	Likert scales: experiences with HCPs, if patients had to educate HCPs, information provided, describe experiences	5
Speer & McPhillips (2012)	To explore transgender patients experiences of interacting with psychiatrist in a gender identity clinic in order to advance understanding of patient centred communication	Qualitative; interviews	UK	21	Various transgender identities (19 MtF; 2 FtM)	Not specified	Psychiatry	Self-reported experiences	5
van de Grift et al., (2016)	To examine how mastectomy affects body image in a sample of	Quantitative nonrandomized; survey	The Netherlands	26	Transgender men	18-59 (M=26.1)	Mastectomy	Body Image Scale for Transsexuals, Multidimensional Body-Self Relations Questionnaire,	3

	transgender men							Appearance Schemas Inventory, Situational Inventory of Body Image Dysphoria, Body Image Quality of Life Inventory, Rosenberg Self-Esteem Scale	
van de Grift et al., (2017a)	To explore how gender affirming healthcare affects gender dysphoria and body satisfaction six years after clinical entry	Quantitative nonrandomized; survey	The Netherlands, Belgium, Germany	201	Various transgender identities (135 AMAB, 66 AFAB)	AMAB M (SD): 39.2 (12.9) AFAB M (SD): 30.6 (11.3)	Various Gender Affirming Treatments	Utrecht Gender Dysphoria Scale, Body Image Scale for transsexuals, Symptom Checklist-Global Severity Index, Satisfaction With Life Scale, Subjective Happiness Scale, Cantril Ladder	4
van de Grift et al., (2017b)	To assess patient reported outcomes and surgical decision making among a cohort of transgender men undergoing mastectomy	Quantitative nonrandomized; survey	The Netherlands	54	Transgender men	18-59 M = 25.8	Mastectomy	Likert (burdensome process, depression, anxiety, femininity/masculinity of chest, complications satisfaction with scars, sensitivity, nipples, shape, symmetry, overall appearance)	4
von Vogelsang, Milton,	To explore how transgender	Qualitative; interviews	Sweden	6	Various transgender identities (3 MtF, 3 FtM)	20-36	Various gender affirming	Self-reported experiences	5

Ericsson & Stromberg (2016)	patients experience interactions with healthcare professionals when undergoing gender affirming healthcare						procedures		
Staples et al. (2019)	To investigate body satisfaction and sexual distress according to transition related treatment status	Quantitative	USA	317	Various transgender identities (35 trans women, 74 trans men, 32 genderqueer/gender nonconforming, 176 other)	M = 28.11 (SD = 6.94)	Various gender affirming procedures	Modified Female Sexual Distress Scale—Revised (FSDS-R), single item question for body satisfaction, single item questions for transition status	5
Kelly et al., (2019)	To investigate long-term effects and to compare outcomes between cricothyroid approximation (CTA) and glottoplasty (GP)	Quantitative	Sweden	24	Transgender women	M = 45.5 (SD = 10; range = 27-64)	Voice therapy, cricothyroid approximation, glottoplasty	Questionnaire developed by authors; some questions from the post gender-confirming pitch raising surgery questionnaire from La Trobe University	4
Stein et al., (2020)	To investigate the association between obesity and postoperative	Quantitative	Canada	97	Transgender (not specified)	Obese patients significantly older	Mastectomy	BODY Q	3

	patient-reported outcomes					(mean = 29 years vs mean = 24 years p<0.001)			
Brown et al., (2020)	To determine whether the addition of glottoplasty to VT results in greater fundamental frequency elevation and improvement in quality-of-life measures	Quantitative	USA	48	Transgender (not specified)	Voice therapy only: mean age = 35.6; SD = 14.2; voice therapy with glottoplasty: mean age = 35.5; SD = 9.5	Voice therapy, glottoplasty	Trans Woman Voice Questionnaire (TWVQ), and Voice Handicap Index-10 (VHI-10)	4
Bustos et al., (2020)	To describe the nipple split sharing technique during chest wall masculinization surgery comparing surgical, patient-reported outcomes (PRO) and aesthetic results with the	Quantitative	USA	34	Transgender (not specified)	Conventional technique: median age = 24; novel technique: median age = 27	Mastectomy	Likert and BODY Q	4

	conventional technique								
Garcia & Crosby (2020)	To describe the social determinants of health that shape access to health services for transgender women in Oregon	Qualitative; interviews	USA	25	Transgender women	M = 27.56 (SD = 6.21)	Various gender affirming procedures	Self-reported experiences	5
Meyer et al., (2020)	To document and categorize the types of unmet expectations that are common in the TGD patient–health care provider social dynamic in the Central Great Plains of the United States	Qualitative; interviews	USA	27	Various transgender identities (14 trans women, 10 trans men, 3 non-binary)	M =36 (range = 22-64)	Various gender affirming procedures	Self-reported experiences	5
MacKinnon et al., (2020)	To explicate how standardized readiness assessments coordinate access to hormones and surgeries in Canada	Qualitative; interviews	Canada	9	Transgender (not specified)	Not specified	Surgery assessment	Self-reported experiences	5

Harrison, Jacobs & Parke (2020)	To gain an in-depth understanding of the lived experiences of adults with gender dysphoria seeking treatment in the UK	Qualitative; interviews	UK	8	Various transgender identities (2 trans men, 6 trans women)	M = 33 (SD = 12.69, range = 22-60)	Various gender affirming procedures	Self-reported experiences	5
Willis et al., (2020)	To examine supportive and obstructive points of interaction with health-care professionals, and to identify key learning messages for improving trans-related health care from the perspectives of trans-identifying adults in later life	Qualitative; interviews	UK	19	Various transgender identities (15 trans women, 4 trans men)	50-74 years	Various gender affirming procedures	Self-reported experiences	5
Frohard-Dourlent, MacAulay & Shannon (2020)	To explore transgender patients' experiences of surgery readiness assessments	Qualitative; interviews	Canada	35	Various transgender identities (19 transfeminine, 13 transmasculine, 8 non-binary)	24-69 years	Surgery assessment	Self-reported experiences	5

Hughto et al., (2020)	To examine associations between gender affirmation experiences and self-reported depressive, anxiety, and stress symptoms	Quantitative	USA	288	Various transgender identities (234 trans masculine spectrum; 54 trans feminine spectrum)	M = 33 (SD = 13)	Various gender affirming procedures	Adapted measure from Rood et al., 2015,2016; Depression, Anxiety, and Stress Scale (DASS-21)	4
McNichols , O'Brien-Coon & Fischer (2020)	To provide patient-centric insight on self-image and other concerns that arise during surgical transition	Quantitative	USA	246	Transgender men	Not specified	Various surgeries	Questionnaire developed by authors	4
Ker et al., (2020)	To evaluate service users' and health professionals' experiences of a pilot clinic at Mauri Ora (Victoria University of Wellington's Student Health and Counselling Service) that provided gender-affirming hormones	Qualitative; interviews	New Zealand	4	Various transgender identities (3 female, 1 non-binary/neutrois)	M = 20 (range 18-26)	Primary care, HRT	Self-reported experiences	5

	through primary care								
Akhoondi nasab et al., (2020)	To compare outcomes and satisfaction with a new technique of coronaplasty and the traditional Norfolk method	Quantitative	Iran	40	Transgender (not specified)	Not specified	Phalloplasty	Likert scale	4
Bradford, Rider & Spencer (2019)	To explore associations between hair removal and psychological wellbeing in a transgender sample	Quantitative	USA	281	Various transgender identities (159 trans women, 121 non-binary/gender queer)	M = 31.94 (SD = 11.76; range = 18-68)	Hair removal	Situational Inventory of Body-Image Dysphoria, Short Form (SIBID-S), Positive and Negative Affect Scale (PANAS-X), Generalized Anxiety Disorder 7-Item (GAD-7), Patient Health Questionnaire 8-Item (PHQ-8)	3
Regmi et al., (2019)	To explore how hormones are used, types of hormones used and side effects experienced by transgender women after hormone use in Nepal	Qualitative; focus groups and interviews	Nepal	62	Transgender women	M = 23.06 (SD = 3.9)	GAHT	Self-reported experiences	5
Pang, Gutman & deVries	To explore the concerns and explicit plans	Qualitative; focus groups and interviews	Canada	24	Various transgender identities (18 trans women, 6 trans men)	M = 70 (range = 55-89)	Various gender affirming	Self-reported experiences	5

(2019)	for later life care among a transgender sample						procedures		
Lewis et al., (2019)	To evaluate transgender/gender nonconforming (TGNC) adults' worries and coping actions related to discrimination by healthcare professionals	Quantitative	USA	316	Transgender (not specified)	Median = 27 (range = 18-67)	Various gender affirming procedures	Questionnaire developed by authors; Patient Health Questionnaire-2; Generalized Anxiety Disorder-7 Scale; Everyday Discrimination Scale (Short Form)	3
Neuville et al., (2018)	To assess the safety, feasibility, and patient satisfaction of the ZSI 475 FtM	Quantitative	France	20	Transgender men	M = 37.9 (SD = 7.6; range = 26-50)	Phalloplasty	International Index of Erectile Function 5 (IIEF-5), Erectile Dysfunction Inventory of Treatment Satisfaction (EDITS), and Self-Esteem and Relationship (SEAR) Questionnaire	4
Mohamed & Hunter (2018)	To investigate transgender women’s experiences and attitudes to HRT, and expectations of what might occur and/or what occurred after they reached	Mixed Methods	UK	67	Transgender women	M = 49.67 (SD = 14.87; range = 20-79)	GAHT	Survey with standardized measure [Beliefs about Medicines Questionnaire (BMQ)] and open questions	5

	“menopausal age.”								
Friley & Venetis (2021)	To investigate the salient information assessment themes that contribute to transgender patients’ decisions to disclose or withhold their gender identity from medical providers	Qualitative; interviews	USA	26	Transgender (not specified)	M = 33.96 (SD = 13.38; range = 18-65)	Various gender affirming procedures	Self-reported experiences	5

*terminology used in original article; transmasculine = a person who was assigned a female sex at birth and now identifies as a different gender; transfeminine = a person who was assigned a male sex at birth and now identifies as a different gender (Owen-Smith et al., 2018)

3.4 Review Findings

Using the process of narrative synthesis, four key factors emerged as associates of experiences (See Figure 3.2). These were: demographic factors, procedure related factors, psychological factors, and healthcare interactions. More detailed findings can be seen in Table 3.2.

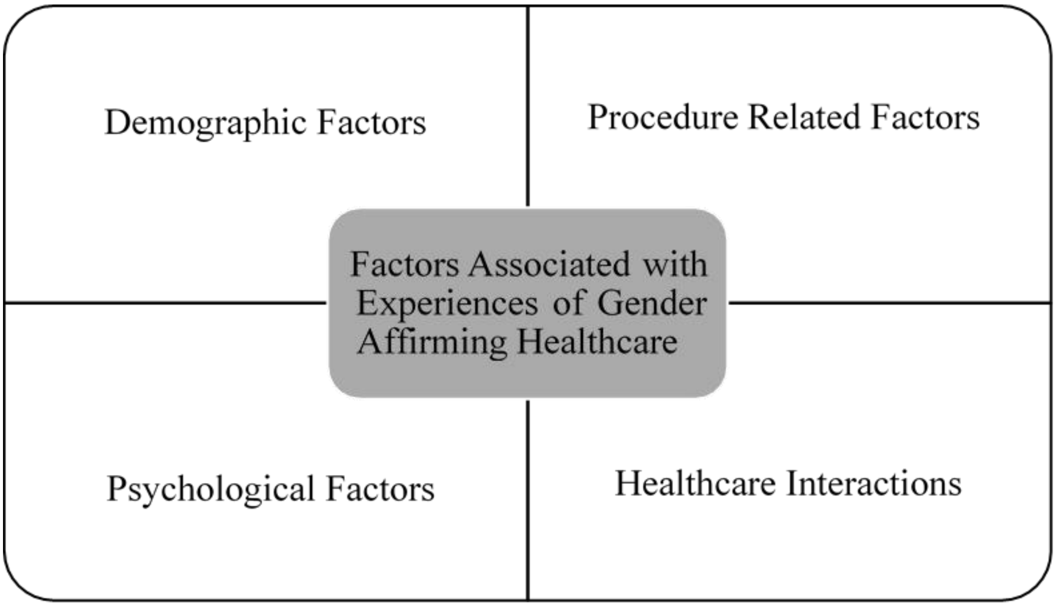

Figure 3.2: Themes identified from review findings

3.4.1 The Role of Sociodemographic Factors

Sixteen studies investigated the impact of patients' sociodemographic characteristics on their experiences of GAH. Commonly investigated factors included gender identity, age, financial circumstances, and location, among others. Transgender men rated their experiences with HCPs more poorly than transgender women, and non-binary participants reported specific challenges that they felt were not faced by binary (identifying as male or female) transgender patients, which will be discussed in more detail below. (Lykens et al., 2018; Riggs et al., 2014; Frohard-Dourlent et al., 2020; Friley & Venetis, 2021). Another example of the role gender identity played in healthcare experiences was that participants assigned male at birth (AMAB) rated their experiences with psychiatrists more highly than participants who were assigned female at birth (AFAB) (Riggs et al., 2014).

Similarly, gender identity affected surgery experiences, with participants who were AMAB more likely to report positive experiences of surgery than those who were AFAB (Riggs et al., 2014). Those undergoing male to female (MtF) surgeries reported significant improvements in terms of psychiatric support, friends and family support, user organization support and improved quality of relationships when compared to those undertaking female to male (FtM) surgeries (Khoosal et al., 2011). However, it is important to note that participants in this study were mostly transgender women (n = 104), with only a small number of transgender men (n = 8), so these results should be interpreted with caution.

Patients who identified outside of the gender binary of male and female often had unique healthcare experiences shaped by their identity in the studies reviewed. One study (Lykens et al., 2018) found that such patients reported having to reframe their needs in binary terms to access GAH, which was attributed to a lack of HCP knowledge around non-binary identities. One non-binary participant explained that their transition involved stopping HRT and seeking surgery, which was misinterpreted by a HCP as uncertainty and regret (Frohard-Dourlent et al., 2020). Some participants described shame about having to “borrow” the transgender label, with others reporting that they left clinics due to a lack of understanding from HCPs as well as a lack of non-binary options on intake forms (Lykens et al., 2018; Friley & Venetis, 2021).

However, not all studies that examined the role of gender identity found an effect. For example, one study (Van De Grift et al., 2017a) found that sex assigned at birth was not predictive of body satisfaction, while another (Agarwal et al., 2018) found no correlation between gender identity and body uneasiness or quality of life in those undergoing masculinizing mastectomies.

A number of other sociodemographic factors were explored in the studies reviewed. For example, age was associated with mastectomy outcomes in transgender men, with older age, as well as lower BMI and larger breast size all predicting a greater improvement in body image post-operatively (Van De Grift et al., 2016). However, BMI did not always affect experiences of mastectomy. A different study comparing obese and non-obese patient outcomes of masculinizing mastectomy found no significant differences in BODY Q scores between the two groups (Stein et al., 2021). The role of health status was explored by another study, which found that participants with lower self-reported health status reported greater worry about discrimination from primary care practitioners (Lewis et al., 2019).

Age was briefly explored in some studies, with a participant in one study noting that they were refused GAH when they sought this at the age of 16, because HCPs felt that the patient was too young to be sure of their gender identity (von Vogelsang et al., 2016). Age also played a role in how older individuals experienced GAH, with some participants in one study reporting concern about “losing time” by seeking gender affirming care later in life (Willis et al., 2020). However, conversely, it is interesting to note that a study comparing scores from the Beliefs About Medicine Questionnaire (BMQ) between two groups- those aged under 50 years, and those aged over 50 years- found no significant differences in GAHT necessity between the two groups (Mohamed & Hunter, 2019).

Some of the most prominent sociodemographic factors found to impact on experiences were those relating to finances and location. These were often interlinked- specifically, where individuals lived often impacted the available treatment options and whether they had to travel for healthcare- something which involved additional costs. For example, one study found how those living in Wales had to be referred to a gender identity clinic in England, resulting in a long and costly commute, which participants reported as an additional barrier (Willis et al., 2020). Meanwhile, those in Oregon, USA reported that they required two assessments in order to be referred for gender affirming surgery (Garcia & Crosby, 2020). As well as the cost of the assessments, many patients face additional travel costs, as there are a limited number of HCPs who can conduct these assessments, with participants in another US-based study noting that most qualified HCPs are located in urban areas, creating an additional barrier for those living in more rural areas (Frohard-Dourlent et al., 2020). Often, patients have to travel to different states to have surgery, which is another financial barrier (Garcia & Crosby, 2020).

In one sample of 246 transgender men, only 1.5% had undergone phalloplasty (McNichols et al., 2020). When those who had not undergone this surgery were asked the reasons for this, 53% reported that cost was a barrier, while 15% reported that having to travel long distances to access the surgery was a barrier (McNichols et al., 2020). Meanwhile, a study exploring hair removal treatments among transgender women and non-binary individuals found that of those reporting barriers to this treatment, 95% attributed this to the cost involved (Bradford et al., 2019). In one study, a participant reported that their HCP "did not agree" with gender affirming hormone therapy being funded by the NHS and would only prescribe hormones if the patient was willing to pay for the prescription themselves (Willis et al., 2020). In another study, a patient reported having a positive experience of seeking gender affirming care and noted that this was likely due to seeking care privately (Harrison et al., 2020).

While many transgender individuals have their treatments covered by insurance, not all insurance companies cover these treatments, which can act as a barrier to those seeking GAH (Garcia & Crosby, 2020). Some individuals moved to areas where treatment was more accessible, such as Oregon in the USA, where there is an informed consent model of gender affirming care, as well as a number of insurance companies that cover gender affirming treatments (Garcia & Crosby, 2020). However, some individuals noted that even areas like Oregon had their own issues, such as understaffed clinics and long waiting times for genital surgery (Garcia & Crosby, 2020).

Occasionally the culture of different locations played a role in how transgender patients experienced healthcare. For example, those living in the “bible belt” of the USA expressed concern about how HCPs would treat them, with one individual reporting that their HCP advised them that prayer would heal their gender dysphoria (Friley & Venetis, 2021). Taken together, these studies highlight the potential inequalities faced by transgender people living in different locations, with those having fewer financial resources being particularly disadvantaged. While demographics do not always affect experiences of gender affirming healthcare, they often impact what healthcare is accessible to individuals as well as how they interact with healthcare professionals. Ways of addressing location-based issues could include utilizing telehealth, such as video calls, which would also be beneficial during the COVID-19 pandemic. In terms of other demographics such as gender identities, it may be useful for transgender and LGBT organizations to provide training for HCPs in order to educate them on how different groups of transgender people experience healthcare as well as additional needs they may have. It is notable that some demographics such as race and ethnicity were not explored in the studies reviewed. As these factors may impact how individuals interact with and experience gender affirming healthcare, further studies should explore the role that these factors may play.

3.4.2 The Role of Treatment Related Factors

Twelve studies revealed how experiences differed depending on the type or number of treatments received. For example, researchers in one study (Owen-Smith et al., 2018) split transgender participants up into 5 categories according to their treatment history: (i) no gender affirming treatment to date, (ii) GAHT only, (iii) GAHT and top surgery, (iv) GAHT and partial bottom surgery, and (v) GAHT and definitive bottom surgery. They found that patients undergoing each stage had generally higher comfort with one’s body, lower anxiety, and lower depression, implying that a greater engagement in GAH led to more positive experiences (Owen-Smith et al., 2018). However, it is important to note that not all transgender people will wish to undergo all treatments.

Similarly, another study found that the number of gender affirming treatments a patient had undergone was significantly inversely associated with depression, anxiety, and stress symptoms (Hughto et al., 2020). Meanwhile a study exploring hair removal found that the number of hair removal sessions undergone was significantly correlated with satisfaction (Bradford et al., 2019). In another study, the authors found that those who had received GAHT had significantly higher body satisfaction compared to those who wanted to receive this treatment (Staples et al., 2019). The same was also true for those who had undergone surgery compared with those who wanted to have surgery (Staples et al., 2019). The findings of these studies suggest that availing of multiple gender affirming treatments results in more positive outcomes.

Patient experience also varied by surgical technique. For example, in one study exploring mastectomy outcomes among transgender men, those who underwent concentric circular mastectomy were less satisfied that those who underwent inframammary skin resections with free nipple grafts (van de Grift et al., 2017b). Meanwhile, another study compared two groups undergoing double incision mastectomy with free nipple grafts, but one group underwent the traditional method of nipple grafting, while the other underwent a split sharing method of nipple grafting (Bustos et al., 2020). The authors found that those who underwent the split sharing method had significantly higher scores for the nipple module of the BODY Q scale compared with those who underwent the traditional method, while the chest module BODY Q scores did not differ between the two groups (Bustos et al., 2020). Another study compared the traditional Norfolk method of coronoplasty for phalloplasty with a novel technique and found that patients who had undergone the novel technique of coronoplasty rated their results as significantly more acceptable than those who underwent the traditional technique (Akhoondinasab et al., 2020).

Similarly to the studies comparing traditional and novel surgery methods, one study explored transgender men’s experiences of the ZSI 475 FtM erectile prosthesis (Neuville et al., 2019). As those electing for an erectile prosthesis after phalloplasty often need to have this replaced after a number of years, several participants had previously had a different erectile prosthesis prior to the ZSI 475 FtM. 75% of participants who had previously had a different prosthesis reported that that the ZSI 475 FtM was “better” or “a lot better” than their previous prosthesis, citing reasons such as better stability of the prosthesis, a harder glans and reduced inopportune deflation (Neuville et al., 2019).

Two studies in the review compared methods of voice feminization. One compared patients who underwent cricothyroid approximation with patients who underwent glottoplasty (Kelly et al., 2019). The authors found that those who underwent glottoplasty experienced significant increases in being perceived as female, as well as significantly higher satisfaction with voice from baseline to post-op, whereas those who underwent cricothyroid approximation did not experience either of these (Kelly et al., 2019). In addition to this, those who underwent cricothyroid approximation rated their voice as “rough or hoarse in general” significantly higher than those who underwent glottoplasty (Kelly et al., 2019).

Another study compared voice therapy alone with voice therapy and glottoplasty, and found that, while both groups had a significant increase in in Voice Handicap Index-10 (VHI-10) scores, only those who had also undergone glottoplasty had a significant increase in Trans Woman Voice Questionnaire (TWVQ) scores (Brown et al., 2021). In addition to this, the group that also underwent glottoplasty had a significantly greater improvement in TWVQ and VHI-10 scores compared with those who had only had voice therapy (Brown et al., 2021). The findings from both studies suggest that glottoplasty offers the best outcomes for transgender women and non-binary people seeking gender affirming voice treatments. It is interesting to note however, that in the study exploring glottoplasty and voice therapy, those who later underwent glottoplasty had significantly worse VHI-10 scores compared to those who did not undergo glottoplasty (Brown et al., 2021).

Surgical complications also appear to impact patient wellbeing, with patients who did not experience any long-term surgical complications reporting significantly improved quality of life, self-esteem, feelings of completeness, improved intimate relationships and improved work-life balance (Khoosal et al., 2011). This may be because concentric circular mastectomies more frequently required secondary corrective surgeries, which may have led to more negative patient experiences (van de Grift et al., 2017b). Expectations of complications may also affect decisions around what treatments patients seek. In a sample of trans men, 59% of those who had not undergone phalloplasty reported that fear of complications was one reason for not seeking this surgery (McNichols et al., 2020). While the above studies investigated experiences of undergoing regulated treatments, one study in the review explored experiences of transgender individuals undergoing unsupervised silicone injections and found that patients often reported side effects including liver and kidney damage, skin infections and abscesses, suggesting that such treatments lead to more negative experiences (Nemoto et al., 2005).

It is beneficial to consider how different treatment options and methods may have different outcomes, as HCPs can learn from these figures and begin to offer different techniques and methods in order to increase patient satisfaction and reduce complications. It is also beneficial for patients seeking gender affirming care to learn about how different treatment types are associated with different outcomes. It may be useful for HCPs offering various types of treatments to present this information to their patients in order to assist their decision around what treatment type they wish to undergo. The majority of the findings here focus on surgical techniques. However, as there are various delivery methods for GAHT, it may also be useful for HCPs to provide information about differences between these to their patients.

3.4.3 The Role of Psychological Factors

Psychological factors were found to predict treatment experiences in just four studies reviewed. In a study (Agarwal et al., 2018) on mastectomy outcomes for transgender men, researchers found that while overall body image significantly improved after mastectomy, participants with pre-existing mental health conditions had a poorer body image before undergoing surgery, and a greater improvement in body image from pre-op to post- op. Conversely, a study (Van De Grift et al., 2017a) on various gender affirming treatments found that high body dissatisfaction at clinical admission predicted consistent body dissatisfaction and lower psychological functioning at follow up.

Psychological factors also influenced interactions with HCPs. For example, those with higher levels of anxiety reported significantly higher levels of worry about discrimination from a range of HCPs including pharmacists, primary care practitioners and transgender health specialists (Lewis et al., 2019). Similarly, mental wellbeing was associated with experiences with general practitioners (GPs), with moderate positive relationships emerging between mental wellbeing and (1) feeling greater comfort with GPs and (2) feeling respected by GPs (Riggs et al., 2014).

Meanwhile participants in another study discussed the struggle of balancing communicating the distress of gender dysphoria with not wanting to be perceived as too distressed to receive treatment (MacKinnon et al., 2020). One participant reported feeling that HCPs did not think she was ready for surgery as she was experiencing suicidal ideation and had to insist that she was receiving therapy for this in order to access surgery (MacKinnon et al., 2020). Meanwhile, in another study, one participant reported that a HCP was sceptical of her identity and gender dysphoria because the patient “did not look suicidal” (Willis et al., 2020).

The findings of these studies suggest that it is important to ensure that the mental health of those undergoing GAH is monitored and that patients are provided with adequate mental health supports as they undergo medical transition. As these studies focus mainly on general mental wellbeing, stress and anxiety, it may be useful for future research to explore how transgender patients with less common mental health issues such as schizophrenia and personality disorders experience accessing healthcare.

3.4.4 The Role of Healthcare Interactions

The most commonly investigated set of factors in the review were healthcare interactions, which were explored in 22 studies. These are discussed according to a number of different subcategories below.

Positive Interactions

Several studies explored aspects of HCP interactions that patients felt were positive. For example, patients noted that they appreciated when their chosen name and correct pronouns were used by HCPs and receptionists in primary care centres (Bell & Purkey, 2019). HCPs sometimes took steps to promote a positive experience among their transgender patients, such as asking patients how they preferred to be referred to (von Vogelsang et al., 2016).

Patients used various words to describe the HCPs who they felt they had positive relationships with, including “friendly”, “relaxed”, “professional”, “knowledgeable”, “humane” and “caring” (Riggs et al., 2014; Speer & McPhillips, 2013). The importance of communication was highlighted in several studies, with participants explaining that they appreciated when HCPs listened to them, allowed them to talk about aspects of their life separate from their transition, explained why assessments were conducted, and answered questions (von Vogelsang et al., 2016; Speer & McPhillips, 2013). Other aspects of HCP interactions that participants felt were positive included when HCPs put nervous patients at ease, validated non-binary gender identities, ensured patience privacy and did not delay access to surgery (von Vogelsang et al., 2016; Speer & McPhillips, 2013; Frohard-Dourlent et al., 2020). The importance of HCP interactions could particularly be seen in one study, where one participant discussed how he initially did not trust HCPs due to a past negative experience, but regained his trust following a positive experience with another HCP (Willis et al., 2020). Furthermore, despite assessments being seen as a primarily negative aspect of GAH, some patients viewed them as helpful spaces to discuss the risks and benefits of treatment (Frohard-Dourlent et al., 2020).

Negative Interactions

Despite these positive experiences, negative experiences were more prevalent throughout the studies reviewed. When describing HCPs that they had negative interactions with, participants used words such as “aggressive” and “dismissive” (Speer & McPhillips, 2013). Negative interactions were frequently reported as the opposite of positive interactions, such as HCPs who used the incorrect name or pronouns to refer to patients, rushing patients, not explaining the rationale behind assessments, and not taking the time to answer questions (von Vogelsang et al., 2016; Bell & Purkey, 2019; Speer & McPhillips, 2013; Meyer et al., 2020). Participants also disliked HCPs who they perceived as “gatekeeping” treatment, who made patients wait longer or take lower doses of HRT, who made patients show parts of their bodies when not relevant, and who they felt asked “ridiculous or offensive” questions during assessments (Riggs et al., 2014; Bell & Purkey, 2019; Speer & McPhillips, 2013; Frohard-Dourlent et al., 2020; Meyer et al., 2020). Further examples of specific negative experiences are provided below.

Dependence on HCPs

Participants across the various studies frequently discussed the idea of feeling dependent on HCPs (von Vogelsang et al., 2016; Linander et al., 2017). Patients perceived HCPs deciding whether they could access care negatively and felt that assessments were a way of “gatekeeping” healthcare, with HCPs who required two assessments seen as excessive (Frohard-Dourlent et al., 2020).

Patients often felt like they had to present a certain way in order to access GAH, such as wearing certain clothes to appease HCPs, often fearing that treatment would be revoked if they did not present in a way that they thought HCPs approved of (von Vogelsang et al., 2016; Bell & Purkey, 2019; Speer & McPhillips, 2013). In some cases, patients were criticized if HCPs felt they did not try hard enough to “pass” as the gender they identified as, or in one case when a patient’s chosen name was not seen as feminine enough (Willis et al., 2020; Speer & McPhillips, 2013). Participants also felt a need to provide a specific narrative to HCPs, and often sought advice on what to say from support groups who would provide a “script” of what to say and hold practice interviews (Bell & Purkey, 2019). Feeling dependent on HCPs had implications for how patients engaged with health services, with 3 participants in one study noting that although they had considered seeking GAH, they decided not to pursue this partially due to feelings of dependence on HCPs (Linander et al., 2017).

Lack of Knowledge Among HCPs

Another prevalent issue across various studies was a lack of knowledge about transgender people and GAH among HCPs (von Vogelsang et al., 2016; Mohamed & Hunter, 2019; Bell & Purkey, 2019; Meyer et al., 2020). Examples of this included ignorance surrounding transgender identities, such as one lesbian transgender woman who was asked “wouldn’t it be easier if you continued to be a guy?” (von Vogelsang et al., 2016), a lack of knowledge about funding options for surgery (Willis et al., 2020), specific issues such as pregnancy among transgender men (Linander et al., 2017) and even sometimes around treatments themselves, with one patient reporting that they were given the incorrect dose of

GAHT and had to seek care elsewhere (Garcia & Crosby, 2020). Some patients turned to self-medication due to a lack of knowledge among HCPs (Nemoto et al., 2005), while others sought information about GAH online and from support groups (Bell & Purkey, 2019; Linander et al., 2017; Lykens et al., 2018; Radix et al., 2014). One study found that because there are no transgender specialists in Nepal, patients often relied on friends and the internet for information about GAH (Regmi et al., 2019).

Sometimes, information from others impacted patient expectations of HCP interactions, with some participants in one study mentioning that they felt hesitant to seek care due to hearing about other peoples' negative experiences of HCP interactions (Radix et al., 2014). Participants in another study reported avoiding healthcare due to a lack of transgender specialists, with one stating that they would "rather die than go for a check-up" (Regmi et al., 2019).

Seeking knowledge elsewhere also came with challenges. Information was not always readily available on some topics. For example, the process of assessment was viewed as complicated, with patients reporting that there is a lack of information around how to navigate this process (Frohard-Dourlent et al., 2020). Meanwhile, those self-medicating struggled to find information about safer methods of injecting silicone (Radix et al., 2014). They also noted that HCPs were sometimes critical of self-medication, which they perceived negatively (Speer & McPhillips, 2013).

HCPs themselves did not always provide detailed information, with participants of one study reporting that HCPs did not explain the available treatment options to them (Harrison et al., 2020). Despite a general lack of knowledge among HCPs, many were happy to be educated and learn about transgender issues, which was seen as a positive by patients (Willis et al., 2020; Meyer et al., 2020). Much of this education came from patients themselves, with 71.2% of one sample reporting having educated a HCP on transgender healthcare (Lewis et al., 2019) and several other studies finding this to be a common theme (Willis et al., 2020; Garcia & Crosby, 2020; Bell & Purkey, 2019). Participants in one study described having to educate their HCPs on their health needs as “exhausting” and “frustrating” (Bell & Purkey, 2019).

Participants perceived different HCPs as having differing levels of competency when it came to providing gender affirming care. One study found that 52.5% of the sample viewed pharmacists as having little/no competency in providing gender affirming care, 40.4% viewed primary care practitioners as having little/no competency in providing gender affirming care, with only 1.5% viewing transgender specialists as having little/no competency in providing gender affirming care (Lewis et al., 2019). While it is promising that this percentage decreases for those working more directly with transgender patients, it is interesting to note that another study found that while assessors play a role in determining access to surgeries, patients felt that these HCPs were less knowledgeable than their regular HCPs and less competent in determining eligibility for surgery as they spend less time with each patient (Frohard-Dourlent et al., 2020). In one case, a patient attended five sessions with a therapist who could not diagnose her with gender dysphoria and had to seek care elsewhere (Garcia & Crosby, 2020). In another study, one individual had sought care from 42 HCPs before he found one who was willing to treat him (Pang et al., 2019).

Disclosing one’s transgender identity often shaped interactions with HCPs. This was not always a choice made by the patient. One transgender woman often had to “out” herself at regular doctors’ appointments by explaining that she does not have periods (Meyer et al., 2020). Another patient was effectively “outed” by their HCP who loudly discussed their name change while other patients in the waiting room could hear the conversation (Meyer et al., 2020). Sometimes, HCPs did not keep this information private, for example in one case where a patient reported overhearing a HCP discussing his transgender identity with a colleague and laughing (Meyer et al., 2020). HCPs who knew of patients' transgender identities also often assumed that any mental or physical health issues were related to the patient being transgender or receiving GAHT (Friley & Venetis, 2021). In one case, a patient's transgender identity was brought up unnecessarily during an appointment for asthma (Radix et al., 2014). HCPs sometimes changed how they interacted with patients as they underwent GAH, with one patient reporting that a nurse they had previously attended became "difficult" with them once they had undergone surgery (Willis et al., 2020).

In spite of the above, not all studies found interactions with HCPs to effect mental wellbeing. For example, one study (Ho & Mussap, 2017) found that satisfaction with HCPs and the Standards of Care were not correlated with the Steps to Transition Scale (STT), Transgender Congruence Scale (TCS), Rosenberg Self-Esteem Scale (RSES) or the 21-item short form version of the Depression, Anxiety and Stress Scale (DASS-21) (Coleman et al., 2012).

Waiting Times

Waiting times emerged as a barrier to care in four studies. HCPs often made patients wait long periods before starting GAHT or undergoing surgery in order for patients to be sure of their identity, and sometimes started them on lower doses of GAHT at the beginning, with many patients reporting that they felt the waiting times were unnecessary (Meyer et al., 2020). One patient reported that she had been waiting for four years to access GAH at the time of the study and explained that the wait had had a negative effect on her mental health (Harrison et al., 2020). Participants in this study felt that gender clinics did not offer mental health supports to those waiting to receive treatment, despite the wait and gender dysphoria causing patients distress (Harrison et al., 2020). Participants reported frustration at the lack of communication from gender clinics in relation to waiting times and expressed concern that they would be forgotten about on the waiting lists (Frohard-Dourlent et al., 2020; Harrison et al., 2020). One study ran a pilot clinic in a primary care centre offering GAHT to transgender patients, and one of the factors that patients reported as a benefit of this was the shorter waiting times for the clinic as opposed to hospitals (Ker et al., 2020).

Concerns/Fears Regarding Healthcare Interactions

In addition to experiences of healthcare interactions, some studies explored expectations of these, with many finding that participants often had specific concerns or fears regarding healthcare interactions. Often these concerns were related to fear of discrimination. For example, of those reporting barriers to accessing hair removal services, 36% reported anxiety/fear around seeking this service (Bradford et al., 2019). Meanwhile, another study assessed concern about discrimination from various types of HCPs. This study found that 41.6% of the sample reported some/a lot of worry about discrimination from pharmacists, 54.6% reported some/a lot of worry about discrimination from primary care practitioners, and 11.8% reported some/a lot of worry about discrimination from transgender specialists (Lewis et al., 2019).

Anxiety around being assessed for treatment by HCPs was also prevalent across a number of studies, with participants of one study describing the process of assessment as "nerve wracking" and "panic inducing" and reported a fear of being denied for surgery (Frohard-Dourlent et al., 2020). They also reported feeling as though they had to fit a "script" of what HCPs "wanted to hear" in order to be approved for surgery, often omitting certain details and feeling that they could not be honest with HCPs (Frohard-Dourlent et al., 2020; MacKinnon et al., 2020). Participants also feared that expressing any uncertainty about their identity would prevent them from receiving GAH (MacKinnon et al., 2020).

Healthcare Settings

Finally, a number of studies in the review found that healthcare settings also played a role in shaping experiences. A study (Hughto et al., 2018) exploring the experiences of transgender women who had been incarcerated in male prisons, found many of these participants reported negative experiences. One of the most frequently cited issues was a difficulty accessing GAHT, with some participants reporting difficulty providing documentation to show that they had previously been on GAHT, and others reporting that they were given lower doses of GAHT in prison. Some participants also reported negative experiences with prison HCPs, such as one participant who was frequently misgendered by a mental health counsellor and compared the experience as similar to conversion therapy, as well as another participant who was told by a nurse “you’re not a girl, you’re a he” (Hughto et al., 2018). In order to navigate healthcare in prison, participants would often go to specific HCPs who they knew were supportive of transgender patients (Hughto et al., 2018).

Another study (Khoosal et al., 2011) found significant differences between those who had surgery in private and public settings, with private settings associated with significantly more surgical and nursing support as well as significantly higher quality of life than in public settings. One study exploring satisfaction with HCPs involved in delivering GAH found that patient satisfaction with psychiatrists was lower than patient satisfaction with other HCPs, including psychologists, GPs, and surgeons (Ho & Mussap, 2017). The reason for this was not explored, however as much of the above negative experiences centre around the assessment process with psychiatrists, it could be the case that these HCPs are perceived more negatively by transgender patients because of their role in this process.

Participants felt that signposts of support for LGBT patients in clinics created a positive experience (Meyer et al., 2020). Meanwhile, another study found that patients preferred to receive GAHT in a primary care clinic as this setting was “familiar” and they had already established a relationship with the HCPs there (Ker et al., 2020). The participants in this study felt that the hospital was “intimidating” and a “bigger deal” than primary care settings and felt that staff in the hospital were “gatekeeping” rather than “supporters” like the staff in the primary care centre (Ker et al., 2020).

The above findings could be used to educate HCPs in order to promote positive healthcare interactions and minimize negative healthcare interactions. HCPs could be educated on varying transgender identities and needs. Specific ideas suggested by participants, such as signposting support of LGBT identities in clinics could be implemented in order to improve the patient and provider relationship. In addition to this, as many of the findings above arose from discussions with transgender patients, it may be useful for HCPs wishing to improve experiences of healthcare for their transgender patients to create a committee of patients who can provide feedback about what could improve in primary care centres and hospitals as well as ways HCPs and their transgender patients can build more positive relationships. As waiting times arose as an issue, it may also be useful to provide support for those awaiting care, either in the form of support groups and helplines, as well as advice on what non-medical aspects of transition (e.g. social or legal) patients can focus on while they wait to access care.

Table 3.2: Systematic Review Findings

Theme	**Specific factor**	**Studies finding an effect**	**Studies not finding an effect**
The Role of Socio-demographic Factors	Gender identity/assigned sex at birth	• Likelihood to have undergone surgery differed by assigned sex at birth, with AMAB more likely to have undergone surgery than AFAB participants (Riggs et al., 2014) • Sex assigned at birth affected how patients perceived experiences: AFAB patients rated experiences with HCPs more poorly than AMAB patients (Riggs et al., 2014) • Non-binary patients reported specific barriers that they felt were not experienced by binary patients (Lykens et al., 2018) • Trans women reported significant improvements in support and relationship quality following surgeries while trans men did not (Khoosal et al., 2011)	• Van de Grift et al. (2017a) found that assigned sex was not predictive of body satisfaction • No correlation between gender identity and BUT-A GS and BREAST-Q scores (Agarwal et al., 2018)
	Age	• One participant recalled being refused gender affirming healthcare when at 16 years old due to HCPs feeling that they were too young to be sure of their gender identity (von Vogelsang et al., 2016) • Older age predicted greater improvements in body image post mastectomy in transgender men (van de Grift et al., 2016). • Patients who underwent surgery before 30 years old reported significant satisfaction (Khoosal et al., 2011)	• Van de Grift et al. (2017a) found that age was not predictive of body satisfaction • No correlation between age and BUT-A GS and BREAST-Q scores (Agarwal et al., 2018)
	Other	• Lower BMI and larger breast size predicted greater improvements in body image after mastectomy in trans men (van de Grift et al., 2016).	• No significant correlation between sexual orientation, gender identity, education level, employment status, or income and BUT-A GSI and BREAST-Q scores (Agarwal et al., 2018)

Theme	**Specific factor**	**Studies finding an effect**	**Studies not finding an effect**

The Role of Treatment-related Factors	Complications	• Patients who did not experience any long-term surgical complications reported significantly improved quality of life, self-esteem, feelings of completeness, improved intimate relationships andimproved work life (Khoosal et al., 2011)	• N/A
	Number of procedures	• Owen-Smith et al. (2018) found that those who had undergone more treatments had lower anxiety and depression and higher comfort with one's body • Proportion of low Transgender Congruence Scale (TCS) scores were almost four times higher in the"no treatment" category compared with the "HRT and definitive bottom surgery" category • Depression and anxiety were higher in no/few treatment groups • Body-gender congruence and body image satisfaction were higher in groups with more treatments	• N/A
	Type of procedure	• Van de Grift et al. (2017b) explored mastectomy in transgender men by comparing concentric circular method and inframammary skin resection with free nipple grafts and found that the inframammary skin resection with free nipple grafts group was significantly more satisfied on most aspects of the chest compared with the concentric circular group	• N/A
The Role of Psychological Factors	Mental Wellbeing	• Trans men with pre-existing mental health conditions had on average poorer body image before undergoing mastectomy and a greater improvement in body image from pre-op to post-op (Agarwal et al., 2018)	
The Role of Healthcare Interactions	Positive interactions	• Participants liked HCPs who were "friendly", "relaxed" and answered their questions (Speer & McPhillips, 2012) • Participants appreciated when their chosen name was used by HCPs (Bell & Purkey, 2019)	• Satisfaction with standards of care and satisfaction with HCPs not correlated with STT, TCS, RSES, or DASS-21 (Ho & Mussap, 2016)

Theme	Specific factor	Studies finding an effect	Studies not finding an effect
		• Participants reported liking HCPs who “knowledgeable” and “caring” (Riggs et al., 2014) • Participants appreciated when the rationale behind assessments was explained, being treated as individuals, being listened to, having privacy during HCP interactions, being put at ease when they were nervous, not having surgeries delayed and not having their lifestyles overly questioned (von Vogelsang et al., 2016) • HCPs occasionally took steps to create a more positive experience for patients, such as asking how they would like to be referred as (von Vogelsang et al., 2016) • Moderate positive relationships were found between mental wellbeing and (1) feeling comfortable with GPs, and (2) feeling respected by GPs (Riggs et al., 2014)	
	Negative interactions	• Participants perceived experiences where HCPs used the incorrect name as negative (Bell & Purkey, 2019) • Participant reported being criticized for not trying hard enough to “pass” as female (Speer & McPhillips, 2012) • Participants disliked HCPs who were “gatekeeping” and “asked ridiculous or offensive questions" (Riggs et al., 2014) • Participants reported feeling pressure to present in a certain way to access treatment or avoid having treatment revoked (Bell & Purkey, 2019; von Vogelsang et al., 2016) • Participants disliked HCPs who were “rude”, “aggressive” and rushed patients (Speer & McPhillips, 2012) • Participants reported feeling dependent on HCPs, leading three participants to avoid seeking care (Linander et al., 2016) • Participants disliked being referred to by the incorrect name and pronouns, being asked irrelevant questions and not having the rationale for assessments explained to them (von Vogelsang et al., 2016)	N/A

Theme	**Specific factor**	**Studies finding an effect**	**Studies not finding an effect**
		• One lesbian transgender woman disliked being asked “wouldn’t it be easier if you continued to be a guy?” by a HCP (von Vogelsang et al., 2016) • One participant’s trans status was brought up by a HCP when the participant felt this was not relevant as they had sought care for asthma (Radix et al., 2014) • Participants reported negative experiences with HCPs who would use the incorrect pronouns when speaking to patients and reported seeking specific HCPs that they knew were supportive of transgender patients (Hughto et al., 2018)	
	Lack of knowledge	• Patients reported self-medicating due to a lack of knowledge among HCPs (Nemoto et al., 2008) • Patients felt that HCPs lacked knowledge around specific issues such as pregnancy in transgender men and often turned to the internet and other transgender people for information and support (Linander et al., 2016) • Participants often reported turning to support groups for information instead of HCPs due to a lack of knowledge among HCPs (Bell & Purkey, 2019; Lykens et al., 2018; Radix et al., 2014) • Participants sometimes hesitant to seek care after hearing about negative experiences of other transgender people (Radix et al., 2014) • Patients occasionally avoided preventative care* due to previous instances where there was a lack of knowledge among HCPs (Bell & Purkey, 2019) • Patients reported struggling to find information on silicone injection safety (Radix et al., 2014) • Participants in Van Vogelsang et al. (2016) reported a lack of knowledge among HCPs	N/A

Theme	Specific factor	Studies finding an effect	Studies not finding an effect
	Healthcare settings	• Transgender women who had been incarcerated in male prisons experienced difficulties accessing HRT in prison, as the prison required documentation that stated the patient had been on HRT prior to being incarcerated. This was a barrier for those who had been self-medicating as well as one participant who did not have paperwork to show this due to homelessness (Hughto et al., 2018) • Participants in the Hughto et al. (2018) study also reported that they were given lower doses of HRT than they required • Incarcerated participants often stopped taking HRT in order to avoid having to be openly transgender in prison to avoid discrimination (Hughto et al., 2018) • Khoosal et al. (2011) found that experiences of surgery differed between private and public settings, with those who had surgery in private settings reporting significantly more surgical and nursing support, as well as significantly higher quality of life than those who had surgery in public settings • Ho and Mussap (2017) explored satisfaction with different HCPs and found that psychiatrists were rated the lowest (lower than psychologists, GPs, and surgeons) • Participants did not feel represented in healthcare literature (Radix et al., 2014)	N/A

**type of preventative care was not specified by the authors*

3.5 Discussion

This review aimed to explore the factors that influence patient experiences of GAH. The studies reviewed explored a range of different influences on these experiences, with findings also highlighting the complex processes involved in receiving GAH. There was strong evidence to suggest the role of interactions with HCPs as determinants of both positive and negative experience, with some suggestion that sociodemographic factors may also influence this. Only a handful of studies explored the roles of treatment type and psychological factors on patient experience, suggesting that further study on these themes is required in order to draw more fulsome conclusions. Taken together, these findings could be informative for those aiming to improve healthcare experiences and outcomes for transgender patients.

The finding that demographics may play a role in how patients experience GAH suggests that identifying as transgender is not the only factor to influence experiences of GAH. Differing demographics of transgender patients have unique needs, such as non-binary patients who report that their identities are often erased in GAH settings. Differences in how transgender men and women rated their satisfaction with psychiatrists also illustrates how gender identity affects experiences of healthcare (Lykens et al., 2018; Riggs et al., 2014). Those from ethnic minorities may also be at risk of negative experiences, (Nemoto et al., 2005) although less research has examined this to date. Treatment also appeared to differ depending on gender identity, with one study (Van De Grift et al., 2017a) finding that most transgender women underwent genital surgery and most transgender men underwent chest surgery. This may influence the experiences of patients, as more invasive surgeries may lead to different satisfaction rates or changes in body image. As one study (Owen-Smith et al., 2018) found that those undergoing more forms of treatment tend to report positive outcomes, the number of treatments undergone may also play a role in satisfaction.

Financial factors also shaped healthcare experiences, with cost acting as a barrier in some cases (McNichols et al., 2020; Bradford et al., 2019), and additional costs arising in some instances, such as in the form of travel costs for those living in rural areas, as well as having to pay for assessments in order to access surgery (Frohard-Dourlent et al., 2020; Willis et al., 2020). However, not all studies that investigated the role of sociodemographic factors found an effect, suggesting that there are other factors at play in determining patient experience.

Psychological factors emerged as possible influences on outcomes and experiences in three of the studies reviewed (Riggs et al., 2014; Van De Grift et al., 2017a; Agarwal et al., 2018). This suggests that it may be worthwhile for HCPs to assess patients' mental wellbeing before they undergo treatment in order to manage expectations of treatment. For example, as experiences differed depending on the type of procedure participants underwent, it may be of important for HCPs to inform their patients of complication and satisfaction rates for each procedure in order to manage expectations and involve the patient in the decision-making process (Khoosal et al., 2011; Owen-Smith et al., 2018; van de Grift et al., 2017b).

A clear finding from the review is that interactions with HCPs strongly influenced whether patients perceived their experiences of GAH as positive or negative, with specific actions taken by HCPs linked to patient experience in a number of studies (Riggs et al., 2014; Khoosal et al., 2011; von Vogelsang et al., 2016; Hughto et al., 2018). Actions viewed in a positive way, such as affirming patients' gender identity through the correct use of names and pronouns, could be used to inform the development of guidelines for HCPs working with transgender individuals undergoing GAH. Lack of knowledge among HCPs also emerged as a theme to negatively impact patient experience, which is in line with the findings of a previous review (Heng et al., 2018), suggesting that this is a wider problem for transgender patients in healthcare settings. However, it is significant and perhaps surprising that lack of knowledge about transgender identities emerged as a theme among those providing healthcare specifically for transgender patients. This implies that such HCPs need to be better informed regarding transgender issues and consider the impact that this has on their patients.

Many participants in the studies reviewed reported turning to the internet and other transgender people as information sources when their HCPs could not provide this (Lykens et al., 2018; Bell & Purkey, 2019; Linander et al., 2017; Radix et al., 2014). It is clear from this review that there are a number of things that HCPs can do in order to provide better care for these patients. Aside from a clear need to promote a positive and non-judgemental environment during consultations, enhanced education for HCPs will better prepare them to provide information to their patients undergoing GAH.

3.6 Limitations

One limitation with this review was that it focused only on published material and could have missed differing perspectives from non-published material such as non-peer reviewed reports, including dissertations or conference abstracts. Although the quality of included studies was high, many of the studies were investigated in the USA and may not be generalizable to other contexts. In addition to this, different countries differ in their treatment pathways and options for GAH. Search terms could also have failed to include all available literature. Also, only seven studies involved a longitudinal design which makes it difficult to draw conclusions surrounding the causal factors in patient experiences.

It is also notable that non-binary participants were underrepresented in the included studies with only one study focusing exclusively on non-binary experiences and studies with varied transgender identities having only a small number of non-binary participants. In addition to this, the Utrecht scale used in one study (Van De Grift et al., 2017a) is designed for binary transgender males and females, meaning that the validity of responses from nonbinary participants is questionable (Arnoldussen et al., 2020). A newer version of the scale has since been designed and should be used when conducting research with non-binary participants in future (McGuire et al., 2020).

Further research into experiences of GAH should aim to have a diverse sample to explore the needs of specific samples within the transgender population as well as those with intersecting marginalized identities.

3.7 Conclusion

This study addressed a gap in the literature and provides a valuable insight into how transgender patients experience GAH and the factors that influence these experiences. In this review, transgender patients were shown to have a wide range of experiences in relation to GAH, with several factors influencing these experiences. These factors should be taken into consideration when providing GAH in order to promote positive healthcare experiences among transgender patients. In the next chapter, the findings of Study 2 will be discussed.

Chapter 4: Qualitative Study Results

This chapter will discuss the results of the qualitative study and the themes that emerged from the interviews.

4.1 Participant Characteristics

Participants were 10 transgender people living in Ireland. Of these, four identified as transgender men, four identified as transgender women, one identified as transmasculine and one identified as both a trans man and non-binary. The last two participants were broadly categorized as non-binary as they did not identify as completely male or female. Ages ranged from 18 to 62, with transgender women generally being older (M= 40.25) than transgender men (M= 23.5) and non-binary participants (M= 26). Participants were living in five different counties, with five participants living in Dublin, with the other five dispersed across the country.

Stage of medical transition varied between participants, with eight participants awaiting some form of gender affirming healthcare and eight participants having undergone some form of gender affirming healthcare. Aside from assessment, the most common form of healthcare undergone was GAHT (n=5), with two men having undergone surgery. Six participants were awaiting GAHT, and seven were awaiting various forms of surgery. An overview of participant demographics can be seen in Table 4.1.

Table 4.1: Participant demographics

Pseudonym	**Age**	**Gender Identity**	**Location**	**Healthcare Undergone**	**Healthcare Awaiting**
Jake*	19	Transgender man	Dublin	Assessment Top surgery HRT (3 years)	None
Cameron*	22	Transgender man/non-binary	Cork	Assessment	HRT Top surgery
Alex*	30	Transmasculine	Cork	Assessment HRT (2 years)	Top surgery
Luke*	22	Transgender man	Limerick	Assessment	HRT Top surgery

Sharon*	47	Transgender woman	Meath	Self-medicating with HRT (1.5 years)	Assessment, Facial and body feminization surgeries, top surgery, bottom surgery
Alison*	18	Transgender woman	Kildare	Assessment	HRT Speech therapy
Sarah*	62	Transgender woman	Dublin	None	Assessment, HRT, top surgery
Michael*	21	Transgender man	Dublin	None	Assessment, HRT, top surgery, bottom surgery
Andris*	32	Transgender man	Dublin	Assessment, HRT (11 years), top surgery, revision for top surgery, hysterectomy	None
Róisín*	34	Transgender woman	Dublin	Assessment, HRT (1.5 years)	Bottom surgery

**Not participants' real names*

4.2 Themes

Five themes were identified from the data which centred around expectations and experiences of gender affirming healthcare, as well as barriers to accessing this care and sourcing information on gender affirming healthcare. An overview of these themes and subthemes is shown in Figure 4.1. The themes identified address objective two of the project by exploring the expectations and experiences of gender affirming healthcare.

4.3 Theme 1: The Importance of Socio-Cultural Context

Some participants (n= 3) emphasised their socio-cultural context as a key influence on their experiences of being transgender, with many (n = 9) referring to the importance of social support.

4.3.1 Being Transgender in a Different Era

A number of older participants discussed how society's understanding and acceptance of transgender people differed during the 1960s-1990s and how this impacted their experience of coming to terms with being transgender as well as whether or not they chose to come out.

Sarah, a transgender woman who was 62 years old at the time of the interview explained: *"There was a whole era of people…who couldn't come out".* Sharon, another transgender woman in her late 40s explained that there was a lack of knowledge about transgender identities: *"there was no name for it back then",* and went on to discuss the first time she learned about transgender people, which was from a newspaper article in 1985: *"I was working a summer job in a male orientated factory and they were all around it [newspaper article] going "aw look at the state of that" "freak" and all, and I just went quiet…because I was just looking at it going "oh my God, there's hope for me"".* Although seeing the possibility of medical transition gave Sharon hope, she remained closeted due to the context of Ireland in the 1970s and 1980s: *"I lived a lie all my life, that's because I lived through the 1970s and 80s".*

Society's views of transgender people had a similar influence on Sarah, who has only recently begun to come out to her family: *"I thought I was wrong. I mean you do have to*

think of the era as well". She explained that this was true for many others at this time: *"if I was to come out in the late sixties what would have happened?"* She also noted that while some people did come out during the 1960s, it was uncommon: *"for each one of them there's probably a hundred who didn't".* She also explained the implications of being unable to come out as transgender: *"the cost to not dealing with it, it is whether you like it or not, loss of life in cases. Or destroyed lives from drugs and alcohol".*

Róisín, a 34-year-old transgender woman provided an insight into attitudes towards transgender people during the 1990s, recounting how she overheard a radio conversation during the 1990s about Lydia Foy, an Irish transgender woman who fought to be legally recognised as female: *"I was like "that's a thing? We can do that?" so I turned to my mam, [sighs] and I say… "oh what's a transsexual?"* and she says, *"oh that's a person who's rejected the body God gave them".* Róisín explained the influence this had on her, and how she came out later in life as a result: *"at that point I was still incredibly religious… for me that was the difference between me coming out at 12 or 13, and me coming out at 30".*

4.3.2 Growing Support and Acceptance of Transgender People

Many of the participants in this study who came out in more recent years reported being supported in their gender identity.

Sarah discussed how support had become more available for her since she first realised that she was transgender: *"the difference for me now is where I tried to deal with this before I had no support, nothing…now I'll get through this because I have my counsellors, I have my doctor, I have the two or three groups that I'm in. I've got Facebook support from you know the few people that know me".* She has recently come out to her five children, and they were supportive of her identity: *"my five kids are fine. One of them… has a lot of LGBT friends".* She also noted that she felt more comfortable to try dresses on in shops: *"now so many places are trans friendly and I have no problem now in in shops asking can I try a dress on".*

4.3.3 The Importance of Social Support

Many (n = 4) of the younger participants felt accepted by their families and friends upon coming out. Jake, a 19-year-old transgender man came out to his parents as a young teenager: "*even if it took them a little bit of time to get on board with some stuff…my parents were very willing to notify other members of my family, so that I didn't have to".* They also financially supported his medical transition: *"it was a fortunate situation where my parents could afford to bring me abroad to have surgery".* His school was also *"very supportive"* of his identity: *"even though I did have some hiccups and issues here and there, they were overall very like, facilitating and very willing to help".* However, he stressed that his experience was *"a lot easier than the vast majority of people".*

Alison, an 18-year-old transgender woman was also supported by her family: "*they* *are extremely supportive and are really helping to push, like not push me but push for me to get to these stages".* She also discussed having supportive friends: *"a lot of my friends are in the LGBTI+ community and…they've been amazing".* Like Jake, she acknowledged that this is not the case for everyone: "*I'm kind of lucky in that regard because I know people who aren't".* Sharon explained that her friend group were supportive of her identity: *"I do have a big group of friends"* She explained that she had *"not lost any friends",* but that *"the lads don't call around like they used to".*

Michael, a 21-year-old transgender man was also supported by his family: *"my parents are really supportive… my brother has been really great about it".* He was in his first year of university at the time of his interview and discussed receiving support from his peers and lecturers: *"I've had a really positive experience in college em with classmates and my peers…my lecturers were so supportive as well".* He also explained that meeting other transgender people became a source of support for him: *"One of the most positive parts of coming out was meeting other trans people, developing friendships".*

It appears that support for transgender people in Ireland has grown in recent years, with younger participants reporting positive experiences of coming out as transgender to family and friends. It is important to note however that the three oldest participants were transgender women, while most of the younger participants were transgender men and non-binary people (with the exception of Alison who was an 18-year-old transgender woman). However, as section 4.6 will discuss, all participants faced barriers when attempting to access gender affirming healthcare.

4.4 Theme 2: Difficulties Accessing Information

Patients reported finding information about gender affirming healthcare in a variety of places, but a general theme was a difficulty in accessing reliable information. The three biggest sources of information on gender affirming healthcare discussed were other transgender people (n=8), the internet (n=5), and HCPs (n=2). Responses often highlighted the lack of information provided. The sources of information played a role in shaping participant experiences.

4.4.1 Information from HCPs

Most participants went to their general practitioners (GPs) as the first step in their medical transition. However, although GPs were often supportive of patients' identities, many lacked knowledge around transgender healthcare and were unable to offer information on gender affirming healthcare available to transgender patients, although they often researched options for their patients.

Cameron described his interaction with his GP: "*I was his first trans patient... he didn't know a whole lot about the process, so he wasn't able to tell me anything*". Despite being unaware, Cameron said his GP "*straight away went and was researching...and changed my name and gender in the file".* Cameron appreciated his GP's support but said that he "*just wish[ed] he had been, em kind of more informed about it".* Jake had similar experiences with his GPs: "*both of which have like not had a particularly like, large amount of information but very willing and supportive*". Sarah described her GP as *"exceptional",* explaining how *"my own doctor would say to me "I am not an expert. You're my only trans patient, so I'm going to go find out for you, I'm going to ring [gender clinic]"".* Alex had a different experience with their GP, who *"knew what the pathways were".* They explained: "*I'm not her first patient who's trans, which I think helps, so she's very aware".*

Some participants did not feel that they were adequately informed about the effects of GAHT from HCPs. Róisín explained that she is happy with the changes she has experienced but would like to have been more informed by HCPs: *"it would have been nice to know that going into it".* She explained that some changes were not explained to her, saying *"you can be surprised by some stuff".* Jake also felt that the effects of GAHT were not explained to him in detail, although he notes that this may be due to the fact that he was already aware of these: *"I feel like part of that is because I really did already know…but it wasn't ever explicitly that I recall, said to me".* He also felt that the variability of GAHT was not adequately explained to him: *"nobody ever really said to me that… everybody's experience is going to be different…It was a fine thing to discover on my own, but it would have been potentially helpful before to know".* Alex was disappointed that they were not provided with a timeframe for different effects of GAHT: *"I asked them you know what's the timeline to expect changes on and they weren't able to give me an answer".* Jake felt that patients should be better informed of the effects of GAHT: *"potentially there'd be like a bit more communication from the healthcare professionals that I interacted with about what the actual changes would be. Just to be reassured".*

4.4.2 Information from Other Transgender People

The largest source of information appeared to be from others who had received gender affirming healthcare, with seven participants referencing this as a source of information.

Cameron found himself reliant on word of mouth when seeking an assessment for gender dysphoria after a psychiatrist refused to assess him: "*she couldn't point me towards anybody else who could do it for me".* He also struggled to obtain information about waiting times for the gender clinic and discussed contacting them to find out how long he would have to wait: *"she wasn't really able to tell me anything, so I'm just hoping I'll get a call back".* Discussing how he obtained information, he explained*:* "*it's all word of mouth. That's been like, anyone I've talked to has said all the information they've gotten has been from other people".* This experience was echoed by Luke, who said that the only place he could find information was from other transgender people: "*I only knew about sort of the different steps because I had trans friends who could tell me "these are the different steps"".*

The implications of other patients being a source of information about gender affirming healthcare meant that participants' experiences were often shaped by what they heard about the experiences of others. Participants reported hearing mostly negative experiences from others. Michael discussed hearing about a psychiatrist from others who had been assessed: "*I haven't heard good things…his way of assessment… is very outdated…I've heard he kind of in some cases will make things more difficult… I've also heard that em their questionnaire questions are very invasive and stuff like that".* Meanwhile, Cameron reported hearing about negative experiences with an endocrinologist: *"I've heard that…he's not really that nice".* However, he acknowledged that this may not be representative of everybody's experience: *"maybe whoever told me that just like got him on a bad day in a bad mood".* Cameron also reported hearing that "*they [gender clinic] can be kind of against non-binary people"* and was concerned that his non-binary identity would be a barrier to receiving treatment. He planned not to disclose this part of his identity: *"I don't want to be the kind of person who has to lie to get hormones but… if it's something that comes up I'm going to say that I'm binary".*

Jake also reported hearing about negative experiences with healthcare professionals (HCPs), which influenced his expectations: *"I had been told kind of like what to expect. So, my expectations were low, because what I had been told to expect was quite bad, so I hadn't got high hopes and you know, it pretty much matched up to what I got".*

Sharon, who was currently self-medicating with testosterone blockers and oestrogen was sceptical that she would receive the correct dosage of oestrogen from the gender clinic, as she has *"heard actually that they're giving out too little and a lot of the girls that are going to [gender clinic] get a top up, as in get the contraceptive pill off one of their cis female friends as a top up".*

Participants also reported hearing about negative experiences with a specific HCP. Alex, who is 30 years old and identifies as transmasculine said that they "*heard that [they do]* *good work”,* but that while the surgery results were good, their “*bedside manner isn’t the best”.* They explained hearing that the HCP often misgendered their transgender patients: *“I heard that [they have] a habit of calling [their] patients by female pronouns… you’d think well they’re there for top surgery maybe they’re not using female pronouns”.* This was echoed by Andris, a 32-year-old transgender man, who had been planning to have a revision surgery with this HCP before hearing a friend’s experience: “*he told me that [their] bedside manner isn’t really great, I’ve also heard that [they] misgendered another person who went to see [them] for a consultation…so after I heard that and then my friend’s experience I thought no”.* Andris subsequently travelled abroad to have surgery instead.

This was a common theme among participants, with three participants having undergone treatment abroad and six participants planning to seek treatment abroad. Luke discussed how common it was for people to seek surgery abroad: *“I know in a lot of online groups, people talk about top surgery options in Europe, places like Poland em and I hear more people, or I see more people talking about options outside of Ireland than I do people in Ireland”* Participants often heard more positive experiences from those who went abroad. Cameron hoped to travel to Poland to have surgery and described hearing from a friend who had travelled there: “*I’ve heard such fantastic things. The one person I’ve met who’s on testosterone, has had top surgery- he went there. He said that that guy is lovely”.* Cameron explained that he felt it was easier to find information on going abroad for surgery than seeking GAHT in Ireland: *“it seems like it’s a lot easier to figure out the top surgery thing than it is to figure out how to get on hormones”.*

Jake travelled abroad for his surgery as *“a lot of the people that I knew who had had surgery in Ireland… didn’t have the same kind of body type as me. I’m a heavier person, so I wanted to see results before having surgery from somebody who was a bit more overweight”.* He explained that the surgeon in Ireland *“did not have those kind of results images* *available".* He described how a friend who had a similar build travelled to the US for surgery and was able to discuss his experience: "*not only did I have like, a physical example that I could physically see, of what my results could look like, but it was also from somebody I trusted and somebody… who I knew would be honest with me about his experience, about his results".* Having seen his friend's and others' surgery results, the participant felt confident about how his results would look, and his expectations were met: "*they really matched what I expected. A common review of the surgeon that I went with was that his results are effectively like a cookie cutter."*

4.4.3 Information from the Internet

As discussed in the above section, participants often struggled to obtain reliable information on available gender affirming healthcare in Ireland from healthcare professionals. This led to five participants seeking information online.

Jake explained how he had sought out information on gender affirming healthcare: "*I had done a lot of my own research, I was fairly confident knowing what was going to occur",* while Luke explained that his information came from "*online resources em through close friends who were trans guys em and definitely trans specific spaces online. Actively searching them".* He explained that his reason for seeking information here is because *"I wouldn't have been able to you know, go to my GP, and say I want this, can you tell me about it, can you tell me about what will change? Because I wouldn't expect them to know".*

Some participants found it difficult to obtain information on the medical transition process in Ireland. Cameron recalls *"trying to look online and find the information specifically about hormone replacement therapy in Ireland and all I found was about hormone therapy for menopausal women".* He said that he found *"absolutely nothing for trans people, besides like TENI and stuff".* Alison also struggled to find information about gender affirming care in an Irish context: *"I've found mostly like America or other countries* *like that which is again like I'm not sure if it's relative to here or relevant to here which is frustrating again".*

Many participants felt that relying on the internet for information could have its dangers. Alison discusses her experience: *"there isn't a whole lot of information available within the Irish healthcare system, it's kind of very online which sometimes really could be dangerous looking stuff up because it could be misleading".* Róisín acquired most of her knowledge on gender affirming healthcare online. She says: *"most of it's been online…it's difficult to find a lot of stuff". She explains the difficulty of relying on the internet for information: "there's a number of like half-truths that are available on the internet that can give people misleading ideas about what HRT is and isn't going to do".* Róisín used the internet to research surgery results from a specific surgeon by looking at reviews people had left online. She felt that it was difficult to get a realistic idea of her own results because *"you don't see those medium results, you don't see people who are just kind of okay or a little displeased, will manage and obviously results given by the surgeons themselves are going to be the best possible results, the best highlights".*

Luke was also concerned about having realistic expectations when seeking out surgery results. He described how he would often see ideal surgery results: "*you see all these pictures of perfect top surgery results…but they also a lot of the time have uh like hairy chests and rippling six packs as well*". To ensure he saw a range of results, Luke explained *"I would actively seek out bad results…so what happens when top surgery goes wrong"*

Luke was interested in knowing how people whose surgeries had not gone to plan had reacted, so that he would have an idea of how he would feel if the same happened to him*:* *"what I found was a lot of eh trans guys saying you know "yes this didn't go the way that I wanted and uh I was super unhappy that my body didn't accept these changes, but I'm still much happier than I was before"".*

The internet offers a wealth of information on gender affirming healthcare in the form of others' documented experiences and results. It can also offer an insight into less commonly discussed changes, as Luke found when he was seeking information on hormone replacement therapy changes: *"the first I had heard of clitoral enlargement after hormones was from [transgender man] on Instagram…just made me think "wow, you so rarely see*

trans bodies"".

Sharon, who is self-medicating found most of her information about this process online. She discussed her sources of information: *"medical journals…proper ones, I will go through all the like have the method and the outcome and the whatever and the study and how many was in it you know? So, I'd go into that type of detail".* She explained that she tries to avoid online forums used by others who self- medicate: *"I found that they were maybe dangerous, even though there was some sensible information in there, it's a big mixture".* She also explained that while she used academic journals as the basis of her knowledge, others may use these online forums: *"it could be dangerous for someone else, not for me because as I say like I'd be going into the detail. But I think they could be a dangerous place, without them trying to be".*

4.5 Theme 3: Differing Experiences of Healthcare

As discussed above, information obtained was a key influence on expectations formed. In particular, information from other patients led participants to develop different expectations about the processes and outcomes of treatment. These expectations are discussed according to their directionality below.

4.5.1 Positive Expectations

Many participants (n=9) had positive expectations for gender affirming healthcare, hoping it would alleviate their dysphoria. Alison says: *"hopefully they [GAHT]'ll be able to make me feel well make me reach a point where I can feel comfortable with myself".* Michael echoed this with his hopes for specific changes on GAHT: *"I hope it will alleviate dysphoria em then like facial hair would be a major one…I'm looking forward to having a proper beard"*.

Cameron hoped that his changes on hormone replacement therapy would enable him to pass as male: *"I'm really really hoping that it'll just put me in a position where I am finally assumed to be male and it will just like, I have never ever been in that situation before and I know it's gonna feel great when it happens"*.

Sharon recalled expecting her mental health to improve and explains that her expectation was met following treatment: *"I expected the mental health to and it has like I haven't been disappointed there"*. She also expressed positive expectations about surgery: *"for pain or anything like that no I wouldn't be worried or even- I know I wouldn't be disappointed with the outcome…I know it's the right thing for me".* Cameron felt similarly about surgery: *"I do think it'll be okay because it's a common enough surgery and it's you know there's rarely any complications".* Sarah said of surgery: *"it would be nirvana"*.

Overall, participants expected positive results from their treatments, but found it difficult to access this treatment in some cases. Cameron sums this up by saying: *"I am looking forward to it though, but it would just be a lot better if there was a more clear-cut path"*

4.5.2 Negative Expectations

While participants generally held positive expectations around treatments, they often held negative expectations with regard to interacting with HCPs. Luke states: *"I had anticipated…a negative response, em in all cases, with all of the people that I had interacted with".* As discussed above, this was often influenced by hearing about the experiences of others who had undergone gender affirming healthcare.

Jake recalls his expectations of gender clinic HCPs being "*shockingly low, and they* *were not exceeded".* As discussed earlier in this chapter, he had heard from "*peers and my friends"* in support groups who *"had already gotten on hormones and they had already had these experiences with these healthcare professionals".* This then influenced his expectations of HCPs. Having since received GAHT and top surgery, his expectations of these HCPs continue to be negative: *"the expectations are through the floor, frankly, through the floor. I just don't have expectations anymore because there's no point".*

Róisín also had negative expectations of interacting with HCPs, and expressed her mistrust of those working in an Irish gender clinic after she watched a documentary about transgender people in Ireland: "*there were certain turns of phrase and there were certain things that made me very sceptical of a number of medical professionals".* She elaborated on this: *"if someone is operating from the fundamental perspective that transition is the worst outcome, or it's a bad outcome or it's inherently negative, I don't trust them to provide healthcare at all".*

Participants also had negative expectations of a specific endocrinologist and questioned his practice of putting patients on hormone blockers without also administering oestrogen or testosterone. Alison was unsure about this option: "*I don't know how I feel about that".* Michael meanwhile felt discouraged from seeking care from this HCP*: "he insists on putting trans people on blockers and there's not, it doesn't sound very sort of empirical…when you hear stuff like that, it's very it doesn't encourage you to explore the private options".*

Many participants had negative expectations of the assessment process, with some feeling that an assessment was unnecessary. Sarah explained: *"I don't think I could…have the energy to try and "please accept me as trans"".* Luke was fearful that he would not be believed about his identity: "*I was worried about rejection, I was worried about…her going "no, I don't believe you, or I don't feel like this is true"".* Róisín expected the assessment to be distressing and felt that she will have to lie in order to access treatment: "*if I was going to be honest about stuff I could go into huge answers but like if I want to get HRT I have to be like "yep, when I was six I started playing with dolls and wearing dresses and I've only ever thought intensely heterosexual thoughts about men""*.

In terms of treatments, expectations were mainly positive, with negative expectations focusing on complications, side effects and surgery recovery. Michael planned to have phalloplasty in the future, but was aware that it is a surgery with a high complication rate: "*it just seems very invasive but I know that I do need it eventually to feel comfortable in myself and my sexuality but I think with any you know surgery there's always going to be a risk so I think unfortunately you just have to take those sorts of risks"*.

Cameron explained that he expected some of the side effects of HRT to be frustrating: "*I've just gotten like a decent skin routine down and I know like testosterone is probably gonna make my skin oilier… I know you get a bigger appetite…and I know testosterone gives people a lot of problems with getting hot like really easy, that's gonna be hell [laughs]"*.

Cameron was also concerned about the delivery method of HRT, as he had a fear of needles: "*that sounds terrifying"*. However, he was unsure if he would be able to take the gel form of HRT due to eczema: "*I feel like I'm probably going to have to go with the shots just because of my skin and like that's terrifying"*.

4.5.3 Changing Expectations and Uncertainty

As well as positive and negative expectations, participants were occasionally unsure of what to expect from pursuing medical transition. Cameron had an idea of what his gender dysphoria assessment would be like, but was still unsure: *"I didn't really know what to expect, mostly because like I'd never been assessed for gender dysphoria before, but I've been through psychological assessments and had a rough idea"*. Similarly, he had never had surgery before, and was unsure what to expect: *"while I kind of have a vague idea in my head*

I actually don't have any experience with it". Luke echoed this uncertainty: *"I feel like I know a lot about what the changes will be, but it will be very different experiencing those changes*".

Participants also discussed how their expectations of interacting with HCPs had changed over time. Michael explained: *"Up until recently I would have felt very…apprehensive but I do know they've hired a new endocrinologist…, and he sounds very supportive…it's just more the waiting lists".* Meanwhile, Jake discussed the slow process of change: *"I'm sure they are improving…There's definitely a demand for them to improve. I just think it's, you know it's a slow process…So, you know they will eventually be better but… not yet, not now."*

Two older participants expressed uncertainty about transitioning later in life. Sharon was only 47 but was conscious of aging during the wait for surgery. She says that the wait "*is holding back my medical transition. I'll be older, I might not be, health wise I might be able to do it you know?"* Sarah was 62 at the time of the interview and was unsure how hormone replacement therapy will affect her: *"I'm aware of some of the risks, I'm not aware I'm not so aware of what those risks are as you age… introducing oestrogen into my body at my age may have other side effects… I don't want to go down a road that creates medical issues".* Sarah was eager to transition but was wary of the side effects: *"it could make me quite sick, it may not. You don't know, but em, I'm fit and healthy and I want to stay fit and healthy".*

Access to surgery was also uncertain for Michael. He acknowledged that there are currently no surgery options in Ireland for transgender people. Deciding where to travel to access this surgery was also a decision facing Michael: *"where exactly, I don't know. I know a lot of people go to Poland em but the UK is also an option. That might be a bit uncertain with Brexit but em yeah, I'm not sure I would go to Poland. It just seems a bit far. The UK would be better because I have family over there".*

Michael also discussed the uncertainty of having children. Although he was only 22 at the time of his interview, this was a decision he needed to make before beginning HRT, as this can cause infertility. He explained the challenge of making such a big decision: *“it’s a bit daunting to be honest because I don’t even know what career I want”.* He explained that he *“couldn’t imagine having a kid right now”* but that he thinks he *“would like to have kids but how I’d do it is just up in the air”.* However, he is unsure if he will access fertility treatment because of the costs associated with it: *“I’m just not really sure you know if there’d be funding for that. It’s like another expense”.*

4.6 Theme 4: Encountering Barriers

Several participants reported barriers to accessing gender affirming healthcare, including waiting times, cost, and distance. These will be discussed below.

4.6.1 Waiting Times

The most frequent barrier discussed by participants (n=8) was the long wait times to access gender affirming healthcare. Sarah had only recently been referred to a gender clinic at the time of her interview and expected not to receive an update for a long time: “*I won’t hear anything for thousands of years”.*

Wait times varied between participants often depending on factors such as when they were referred, as well as whether they were already linked in with mental health services.

Jake who began seeking this healthcare in 2015 said *“a year and a half’s worth of waiting and working on receiving that healthcare went into it”.* Meanwhile, Cameron was still waiting to be seen by the gender clinic at the time of his interview: *“I was referred to [gender clinic] in 2016…have not seen any of them yet. Haven’t any of the dysphoria diagnosis yet.”* Sharon was also still waiting to be seen by the gender clinic: *“I was put on that [waiting list] in October 2017, and I was initially told… I’d be 17 months waiting, and it’s almost two years now and…I’m currently 211th on the list and according to the trans* *community, the other ones that I know, it means I'll be two or three more years"*.

Róisín was originally referred to the gender clinic in 2017, but sought care abroad after her referral was lost: *"with [UK gender clinic] I reached out to them after I realised it was going to be a three-year wait".* Luke said that he knew another transgender person who waited seven years to begin HRT, and explained that he planned to seek care abroad if he faced a similar wait time: *"I can't even see seven years into the future…can't see myself staying in the Irish system and staying on the waiting list".* At the time of his interview, he was considering seeking care from a UK based gender clinic after hearing about a friend's experience: *"I've another friend who was waiting four or five years, and couldn't wait any longer, so he went and got assessed in Manchester and is now on t[estosterone]".*

Waiting times for surgery were similarly long. Alex was still awaiting a consultation for top surgery at the time of their interview: *"I went on that waiting list a year and a half ago, for a consultation that's meant to be happening this time, but I've heard nothing so who knows when I'm gonna get to that".* Andris required a revision surgery after his original results left him with breast tissue remaining, and decided to seek this care abroad after his appointment was continuously rescheduled: "*they kept pushing the appointment back… then at a certain point I called them and they said "oh the surgeon actually recently retired so now there is someone else"... having been so disillusioned with uh with that hospital in Ireland, I sought other opportunities of something abroad".* Cameron was also planning to travel abroad for surgery due to long wait times in Ireland: *"you have to be on testosterone for like a year before they even put you on the wait list for top surgery and I think then that the wait list for top surgery is like three years"*.

The long wait times were often distressing for participants. Sharon described how her frustration grew as waiting times increased: *"I was comfortable enough with waiting seventeen months or whatever like I can do that but it's near two years".* Cameron experienced a similar increase to his wait time: *“in the beginning it was fine because in the beginning it was only something like 17 months and then it went up”.*

Talking about his feelings around the waiting lists, Luke said: *“it’s definitely something that’s emotional to think that uh I will have to wait this long”.* He elaborated by explaining how long waiting times can harm patient mental health: *“my life at the moment*

isn’t in danger. I don’t feel like…I’m a risk…other trans people who have been waiting for a long time…they would be a suicide risk... I wouldn’t say that about myself... but I can’t say for certain that that wouldn’t be the case if I had to wait however many years for treatment”. Michael felt similarly about the wait, and was considering seeking care privately: “*I want to be on hormones before kind of my fourth year [of university], but I don’t think I’ll get an appointment until then, so I might have to go private plus like the waiting list I think it would have just impacted my mental health”.*

Róisín discussed her frustration with what she described as having to put her *“life on hold”: ““oh you want to transition? Cool. Wait three years and come back to us… just put your life on hold, I’m sure this won’t kill a lot of people”.* Sharon was also frustrated with the waiting times: *“a lot of people I’ve heard from and I agree with it and have started calling it it myself it’s the list in [gender clinic] is called Death Row”.*

Luke explained that he felt that the long wait times were in part designed to ensure that patients would be “sure” of their decision to medically transition, and was frustrated by this idea: *“it’s inaccurate to assume that trans people don’t know that and to assume, “well if we make you wait five years for it, well you’ll be sure of the risks at that point””.* He felt that the wait would have a more negative impact than this: *“I don’t feel like that’ll have any impact on my understanding of the risks or my understanding of it. If anything, it’ll just make it seem more em more urgent”.*

Participants often heard of cases where patients were made wait longer than necessary or refused treatment after waiting and feared the same would be true for them. Alex said that they knew of people who were denied GAHT due to other diagnoses: *"I know of even after three years that they won't get on HRT because you know they might have ADHD or you know be on the spectrum, and these are things that people get denied for".* Meanwhile, Andris described how a friend had difficulty obtaining a referral for surgery: *"it looks like the case could have been lost or it could have been something that she may have said that meant that she wasn't on their good side, things like that. So, kind of a lot of extending the time more than would be required and actually still fighting that as far as I know".*

4.6.2 Cost

Although treatment is available for free through Ireland's public medical system, many participants often sought private healthcare in Ireland and abroad due to long waiting times. However, this was not always accessible due to the financial cost.

Sharon was self-medicating due to long waiting times to access hormone replacement therapy. She discussed the cost of buying hormones: *"a year's supply would be… maybe two and a half thousand euro".* She also explained that this comes "*from little money, because I have the rent"*. She elaborated it on this, describing how she had to get a loan to "stock up" on her HRT: *"I'm the one who buys the shopping, buys the food in, pays the electric…I actually went to a money lender lately and got a loan to get my next batch of medication, you know to stock up because of Brexit.".* Sharon is on a low income, as she had to leave her previous job due to an incident of transphobia and explained: *"I'm doing this all on my social welfare job seekers allowance benefit".* She is also paying for electrolysis and discussed the cost of this: *"it costs me €40 a week for a half an hour of electrolysis".* This was a cost also faced by other transgender women in the study, with Sarah explaining: *"it was costing me at some cases 160/170 euro a week".* Róisín also mentioned that she has paid *"thousands"* on laser hair removal.

Due to long waiting times to access surgeries, Sharon is also planning to self-fund these: *“have got a plan for even the breast surgery too that I’m prepared to pay for it. If I’m doing this already, the laser and electrolysis,* self-*medicating and everything”.* She also plans to pay for facial feminization surgery, which she said would cost: *“around 16,000 to 18,000”.* When the interviewer remarked that this was quite expensive, Sharon made an interesting comparison, saying “*so is my uncle’s car that he just bought”.* Sharon was also planning to pursue monitored hormone replacement therapy from an online, UK based gender clinic. She explained that the benefit of this was that they offered online consultations, which were more accessible to her: *“I don’t have to travel, because I said listen, I’m poor enough as it is”.*

Although other participants wanted to seek care privately, this was not always accessible. Luke explained: “*cost is one thing that would be preventing me from going abroad and seeking that even though I know it would speed up the situation.”.* Cameron also could not afford private healthcare: *“I can’t afford that, so I was gonna have to go to [Irish gender clinic] anyway, and I, I like I don’t like that”.*

Other participants were fortunate that they could access private healthcare. Jake described how his parents’ financial support allowed him to access treatment as a teenager: “*my parents were able to afford to get a private diagnosis for me… my parents could afford to bring me abroad to have surgery”.* Michael has savings, but said it was likely that his parents would financially support his medical transition: “*I do have a good amount of savings...but like my parents would probably support me so I’m fortunate to be in that position”*. He also has health insurance but was unsure if this would cover the cost of gender affirming surgeries: “*I am aware that certain like [insurance companies] are starting to cover them but em yeah, it’s a bit of a grey area”.*

Sarah has been attending mental health services privately for depression and gender dysphoria and explained that she could only access *"proper care"* because she was employed: *"fortunately I'm working so I can afford to go privately. Only for that I don't know".* She is sceptical that she would have received adequate healthcare through the public system: *"Probably not, let's be honest".* She discussed the implications of being unable to access adequate mental health care: *"That's the reality for a trans woman who can afford. The option for that was that I wouldn't be on the earth".* While she insists that medication alone could not have helped her, she notes that *"medication thank god wasn't expensive".* She feels that her counsellors have helped her the most and says that *"I could not have accessed them unless I had the money".*

4.6.3 Distance

The three gender clinics in the Republic of Ireland are located in Dublin, Galway and Louth, meaning that gender affirming healthcare is less accessible for those living in other counties.

Alex, who is currently on GAHT and lives in county Cork explained the inconvenience of travelling to Dublin for healthcare: "*it's a day gone. For like what often is like a ten-minute meeting with somebody".* They felt that there should be services available closer to Cork: *"there's nowhere close by… that means that there's travelling, there's time out em and it's just really frustrating that we don't have a service down here in Cork. We do have the population".*

Michael who is based in Dublin agreed that services should be more widely available: *"I don't think there should be just these pockets in places available. I think, I mean the GPs are under pressure now, but you know cis people can get HRT at a GP".* Other Dublin based participants who did not have as far to travel still found that the commute was inconvenient, such as Andris who explained that it was *"still long travel, an hour each way"* and Jake who explained: *"it's inconvenient to go to [gender clinic] every six months, so I've now gotten eh* *to where I've spaced my months out to a year… it takes a lot of time to get there. It takes a lot of time being there".* Andris, also discussed how he *"had to allocate a whole day even though we all sign in in the morning I still had to wait many hours until I was seen and book that day off",* however, he notes that this seems to be improving and now he only has to take half a day off work: *"since then I know they have tried to improve that so last appointment I think was early in the morning and it was only, I was there from maybe an hour or so, so they seem to be splitting them apart and seeing fewer people each day so it's definitely more efficient".*

4.7 Theme 5: Mixed Healthcare Experiences

In addition to the experiences above, participants discussed a range of experiences, both positive and negative in relation to accessing gender affirming healthcare. These are discussed below.

4.7.1 Positive Experiences

All participants who had undergone GAHT or surgery discussed feeling positive about their changes from GAHT and surgery results (n=5). Róisín described her emotions on GAHT as *"generally more happy"* and said: *"I'm substantially less hostile or substantially less dismissive of people who appear quite cheerful".* Sharon also found that her emotions were positively affected by GAHT: *"I absolutely love it and I'm in tune with my emotions now".* She explained that GAHT had not changed her personality, but that she felt *"stronger"* now: *"it's not that I've changed my personality, it's become brighter. Because I'm a colourful person but it's always been dull here in the background whereas now I'm a stronger person*". She felt that she could *"deal with life better"* now that she is on HRT and explained: *"I'm here I'm alive and I'm determined, whereas back five, ten, fifteen years ago…I'd have lost control, I'd have turned to drink or drugs".*

The physical changes from GAHT alleviated gender dysphoria for many participants.

Róisín explained how this affected her: "*the more I look in the mirror the more I am able to look at myself*"*.* Alex was also satisfied with their changes from GAHT: *"the things I was hoping for were more masculine traits, you know a deeper voice em more muscle mass em so far that has been the way".* They were also happy that they had not received certain side effects from the treatment: "*the stuff I was most worried about, say losing hair hasn't really happened"*. Sharon described one of the changes that had helped her gender dysphoria: *"my testicles have shrunk to half, easily half the size they were, and it gives me great joy and if they could just disappear altogether, I'd be even happier".*

Jake discussed his positive experience of top surgery and how his expectations were met: *"I could em look at other results images and know, "okay I'm probably gonna look like this", and that's exactly what I look like! So, you know, very happy with it".*

Participants also reported positive interactions with HCPs, with particular focus on GPs. Often, these HCPs had little knowledge of transgender healthcare but were willing to learn and find information for their patients. Jake explained that he "*had very good experiences with my GPs, just being very good at like, listening to me".* As mentioned in the Information from HCPs section, Cameron was his GP's first transgender patient, and explained that his GP was supportive of his identity despite not knowing about the medical transition pathways. Alex's GP had previously had other transgender patients, which meant she "*knew what the pathways were".* Alex discussed having a positive relationship with their GP: *"I can trust her really well, like she knows the whole story".* Sarah described her GP as *"exceptional" and* explained that her GP would find information on the process of medically transitioning in Ireland. Sarah's GP also found counsellors for her, which Sarah described as *"lifechanging".* She also spoke about a positive experience she had with a counsellor when she was first coming to terms with her gender identity: *"I'll never forget the first day that I ever spoke about dressing as a woman was with an amazing counsellor I had…I was so* *afraid, but she was brilliant".*

Sharon described a positive experience she had with a psychiatrist that she was referred to for a gender dysphoria assessment: "*she ended up giving me makeup tips, because after the first meeting she was kind of in there going "why were you sent here, when there's nothing up with your head?"… but she recommended me for [gender clinic] so it was about within eight weeks that I had I was on the list but then it was all messed up".*

Michael was already attending a psychiatrist before seeking out gender affirming healthcare and explained that *"he was very good about it even though it wasn't his expertise either".* He was appreciative of having *"that kind of space to explore even when I wasn't out to my parents".*

Jake recounted his experience with his surgeon, saying: *"it was great, I have to say…I had a very positive experience".* He explained how the HCPs put him at ease: "*I don't like hospitals, don't like doctors, don't like needles and…everybody was very em, very good at putting me at ease in that situation".* He also appreciated that the surgeon was *"respectful"* around part of his body that caused him discomfort: *"the surgeon was very sensitive of the fact that obviously like having a chest was uncomfortable for me…very polite and respectful in that respect, and very aware of the fact that it was something that would make you uncomfortable".*

Jake also discussed his experience with the nurse in his GP surgery, who he said was the HCP he interacted with most often: "*one of the most supportive and most helpful medical professionals I've ever encountered. She's very good at giving injections [laughs] so it doesn't hurt! Em, she was very helpful when I was recovering from surgery and provided me with like, extra dressings for my wounds, stuff for scar care, em, just a very eh polite as well, like if she ever wanted to ask any potentially probing questions… she took the necessary steps to make sure that it wasn't like you know making me uncomfortable".*

Róisín is receiving her GAHT from a UK based gender clinic and has had a very positive experience with this: "*the approach has very much been "let us know what's going on with you, we want you to speak to one of our psychologists, literally just so they can know what's going on with you, you know maybe we can offer you certain things or recommend certain things"".* She noted that this differed from Irish gender clinics: "*the Irish healthcare system appears to be very much built around "is there anything we can do to delay or stop you from transitioning"".* She was also appreciative of the fact that the gender clinic was supportive of non-binary individuals: *"they've been absolutely fantastic, incredibly supportive em they're supportive of non-binary people which is incredibly f***ing rare in trans healthcare".*

4.7.2 Negative Experiences

Almost all participants reported some negative experiences of accessing gender affirming healthcare (n=9). Many reported negative experiences of the assessment process. Luke recalled his experience: *"I felt very uncomfortable… it felt weird, uh it felt invasive".* He described the anxiety he felt during the process: "*I was worried about rejection, I was worried about eh her going…"no, I don't believe you, or I don't feel like this is true" em and I.. I felt like I had to be fully honest about my situation, but I also felt like I had to perform…a version of of myself, to receive that diagnosis. There were some questions that I found obviously difficult because they… asked intimate questions about my body and my experiences with my body, my relationships with my body…my relationship history"*. He felt that the psychiatrist was looking for specific answers to *"legitimize [his] experience".* He gave examples of the questions he was asked about his previous relationships: *"" have you only ever been with uh girls or women? So, does that make you a straight trans man?" and I think that was the narrative she was trying to get from me".* He explained that he felt that his experience matched this *"narrative",* but that he knew others whose experiences did not: *"I* *feel like sort of my relationship history benefitted me in terms of her understanding me as a person, but for a friend of mine who is a gay trans man, I wonder how how uh clinical psychologists would react to that".*

Jake described being asked similar questions: *"at the time I was in a relationship with a woman, and em there was a lot of focus on that, the fact that I had a girlfriend and the fact that I was heterosexual".* He described his discomfort with these questions: *"I was sitting in front of this guy who was like, in his 50s, minimum, and I'm like "I'm a 15 year old, and you're asking me about like, my romantic relationship with this person. It's, it's weird, it's uncomfortable, it feels… intrusive, and like you know at the time there wasn't any kind of like "oh well if you don't want to answer something you don't have to" because like this guy is trying to discern whether or not I'm genuinely trans, so they feel like everything is on the table".* Jake felt that his relationship history was not relevant to his gender identity: *"I wasn't a man because I was interested in women, I was a man because I was a man".*

Alex, who identifies as a transmasculine non-binary person discussed feeling a need to hide their non-binary identity during the assessment: *"it kind of felt like if I had said I was transmasculine and that like I use the they pronouns, I just feel like that would've been a no-go with them".* They also felt like they had to lie about their experience in order to access gender affirming healthcare: "*I don't know when I was five…that's what's the narrative they look for... I did feed them the narrative of I like always known, I always wanted to be a boy whereas like ... I'm somebody yeah, I want to present as male, um I have a lot of masculine traits but there's still a lot of femininity in me. But you couldn't say that to them, because they don't see it that way, they see it as very binary thing".*

Alex also had anxiety, but did not disclose this to the psychiatrist as they explained: *"I had learned to become quiet and not talk about those sort of stuff with them because you know again it could have worked against me".* They also found the wait for HRT difficult, and explained how they were harassed on the street: *"it's tough…part of what they want is to live as your chosen gender which is very hard to do when you don't look like your chosen gender. I felt very visible on the street… it was very clear I was queer…that year and a half was so tough because I experienced so much harassment on the street- name calling, em and it just felt I was in this in between limbo land".* Alex explained the dynamic between patients and those conducting the gender dysphoria assessments: *"it's kind of tough when you're working against the people you should be working with… you're trying to prove yourself, you're trying to argue your case".*

Alison also felt a need to fit with a *"narrative"* during the assessment process: *"I didn't behave as a stereotypical girl when I was younger but because you don't appear to do that apparently you're pretending or you're faking it and that's just extremely like it's not even harmful to trans people but it's harmful to as a society as a whole, "this is how men behave, this is how women behave, there's nothing in between"".*

Participants also discussed feeling pushed to follow a specific pathway by HCPs. Jake said that they have *"always felt that the people in [gender clinic] have a slight agenda with what they want the kind of route they want you to take, in that you know I was very strongly encouraged to have surgery with the surgeon in Ireland, even though that isn't what I wanted to do".* However, he went to the US to have surgery because *"it's not about what they want. It's what I want, it's my life, it's my body, it's my identity".* Alex spoke of being encouraged to have a hysterectomy despite not wanting this: *"I was trying to get a referral for top surgery, and they were kind of like "we'll just do the hysterectomy first" and I was a bit like "but I don't want a hysterectomy"".* They explained that they felt that the surgery was invasive and unnecessary, but that the HCPs at the gender clinic were confused by their decision to opt not to undergo this surgery: *"they just didn't seem to get it…I don't think they like the fact that you pick and choose, because I think they want to be the ones like "if you're* *down this road, you have to go for everything"".*

Participants also discussed instances where HCPs made *"inappropriate or rude"* comments. Jake recalled a conversation he had with a HCP in the gender clinic: "*asking me about like, my stance on bottom surgery and whether or not I wanted bottom surgery, and like, this person…is saying to me that "oh, it makes sense that you don't want bottom surgery because the results of bottom surgery for trans men are bad"".* Although Jake opted not to undergo bottom surgery, he felt that the comment was *"insensitive"* and explained: *"it doesn't bother me personally because I'm not seeking that. But I felt like it was an insensitive thing to say…they're seeing people who do want that surgery and they're of that opinion".* Cameron meanwhile described how a psychiatrist "*said something like "don't you want to wait some more time to figure out if you actually want to be a boy or not?"",* which made him uncomfortable.

Some participants discussed their mistrust of gender clinic HCPs. Alex explained: *"I didn't feel like I trusted them, which is something that you know you feel that like people who are helping you make this decision, you feel like you should be able to trust them".*

Meanwhile, Róisín, who was told that her referral had been lost, is sceptical that this is the case. She explains that she "*wouldn't trust them at all",* and suspects that certain referrals were purposely lost. She explained that she felt referrals were lost because of views held by HCPs: *"say for example you know you have a massive backlog of patients and say you fundamentally don't believe them and what they say they are… maybe if you just lose some of those referrals and those people don't reapply, they're not your patients anymore".* Róisín also had negative views of the criteria used during assessments for gender dysphoria in Ireland: *"there's something so painfully f***ing conceited about a cis man saying "oh no, we don't use the WPATH standards, I have my own criteria"".*

Participants held negative views of the healthcare system in Ireland, particularly regarding transgender healthcare. Luke felt that the healthcare system is *"in crisis"* and explained: "*people who are in need of life saving/ medical treatment are dying".* He noted that gender affirming healthcare is often seen as not as urgent as other treatments but explained: *"trans people are dying too. Like my trans siblings are dying because they're not getting the care that they need…I don't see why they shouldn't be prioritised or at least shouldn't be given the same treatment as other people"*. Other participants felt similarly, with Sharon saying: *"I'm disgusted with Ireland as it is and the way we're being treated",* and Alison saying: *""the current state of trans healthcare in this country is like embarrassing"*

Cameron described how his gender identity affected his experience of mental healthcare: *"I was in the psych ward in 2017, and first I was put in the male ward and I was like "right, sick" and then like the next day they were like "we're gonna move you to the female ward" even though I'm legally male…basically what they had said was like "since you haven't started physically transitioning, we're gonna put you in the female ward", so I'm like "so if I had one shot of testosterone in my body that'd be enough for me to stay in the male ward?"… it was really upsetting".*

These negative experiences impacted how participants viewed and engaged with further healthcare services. Sharon has asthma, and described how she does not engage with healthcare for this: *"I'm supposed to be going regular check-ups but because of this, I just have no faith in them at all whatsoever, so I just don't bother at all, and my doctor is Google and hope".*

4.7.3 Lack of Communication

Theme 2 highlighted the lack of information about healthcare provided by HCPs. In addition to this, participants referenced a lack of communication between HCPs and their patients.

This particularly came across regarding communication from gender clinics. Luke said that he had been referred to a gender clinic, but did not know whether he was on a waiting list: *“my referral is with [gender clinic] at the moment, but uh I don’t know what the situation is there. I don’t know if I’m on a waiting list”.* He explained that he felt that he had to be the one to reach out to the clinic for an update: “*I think it’s kind of up to me to call them”.* Cameron also noted that he *“never got a letter”* from the gender clinic. He reached out to the clinic for an update, but they could not provide information on waiting times: *“I waited like a year and I was like “I’m gonna call them just see if I’m on the list, and I did call and I was on the list, but they couldn’t give me a time, like any time I was going to be waiting at that point. I was only told by someone else in the group that the wait had gone up. They didn’t tell me that themselves”.*

Sharon, meanwhile was contacted by the gender clinic, but she noted that this took time: *“she [GP] wrote a letter and it took five months for [gender clinic] to let me know where I am on the list”.* Andris experienced a similar lack of communication when attempting to arrange a revision surgery, explaining that he reached out to the hospital *“numerous times”.* He explained that sometimes he *“got through, sometimes [he] didn’t”.* His appointment was continuously rearranged, and when he asked how long he would have to wait, he was told *“you’re still waiting but we can’t tell you more than that”.* At one point he called the hospital and was informed that the surgeon had retired, which led him to seek care abroad instead, as he had become *“so disillusioned”* with the Irish hospital.

Róisín was *“told it [gender clinic referral] had been lost”,* and was concerned that she would not hear from the gender clinic after changing her postal address: : “*I reached out to them to say…I moved here’s my updated personal information. They haven’t come back to me in regards to that. I’m concerned because apparently a lot of people only ever receive anything by post”.* She felt that postal communication alone was insufficient and felt that patients should also be contacted via email: *“everyone has an email address that tends not to* *change too often. Postal addresses can change quite a bit".* Michael has been referred to the gender clinic and described *feeling "pessimistic and kind of apprehensive"* about *"the lack of you know contact, even when you hear that they lost a hundred [referrals]".*

Sharon also found a lack of communication among GPs to be an issue, as she saw a different GP each time she had an appointment *"they don't communicate with me it's been a thing that they have locums and stuff, so I have to explain myself each time I get nowhere".*

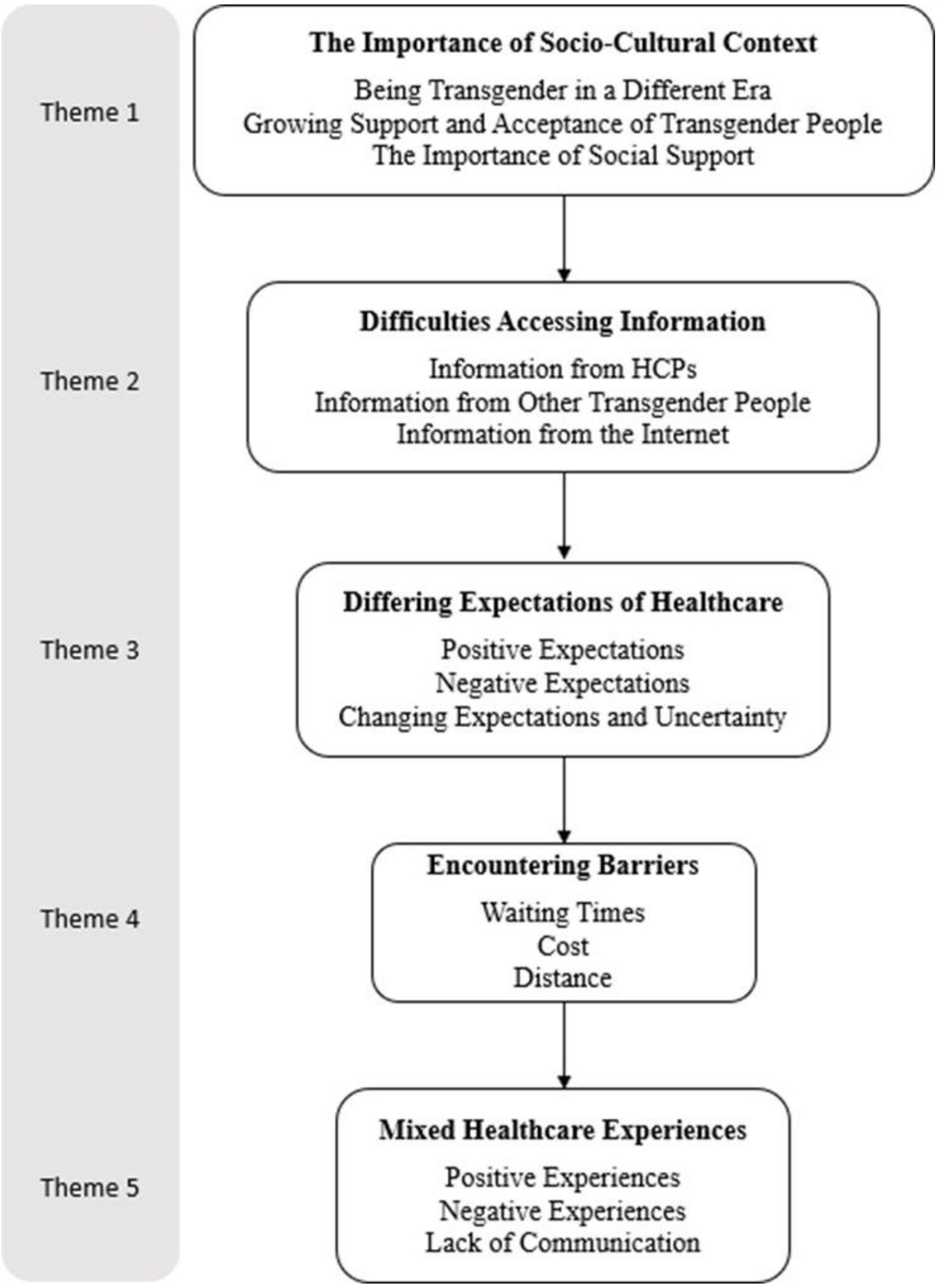

Figure 4.1: Themes

4.8 Conclusion

Overall, participants had a variety of experiences in relation to seeking and accessing gender affirming healthcare, with these experiences often being influenced by the expectations formed. Experiences of treatments were often positive, but many participants faced a number of barriers in order to access these treatments. Areas for improvement of gender affirming healthcare in Ireland were highlighted by participants, and a list of recommendations for healthcare professionals delivering this care will be discussed in the Chapter 6. Before this, Chapter 5 presents a discussion of how the findings of this research compare to existing literature.

Chapter 5: Discussion

As is evident from the results presented in Chapter 4, there were a wide variety of experiences reported from the participants, suggesting that there is considerable diversity encountered by those undergoing or awaiting gender affirming healthcare. Furthermore, the expectations formed by participants varied considerably. Participants also described the importance of socio-cultural context and discussed barriers to care. Taken together with the findings of the systematic review in Chapter 3, these results provide a valuable insight into the experiences of those undergoing gender affirming healthcare which may help inform the development of supports for patients and HCPs. In this chapter, the results are discussed in more detail according to the emergent themes.

5.1 Socio-cultural context

Socio-cultural context and the importance of support emerged as a theme for nine participants, with older participants citing how times had changed for transgender people living in Ireland. In 2015, months after the passing of a referendum to allow same-sex marriage, Ireland became a world leader in legal gender recognition by passing the Gender Recognition Act, allowing individuals to legally change their gender by self-determination (McDonald, 2015). Ireland was the fourth country in the world to allow individuals to self-determine their legal gender (McDonald, 2015). In contrast with Ireland’s progressive approach to legal gender recognition, Andris- originally from Latvia but now living in Ireland- noted that in order to legally change his gender on his Latvian passport, he was required to be sterilized, and therefore underwent a hysterectomy. Many participants were satisfied with legal gender recognition in Ireland, but noted that medical transition was unsatisfactory, a sentiment that was reflected in other themes.

Many participants discussed the importance of support from their families and friends as well as wider society. Younger participants noted that the support of their families and friends had made coming out easier, with some, such as Jake noting that the financial support of his parents aided him in his medical transition. This echoed findings from previous research, which found that transgender adolescents who were supported by their families had significantly higher life satisfaction, less depressive symptoms, and lower perceived burden of being transgender (Simons et al., 2013). Taken together, these findings point to the value of fostering social support for transgender people, particularly those who are in the earlier stages of transitioning.

5.2 Information about gender affirming healthcare

Another notable finding was how participants described the various ways they sought information about gender affirming healthcare in Ireland. Many described struggling to access information, noting that GPs in particular, while often supportive of their identities, lacked knowledge around transgender healthcare and were unable to provide information around pathways to medical transition in Ireland. Notably, this was also reported in an older study of transgender healthcare in Ireland, suggesting that HCPs have not been adequately educated despite a growing acceptance of transgender people in Ireland (Sheehan & Collins, 2004). It also supports previous research by Poteat et al. (2013) who found that HCPs often lacked knowledge about transgender healthcare.

This problem was viewed as a significant one by participants, as GPs were often the first point of contact for those seeking gender affirming healthcare. Due to this lack of knowledge, participants often had to seek information elsewhere, usually online or through other transgender individuals. This is consistent with systematic review findings reported in Chapter 3, such as in Linander et al's. (2016) study where participants described feeling that the onus was on them to seek information about gender affirming healthcare. Similarly to findings in the current study, participants in Bell and Purkey (2019) and Lykens et al.'s (2018) studies described support groups as one of the main sources of information. This highlights the value and importance of peer support in helping transgender people navigate the healthcare system, however it is also concerning that such support emerged as the primary source of information.

Participants discussed the challenges that came along with the difficulty of obtaining information, with Luke and Róisín describing how they often saw either examples of idealized surgery results, or examples of very poor results online and expressing frustration at the lack of "medium results" available. Cameron explained that when seeking information online, he struggled to find information relevant to an Irish context. This implies that there is a clear need for the provision of accurate information from HCPs to enable patients to be better prepared for treatment.

5.3 Expectations of treatment

An important aim of this study was to explore the various expectations that participants had about healthcare. Results revealed that expectations of treatment varied greatly, with participants reporting both positive and negative expectations. However, participants also often reported not knowing what to expect. Instead, significant uncertainty was reported. One assumption of the present research is that undergoing gender affirming healthcare would be of benefit to participants, as this would be in line with findings of previous research (Newfield et al., 2006; Gorin-Lazard et al., 2012; Papadopulos et al., 2017; Zagami et al., 2019). This implies that patients would likely form positive expectations in relation to the outcomes of their treatment. Findings appeared to support this hypothesis, with participants frequently reporting positive expectations of the treatments themselves, hoping that treatment would "alleviate dysphoria", help them to "pass" as the gender they identified as, and make them more comfortable in their bodies.

While participants reported some negative expectations of treatments, such as side effects, or fear of injections in the case of Cameron, fear of side effects appeared to be less of a concern than in studies examining the treatments of other chronic conditions such as cancer

(Hofman et al., 2004; Barton, 2017). This therefore implies that consideration of adverse effects is not a key factor in informing decisions to undergo gender affirming healthcare.

The majority of negative expectations were related to interactions with HCPs, particularly regarding the psychiatric assessment process, which in Ireland is required before any treatment can commence (HSE, 2017). Distrust of HCPs was evident, often stemming from hearing about others' experiences, or in the case of Róisín, watching a documentary about transgender people in Ireland: Participants frequently expressed fear that they would not be believed by psychiatrists, and some planned to lie about their experiences or omit details such as non-binary identities or existing mental health conditions during the assessment in order to access treatment. This was similar to findings from the systematic review reported in Chapter 3. For example, non-binary participants in Lykens et al.'s (2018) study often reframed their needs in binary terms when interacting with HCPs. This supports the finding that interactions with HCPs are important determinants of expectations and experiences.

Many participants also reported being unsure of what to expect, such as Sharon and Sarah, who were both older and unsure of whether they would be eligible for surgeries in the future. The lack of surgical options in Ireland was highlighted by a number of participants. Of the ten participants of this study, 3 had sought care abroad, and six planned to seek care abroad, highlighting the lack of available options in Ireland. Having to travel abroad for surgery was also an issue reported in Sheehan and Collins' (2004) Irish study, suggesting that not much has changed in terms of available services in Ireland over the past 16 years. These findings also imply that uncertainty stems from a lack of reliable knowledge. One way to develop more realistic expectations among patients would be through the provision of personalised information.

One significant finding was that when seeking information about gender affirming healthcare from other transgender individuals, the experiences of others appeared to shape the expectations of the participants. Many were wary of HCP interactions, due to hearing about others' negative experiences. These findings highlight the value participants place on the experiences of other. This can be problematic, as it shapes participant expectations, which in turn often shape experiences. This was also an issue discussed in Linander et al.'s (2016) study, where one participant discussed apprehension around seeking care when they heard of the negative experiences of others, suggesting that this issue is not unique to an Irish context. This implies that HCPs should aim to provide comprehensive information about gender affirming healthcare to patients in order to promote trust and manage expectations.

5.4 Barriers to care

Participants reported a variety of barriers to care in Ireland. The most frequently discussed, mentioned by eight participants, was the long waiting times. This time appeared to be increasing, with Jake and Andris, who began their medical transition eleven and five years earlier respectively reporting shorter waiting times, while Cameron and Sharon reported having already waited two years and expecting to wait another 2-3. Meanwhile Luke mentioned a friend who had waited seven years. These wait times often led participants to seek care abroad due to the distress that waiting had caused. Sharon had turned to self-medication and referred to the waiting list as "Death Row". Luke felt that gender affirming healthcare was not seen as urgent and noted that trans people were dying as a result of waiting to access healthcare.

While the provision of services for transgender care has increased in recent years, these findings indicate that the demand is outstripping supply. The number of patients on the waiting list to see an endocrinologist in one gender clinic increased from 1333 in February 2016 to 2084 in January 2019 (Hospital Waiting Lists, 2019). Although wait times are already lengthy, this research was conducted just before the emergence of COVID-19 in

Ireland. It may now be the case that these wait times have increased, as non-essential health services had been suspended during national restrictions, but are slowly resuming (Pope, 2020; HSE, 2020).

Two participants based a significant distance away from the gender clinics cited distance as a barrier, as the three gender clinics were all long distances from them and required a long and costly commute. Alex felt that there should be a gender clinic in their region. This was a problem that was also discussed in two other Irish studies of transgender healthcare, suggesting that this has been an additional barrier facing those who do not live close to the gender clinics for quite some time (Sheehan & Collins, 2004; McNeil et al., 2013). A number of participants were also dissatisfied with communication from gender clinics, noting that they were not informed of waiting times and increases to these wait times. This suggests that there is a need for improved communication between HCPs and those on waiting lists.

In order to shorten the waiting times, some participants opted to seek care privately. However, the high cost involved in this route was viewed as a barrier for many participants. While some reported that they were able to afford this, others such as Cameron and Luke reported that this made private care inaccessible to them and left them with no choice but to wait for public healthcare. The transgender women in this study also cited the additional costs of hair removal which ranged from “40 euro a week” (Sharon) to “thousands” (Róisín). This means that those on lower incomes are disproportionally affected by this barrier and cannot therefore avoid the first barrier of waiting times by simply pursuing private healthcare. There are various costs associated with medial transition, meaning that one’s socio-economic status often impacts whether patients can afford healthcare and by extension, how long they will have to wait to receive care (Koch et al., 2019).

5.5 General Experiences of Gender Affirming Healthcare

All participants who had undergone GAHT and/or surgery (n = 5) reported positive feelings about their results, noting that receiving these treatments had improved their mental health and lessened gender dysphoria. This supported previous research citing the benefits of gender affirming healthcare, such as Newfield et al. (2006) who reported statistically significant improvement in quality of life among transgender men who had received GAHT when compared with those who had not, and Gorin-Lazard et al. (2012) who found that GAHT was associated with higher quality of life in both transgender men and women. In addition to this, previous research also noted the effect of surgery of quality of life, such as Papadopulos et al. (2017) who found that 91% of transgender women experienced an improvement in quality of life after undergoing gender reassignment surgery, and Zagami et al. (2019) whose systematic review found that various aspects of quality of life improved after undergoing gender reassignment surgeries in both transgender men and transgender women. This suggests that transgender people living in Ireland report similar benefits from gender affirming healthcare. It may be useful for further research to apply the methodologies from the studies listed here to assess whether gender affirming healthcare is associated with quality of life in an Irish sample of transgender patients.

Despite a general lack of knowledge among GPs, many participants reported positive experiences with GPs, noting that they were often very supportive of patients' transgender identities. Other positive HCP interactions were discussed, with Jake citing a nurse in his GP surgery, and the surgeon in the USA who performed his mastectomy as particularly supportive. Róisín also described her relationship with HCPs based in the UK who had been prescribing her GAHT, saying that they'd been "incredibly supportive". This highlights the important role that HCPs can play in the transition process, which echoes the findings from the systematic review.

Unfortunately, the majority (n = 9) of participants reported at least one negative experience of seeking gender affirming healthcare. Similarly to the negative expectations, many of these negative experiences centred around the psychiatric assessment process. In Ireland, a diagnosis of gender dysphoria is required to be access gender affirming healthcare. Participants reported discomfort with questions asked by psychiatrists, and sometimes questioned the relevance of these questions to their transgender identity and plans for transition. This was similar to the findings of the systematic review discussed in Chapter 3, such as in von Vogelsang et al.'s (2016) study where participants described frustration when the rationale behind the assessment process was not explained to them, or when they were asked questions they perceived to be irrelevant or ignorant. It also echoed findings from Riggs et al.'s (2014) study where participants described disliking HCPs who asked questions that they perceived as "ridiculous or offensive", suggesting that this problem is present in multiple countries where a psychiatric model is in place. It may be of benefit for HCPs to work closely with patients to learn which questions may be perceived negatively so that the assessment process can be carried out in a way that is sensitive to the needs of transgender patients.

One concerning finding is that some participants mentioned that they purposely withheld information that they felt would prevent them from being approved for gender affirming healthcare, such as non-binary gender identities, non-heterosexual orientations and relationships and other mental health related diagnoses. The implications of this are that those providing healthcare do not have a full picture of their patients' experiences. Those who have existing mental health diagnoses may not receive additional supports they might need during the process of medical transition, while those who identify outside of the binary of male and female may feel that expectations of a binary transition are placed on them, much like in Lykens et al.'s (2018) study.

Participants frequently reported mistrust of the HCPs. A number of participants disagreed with the psychiatric model of care and were dissatisfied with the state of gender affirming healthcare in Ireland in general.

5.6 Strengths and Limitations

A major strength of this study is that it addressed a gap in the literature by exploring the experiences of those seeking gender affirming healthcare in a current, Irish context. It also explored the additional dimension of expectations and described the role these play in shaping experiences of gender affirming healthcare. As the systematic review did not find any studies exploring the role of expectations of gender affirming healthcare, this research may be one of the first to explore this. The sample used here was varied in terms of gender identity, age and stage of transition, which allowed for the collection of a wide variety of patient experiences.

One drawback is that all of the patients here were white, meaning that the experiences of transgender people of colour in Ireland may have been overlooked. As Nemoto et al. (2008) suggest that experiences of gender affirming healthcare are affected by ethnicity, further research should aim to have a sample that is ethnically diverse. Although this study attempted to incorporate some Patient and Public Involvement (PPI) in the interpretation of results, it could have incorporated PPI on a deeper level by consulting a larger group of transgender service users throughout the process in order to shape the direction that the research took, in line with suggestions by Adams et al. (2017). However, further PPI was incorporated into the interpretation of results, owing to feedback from the Irish transgender population. Other studies in this area should include PPI at all stages.

5.7 Conclusion

Many of the themes that were identified in the qualitative interview study mirrored those identified in the systematic review discussed in chapter 3, as well as being consistent with other literature in this area. However, the current findings also suggest that previously under- researched factors such as expectations came into play when shaping experiences of gender affirming healthcare. These findings provide a comprehensive insight into the experiences of those living in Ireland who are seeking gender affirming healthcare. Further research into the role of expectations and experiences of other healthcare among an Irish transgender sample would further understanding of how this marginalized population experience healthcare. Drawing on these findings, Chapter 6 describes a set of recommendations for those working to support those undergoing gender affirming healthcare.

Chapter 6: Conclusion

The aim of this research was to explore experiences of gender affirming healthcare as well as the factors associated with this. Specifically, the objectives of this project were:

(i) To systematically review factors associated with experiences of gender affirming healthcare globally

(ii) To qualitatively explore expectations and experiences of gender affirming healthcare in a sample of transgender people living in Ireland

Findings of the systematic review suggested that several factors were associated with experiences of gender affirming healthcare, and broadly fell into two categories: sociodemographic and treatment related factors- which included demographics and differing treatments- and psychosocial factors- which included psychological factors and healthcare interactions. The qualitative study, which involved interviews with ten transgender people living in Ireland found that expectations and experiences of treatment were mixed.

Participants cited the importance of socio-cultural context such as acceptance of transgender identities in wider society as well as support from family and friends. Participants also noted that finding information about gender affirming healthcare was challenging, often due to a lack of knowledge from GPs, with many turning to the internet and support groups to seek this information.

Other barriers to care were discussed, and included wait times, cost of treatment and distance from gender clinics. Expectations were mixed, with participants holding more positive expectations of the treatments themselves and more negative expectations of interacting with HCPs. This appeared to be shaped by what participants had heard from other transgender people who had sought this care. Experiences showed a similar pattern with experiences of treatments themselves perceived as more positive than experiences of interacting with HCPs or seeking this care. These findings support previous literature in this area, while also adding to knowledge in this area by exploring the role played by expectations. These findings can allow a set of recommendations to be developed for improving transgender healthcare.

6.1 PPI Feedback

A synopsis describing the main findings of both studies was distributed to the participants of the qualitative interview study as well as on social media, where those awaiting or undergoing gender affirming healthcare were invited to provide feedback (see Appendix VIII). Feedback was received from five past participants (three transgender women and two transgender men) and two other transgender individuals (one transgender man and one transgender woman) who had seen the synopsis advertised on social media.

Three of the past participants noted that the findings accurately reflected their experiences, such as Jake, who noted that the *"synopsis sounds very much in line with my own experience and the anecdotal experiences of my peers outside of your research"*. Meanwhile a patient who had been attending an Irish gender clinic for two years noted that the findings *"reflect my experience very well",* particularly relating to negative experiences of the psychiatric assessment and lack of communication from HCPs. He noted that while communication from the gender clinic had improved, it had previously been so poor that he elected to travel 3 hours to talk with a receptionist as responses often took weeks.

Another patient who reached out agreed that the findings reflected her experiences well, agreeing that social support had been a very important aspect of her medical transition, while she had some negative experiences with HCPs such as one *"awful"* GP whose "*reaction/treatment meant I didn't want to go to her again".* She noted that her experience of treatment itself had been good and that her interactions with HCPs in the gender clinic were *"the most positive experience of anyone I've ever heard of".* However, she explained that a lack of communication as well as a *"breakdown in relationship between the HSE and NHS"* had serious implications for her by resulting her surgery referral being delayed by over three years: *"everything was stalled and as of [S]eptember this year, I am finally on the list, three and a half years after I was originally supposed to be. I have other bad experiences with referrals etc. and like your research found, that was due to lack of communication between HCPs".*

Participants from the qualitative study provided updates of their medical transitions, with Sharon and Sarah reporting that their experiences continued to be quite negative. Sharon noted that she was finally seen by the gender clinic but felt *"sexually assaulted"* during what she described as *"a 4-hour interrogation".* She plans to take legal action against the gender clinic and described the effect seeking gender affirming healthcare has had on her health: *"[b]ecause of the stress caused to me over the past 3 years I have developed a [t]umo[u]r inside my body, this has affected my health profoundly."* Meanwhile, Sarah and Michael had both begun GAHT, privately through a UK based gender clinic, with Sarah explaining that her reason for this was due to negative experiences in Ireland, and noting: *"I am lucky to be in the financial position to be able to take this route".* Such experiences provide evidence of the validity of these findings and the themes that emerged from the studies. Notably, these suggest that the negative experiences that can occur from interactions with HCPs as well as suggesting that many transgender patients are required to seek healthcare abroad due to the lack of adequate supports in Ireland. This PPI input suggests that the findings of this project are reflective of transgender patient experience in Ireland and clearly indicate that there are a number of unmet needs in this group in relation to gender affirming healthcare.

6.2 Recommendations for supporting transgender patients

Drawing upon the findings of this project and the aforementioned PPI feedback, a number of broad conclusions can be drawn. For example, it appears that there is a general mistrust of HCPs, especially those involved in the assessment process, which was associated with negative expectations and experiences for patients, as well as apprehension around disclosing aspects of identities and histories that patients felt may jeopardise their access to gender affirming healthcare. It is clear that the relationship between patients and HCPs could be improved. Transgender patients could also be better supported by transgender advocacy organizations and support groups. Another issue is the challenge of accessing accurate information on gender affirming healthcare in an Irish context.

To address these issues, the following recommendations are suggested:

(i) Provision of information: as many participants in this study reported struggling to access information about gender affirming healthcare in Ireland, there is a need to collate and present this information to the transgender population in Ireland, in order to avoid expectations being shaped by others' experiences. As participants reported seeking this information online and though support groups, it is recommended that this information is presented to patients through a dedicated website or webpage, as well as through the Transgender Equality Network of Ireland. This webpage could provide more detail on what to expect from treatment, an overview of the pathways for patients and GPs and treatments available. Since this research was conducted, there was a recent attempt to address this issue, with the National Gender Service launching a website outlining information on what procedures are available as well as details on the process of accessing these treatments (National Gender Service, 2021).

(ii) Supports for those awaiting treatment: as participants discussed uncertainty around waiting times, communication with those on waiting lists could be improved by providing an estimated wait time which would help tackle any perceptions of uncertainty. In addition to this, those awaiting treatment reported distress around this wait time. It is recommended that supports be put in place for those experiencing gender dysphoria who have not yet received treatment. This might involve a phone line where patients could speak with psychiatrists or psychologists working in the gender clinics. Such an intervention would have the additional effect of promoting a more positive relationship with these HCPs.

(iii) Support for those undergoing treatment: In addition to supports for those awaiting healthcare, it is recommended that those receiving gender affirming healthcare receive ongoing support. For example, many participants reported surprise at certain GAHT changes, suggesting that these patients could have been more accurately informed of the effects of GAHT and supported in the case of challenging effects such as emotional changes on GAHT. Support may take the form of regular meetings between patients and mental health professionals who work within a wider inter-disciplinary team, so that endocrinologists can moderate dosage of GAHT if needed. Formal peer support groups may also be useful, where facilitation responsibilities can be shared by HCPs and patients in order to ensure that information shared is accurate. As many of the transgender women in this study cited the cost of hair removal, financial support for those who wish to undergo this may aid in making this procedure more accessible.

(iv) Training and awareness for GPs: while the HSE and TENI have already produced a guide for GPs (HSE, 2017), and TENI run their Gender Identity Skills Training (GIST) programme which provides three days of training for HCPs, many GPs were reported by participants of this study to be lacking in awareness of transgender identities and healthcare. These resources should be advertised more widely in order to increase uptake. In addition to this, barriers preventing HCPs from taking part in this training should be considered. Shorter workshops taking a few hours or less could be more accessible to those under time constraints, while webinars or online workshops could be a more accessible option for those who would otherwise have a long commute to the training. Workshops and training courses around transgender healthcare have been shown to be successful in educating healthcare providers, as well as increasing their willingness and competency to provide healthcare to this population (Hughto et al., 2017; Sherman et al., 2020).

All the above proposed recommendations point to a need to greater support patients at every stage of their journey as they embark on gender affirming healthcare. Although these recommendations are aimed at improving experiences of gender affirming healthcare in Ireland, they could also be implemented in other countries where relevant. For example, as lack of knowledge among HCPs has been noted in other studies discussed in earlier chapters, training courses aimed at HCPs may be beneficial in other contexts as well as Ireland. The findings of this research suggest the importance of listening to the patient perspective in helping guide interventions for this group which should allow them to feel more informed as to what to expect, and better supported as they cope with the challenges that this entails. While the implementation of all these recommendations may be constrained by lack of resources in the general healthcare system, this research suggests that simple steps, such as providing more information and enhancing communication, may have significant benefits for patients.

6.3 Conclusion

It is evident from the findings of this project that several factors are involved in the experiences of gender affirming healthcare. While experiences were varied, negative experiences were prevalent, especially regarding interactions with healthcare professionals. This is an area for improvement, and implementation of the recommendations discussed above may improve patient and provider relationships. While this research found that experiences of those living in Ireland often mirrored the experiences of those seeking gender affirming healthcare abroad, it also found that expectations appear to play a large role in shaping experiences. This is something that had not previously been researched in detail with regards to gender affirming healthcare. Further research should build on these findings by exploring expectations of gender affirming healthcare in other contexts, especially where the model of care differs from Ireland.

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Appendix I: PRISMA Checklist

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	10
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	N/A
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	2-8
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	8
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	10
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	10,11
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	11
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	120-122
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	11
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	11
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	11

Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	11,12
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	N/A
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	16

Section/topic	**#**	**Checklist item**	**Reported on page #**
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	N/A
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	N/A
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	18
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	19-32
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	19
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	N/A
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	33-55
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	N/A
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	N/A
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	56-58
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	58

Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	58,59
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	N/A

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit: **www.prisma-statement.org**.

Appendix II: Search Terms

PubMed: Transgender persons (MESH), FtM (T/A), MtF (T/A), Non Binary (T/A) transition, gender affirming, gender confirming, hormone, testosterone, estrogen, oestrogen, cross sex, hrt, androgen, endocrinology, surgery, sex reassignment, sex change, gender identity clinic, mastectomy, hysterectomy, blocker, feminiz*, masculiniz*, phalloplasty, vaginoplasty, breast augmentation, breast reduction, metoidioplasty, rhinoplasty, reconstruct*, orchiectomy, Health Services for Transgender Persons (MESH), HCP, healthcare professional, doctor, nurse, endocrinologist, surgeon, quality of life, quality of life (MESH), patient satisfaction (MESH), satisfaction, outcome, patient centred care, patient engagement, clinical interaction, recovery, postoperative, wellbeing, well being, participation, complication, depression, suicide, body image, regret, treatment, patient care, experience, safety, honesty, decision, involvement, emotional support, dignity, kindness, autonomy, empathy, compassion, trust, patient doctor, patient clinician , doctor patient, clinician patient

EMBASE: Transgender (Emtree and free text), Non binary, transition, gender affirming, gender confirming, hormone, testosterone, estrogen, oestrogen, cross sex hormone therapy', hrt, androgen, endocrinology, surgery, sex reassignment', sex transformation', gender identity clinic', mastectomy, hysterectomy, blocker, feminiz*, masculiniz*, phalloplasty, vagina reconstruction' , breast augmentation', breast reduction', metoidioplasty,nose reconstruction', reconstruct*, orchiectomy, hcp, health care personnel', physician, nurse, endocrinologist, surgeon, quality of life', patient satisfaction', outcome, patient engagement', clinical interaction', recovery, postoperative, wellbeing, participation, complication, depression, suicide, body image', regret, treatment, patient care', experience, safety, honesty, decision, involvement, emotional support', human dignity', kindness, autonomy, empathy, compassion, trust, doctor patient relationship', patient clinician'

PsycINFO: DE: "transgender", DE: "transsexual", transgender, transsexual, "non binary", ftm, mtf, DE: "gender dysphoria", DE: "gender reassignment", transition, "gender affirming", "gender reassignment", "gender confirming", DE: "hormone therapy", hrt, hormone, estrogen, testosterone, oestrogen, "cross sex", androgen, endocrinolog*, surgery, DE: "surgery", "sex reassignment", "gender identity clinic", DE: "mastectomy", mastectomy, phalloplasty, vaginoplasty, hysterectomy, DE: "hysterectomy", reconstruction, metoidioplasty, feminiz*, masculiniz*, breast reduction, breast augmentation, rhinoplasty, orchiectomy, HCP, "healthcare professional", physician, DE: "therapeutic processes", nurse, endocrinologist, surgeon, DE: "surgeons", "quality of life", DE: "quality of life", DE: "health related quality of life", DE: "client satisfaction", satisfaction, DE: "health outcomes", "patientengagement", "clinical interaction", DE: "treatment outcomes", recovery, DE: "postsurgical complications", Postoperative, DE: "well being", wellbeing, "well being", complication, RE: "depression (emotion)", depression, suicide, DE: "suicide", DE: "body image", "body image",DE: "regret", regret, treatment, DE: "treatment", DE: "caring behaviors", "patient care", experience, DE: "safety", safety, honesty, DE: "honesty", decision, DE: "decision making", DE: "involvement", "emotional support", dignity, DE: "dignity", kindness, autonomy, DE: "autonomy", DE: "empathy", empathy, compassion, DE: "sympathy", trust, DE: "trust (social behavior)", patient, doctor

Web of Science: TOPIC: transgender, TOPIC: transsexual, TOPIC: "non binary", TOPIC: ftm, TOPIC: mtf, TOPIC: "gender dysphoria", TOPIC: transition, TOPIC: "genderaffirming", TOPIC: "gender confirming", TOPIC: hormone, TOPIC: testosterone, TOPIC: estrogen, TOPIC: oestrogen, TOPIC: "cross sex", TOPIC: hrt, TOPIC: androgen, TOPIC: "hormone replacement therapy", TOPIC: endocrinology, TOPIC: surgery, TOPIC: "sex reassignment", TOPIC: "sex change", TOPIC: "gender identity clinic", TOPIC: mastectomy, TOPIC: hysterectomy, TOPIC: blocker, TOPIC: feminiz*, TOPIC: masculiniz*, TOPIC: phalloplasty, TOPIC: vaginoplasty, TOPIC:

"breast augmentation", TOPIC: "breast reduction", TOPIC: metoidioplasty, TOPIC: rhinoplasty, TOPIC: reconstruct*, TOPIC: orchiectomy, TOPIC: hcp, TOPIC:"healthcare professional", TOPIC: doctor, TOPIC: nurse, TOPIC: endocrinologist, TOPIC: surgeon, TOPIC: "quality of life", TOPIC: satisfaction, TOPIC: "patient centered care", TOPIC: "patient engagement", TOPIC: "clinical interaction", TOPIC: recovery, TOPIC: postoperative, TOPIC: wellbeing, TOPIC: "well being", TOPIC: complication, TOPIC: depression, TOPIC: suicide, TOPIC: "body image", TOPIC: regret, TOPIC: treatment, TOPIC: "patient care", TOPIC: experience, TOPIC: safety, TOPIC: honesty, TOPIC: decision, TOPIC: involvement, TOPIC: "emotional support", TOPIC: dignity, TOPIC: kindness, TOPIC: autonomy, TOPIC: empathy, TOPIC: compassion, TOPIC: trust, TOPIC: "patient doctor", TOPIC: "patient clinician", TOPIC: "doctor patient", TOPIC: "clinician patient"

Appendix III: Interview Guide

Interview Guide

Before the Interview:

- Explain the study
- Go over information sheet
- Ask if they wish to continue, fill out consent form

Background Information:

- Age
- Gender identity & pronouns
- Do they live in Dublin/outside of Dublin?
- A bit about them: are they working/in college/hobbies etc
- How long have they been "out", socially transitioning etc. if at all
- Are they (i) awaiting treatment (ii) currently receiving treatment (iii) completed treatment?

Health-related questions:

- Could you tell me a bit about your experience with healthcare professionals in general?

If Awaiting:

- Do they know what kind of treatment they are waiting for? If so, what treatment(s)?
- Where are they in terms of waiting? [GP? Gender dysphoria diagnosis? Awaiting endocrinology? Second opinion (GD dx) in the case of surgeries? Blood tests? Seen endocrinologist, awaiting go-ahead? Awaiting further stages of surgery?]
- How long have they been waiting?
- How do they feel about waiting for transition-related healthcare?
- What are their expectations of this procedure? [i.e. results, recovery (in the case of surgeries), side-effects, healthcare professionals]
- What was their experience of finding information about this procedure? Do they feel as though they are well informed? Was it difficult to find information?
- Do they have any fears about the treatment?
- If so, what are these?
- Do they have any hopes about the treatment?

If Currently Undergoing:

- What procedure(s) are they currently undergoing?
- In the case of surgeries: what factors decided what type they had?
- How long have they been receiving this treatment?
- Thinking back, what was your expectation of this treatment?
- Did the outcome of it match their expectations?
- Were they surprised by any aspect of the treatment/procedure?
- Do they feel they were well informed about the treatment/procedure?
- How was their experience with healthcare professionals?
- Did their overall experience differ for different procedures (if relevant)?
- How do they feel about the results?

- Would they change anything?
- Do they plan to undergo further treatment/procedures? If so, what procedures?
- If on hormones: what are their expectations as time goes on (as results happen over time)?
- If awaiting another treatment/procedure: what are their expectations of this [i.e. results, recovery (in the case of surgeries), side-effects, healthcare professionals]?
- If awaiting further treatment: do they have any fears? If so, what are they?
- If awaiting further treatment: do they have any hopes? If so, what are they?
- Do they feel well informed about further treatment/procedures (if applicable)

If Completed Treatment:

- What treatments/procedures have they undergone?
- In the case of surgeries: what factors decided what type they had?
- If they have opted not to undergo certain procedures, what factors influenced this?
- For each procedure/treatment: thinking back, what were your expectations?
- Did the outcome of the treatment/procedures match these expectations?
- How did they know that their medical transition was complete?
- What was their experience with healthcare professionals like?
- Did this differ for different procedures (if relevant)
- Would they change anything?
- Did they feel well informed?
- How do they feel about the results?

After study:

- Ask participant if there is anything they would like to add
- Ask if participant still wishes to have their interview included in the study and if they wish to retract anything
- Provide participants with the contact details of mental health organizations and transgender organizations.

Appendix IV: Information Sheet

Maynooth University
National University
of Ireland Maynooth

Information Sheet

Purpose of the Study

I am Jamie Howell, an MSc student, in the Department of Psychology, Maynooth University.

As part of the requirements for the MSc Psychology, I am undertaking a research study` under thesupervision of Dr. Rebecca Maguire.

The study is concerned with the experiences and expectations of transgender individuals accessingtransition-related healthcare.

What will the study involve?

The study will involve a semi-structured interview lasting no more than one hour.

Who has approved this study?

This study has been reviewed and received ethical approval from Maynooth University Research Ethics committee. You may have a copy of this approval if you request it.

Why have you been asked to take part?

You have been asked because you are a transgender person who is awaiting/currently receiving/has received transition-related healthcare.

Do you have to take part?

No, you are under no obligation whatsoever to take part in this research. However, we hope that you will agree to take part and give us some of your time to participate in an interview about your experience. It is entirely up to you to decide whether or not you would like to take part. If you decide to do so, you will be asked to sign a consent form and given a copy and the information sheet for your own records. If you decide to take part, you are still free to withdraw at any time without giving a reasonand/or to withdraw your information up until such time as the research findings are anonymised. A decision to withdraw at any time, or a decision not to take part, will not affect your relationships with Maynooth University.

What information will be collected?

The information to be collected will include some demographic information about yourself (for example: age, gender identity) as well as information regarding your experience with transition-related healthcare (for example: procedures involved, experiences, expectations).

Will your participation in the study be kept confidential?

Yes, all information that is collected about you during the course of the research will be kept confidential. No names will be identified at any time. All hard copy information will be held in a locked cabinet at the researchers' place of work, electronic information will be encrypted and heldsecurely on MU PC or servers and will be accessed only by Jamie Howell (the researcher) and Dr. Rebecca Maguire (the supervisor).

No information will be distributed to any other unauthorised individual or third party. If you so wish,the data that you provide can also be made available to you at your own discretion.

'It must be recognised that, in some circumstances, confidentiality of research data and records maybe overridden by courts in the event of litigation or in the course of investigation by lawful authority.In such circumstances the University will take all reasonable steps within law to ensure that confidentiality is maintained to the greatest possible extent.'

What will happen to the information which you give?

All the information you provide will be kept at Maynooth University in such a way that it will not be possible to identify you. On completion of the research, the data will be retained on the MU server. After ten years, all data will be destroyed (by the PI). Manual data will be shredded confidentially and electronic data will be reformatted or overwritten by the PI in Maynooth University. In the case of sensitive information disclosed, you may be asked after the interview if you wish to retract any/allof the data.

What will happen to the results?

The research will be written up and presented as a summary report and may be published in scientific journals. A copy of the research findings will be made available to you upon request.

What are the possible disadvantages of taking part?

It is possible that talking about your experience may cause some distress. In this case, you may terminate the interview if you wish, and helplines will be available.

What if there is a problem?

At the end of the interview, I will discuss with you how you found the experience and how you are feeling. If you experience any distress following the interview you may contact the organizations provided on the debriefing sheet.

You may contact my supervisor, Dr. Rebecca Maguire (rebecca.maguire@mu.ie) if you feel the research has not been carried out as described above.

Any further queries?

If you need any further information, you can contact me: Jamie Howell, 0894280917, jamie.howell.2015@mumail.ie

Thank you for taking the time to read this

Appendix V: Consent Form

Consent Form

I…………………………………agree to participate in Jamie Howell's research study titled *The Experiences and Expectations of Transgender People Accessing Transition-Related Healthcare.*

Please tick each statement below

The purpose and nature of the study has been explained to me verbally & in writing. I've been able to ask questions, which were answered satisfactorily. ☐

I am participating voluntarily. ☐

I give permission for my interview with Jamie to be audio-recorded ☐

I understand that I can withdraw from the study, without repercussions, at any time, whether that is beforeit starts or while I am participating.

☐

I understand that I can withdraw permission to use the data right up to anonymization of the data (December 1st 2019). ☐

It has been explained to me how my data will be managed and that I may access it on request. ☐

I understand the limits of confidentiality as described in the information sheet ☐

I understand that my data, in an anonymous format, may be used in further research projects and any subsequent publications if I give permission below: ☐

[*Select as appropriate*]

I agree to quotation/publication of extracts from my interview ☐

I do not agree to quotation/publication of extracts from my interview ☐

[Select as appropriate]

I agree for my data to be used for further research projects ☐

I do not agree for my data to be used for further research projects ☐

I confirm that I am over the age of 18 ☐

I agree for my data, once anonymized, to be retained indefinitely in the IQDA archive ☐

I am not suffering from any significant cognitive impairment ☐

I have not been hospitalized for a mental health condition in the last six months ☐

Signed…………………………………. Date……………….

Participant Name in block capitals ……………………………………………..

I the undersigned have taken the time to fully explain to the above participant the nature and purpose of thisstudy in a manner that they could understand. I have explained the risks involved as well as the possible benefits. I have invited them to ask questions on any aspect of the study that concerned them.

Signed…………………………………. Date……………….

Researcher Name in block capitals ……………………………………………..

If during your participation in this study you feel the information and guidelines that you were given havebeen neglected or disregarded in any way, or if you are unhappy about the process, please contact the Secretary of the Maynooth University Ethics Committee at research.ethics@mu.ie or +353 (0)1 708 6019.Please be assured that your concerns will be dealt with in a sensitive manner.

For your information the Data Controller for this research project is Maynooth University, Maynooth, Co. Kildare. Maynooth University Data Protection officer is Ann McKeon in Humanity house, room 17, who can becontacted at ann.mckeon@mu.ie. Maynooth University Data Privacy policies can be found at https://www.maynoothuniversity.ie/data-protection.

Two copies to be made: 1 for participant, 1 for PI

Appendix VI: Protocol for Dealing with Distressed Participants

Dealing with Distressed Participants Ethics Protocol

The following is a procedural protocol for assisting participants who may become distressedwhile taking part in this MSc research project examining the experiences and expectations of transgender people accessing transition-related healthcare:

If a participant becomes distressed or upset during interview;

1. Ask the person if they would like to take a break and if they would like theinterviewer to switch off the recorder.
2. If this distress continues, ask the person if they would like to end the interview and ifthey would like you to call someone to spend time with them, such as a friend or family member.
3. If the individual is comfortable sharing contact details with the researcher, ask thembefore they leave if it would be okay to call them later in the day or the next day to make sure that they are okay.
4. Before leaving, hand the person the sheet with the contact details of a number oforganisations and helplines that may be of some help to them.

The sheet will contain the following contact details:

Transgender Equality Network Ireland: (01) 873 3575

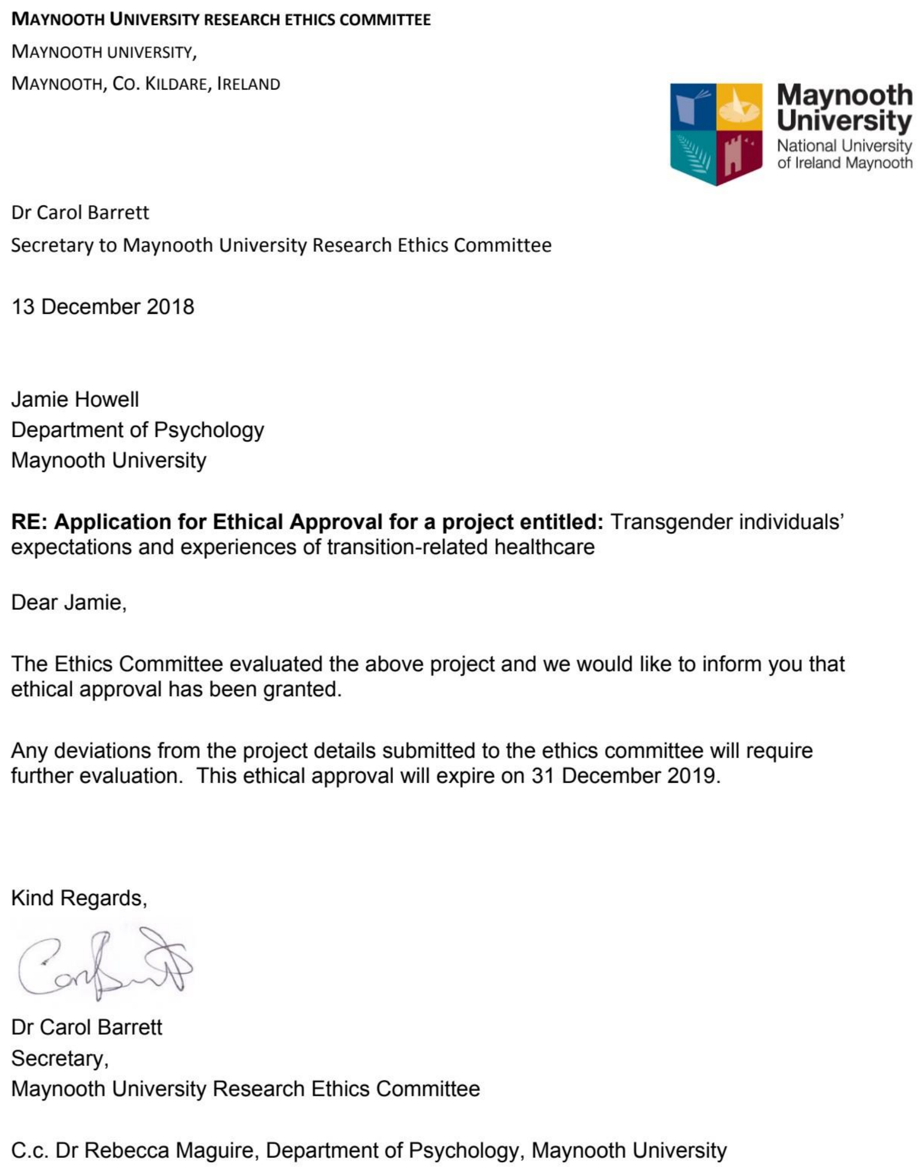
Aware (depression support): 1890 303 302

HIV Ireland: (01) 873 3799

LGBT Helpline: 1890 929 539

Rape Crisis Centre: 1800 778888

Appendix VII: Ethical Approval



MAYNOOTH UNIVERSITY RESEARCH ETHICS COMMITTEE
MAYNOOTH UNIVERSITY,
MAYNOOTH, CO. KILDARE, IRELAND

Dr Carol Barrett
Secretary to Maynooth University Research Ethics Committee

13 December 2018

Jamie Howell
Department of Psychology
Maynooth University

RE: Application for Ethical Approval for a project entitled: Transgender individuals' expectations and experiences of transition-related healthcare

Dear Jamie,

The Ethics Committee evaluated the above project and we would like to inform you that ethical approval has been granted.

Any deviations from the project details submitted to the ethics committee will require further evaluation. This ethical approval will expire on 31 December 2019.

Kind Regards,

Dr Carol Barrett
Secretary,
Maynooth University Research Ethics Committee

C.c. Dr Rebecca Maguire, Department of Psychology, Maynooth University

Reference Number
SRESC-2018-140

Appendix VIII: PPI Advertisement

Maynooth University
National University of Ireland Maynooth

UNDERGOING OR AWAITING GENDER AFFIRMING CARE?

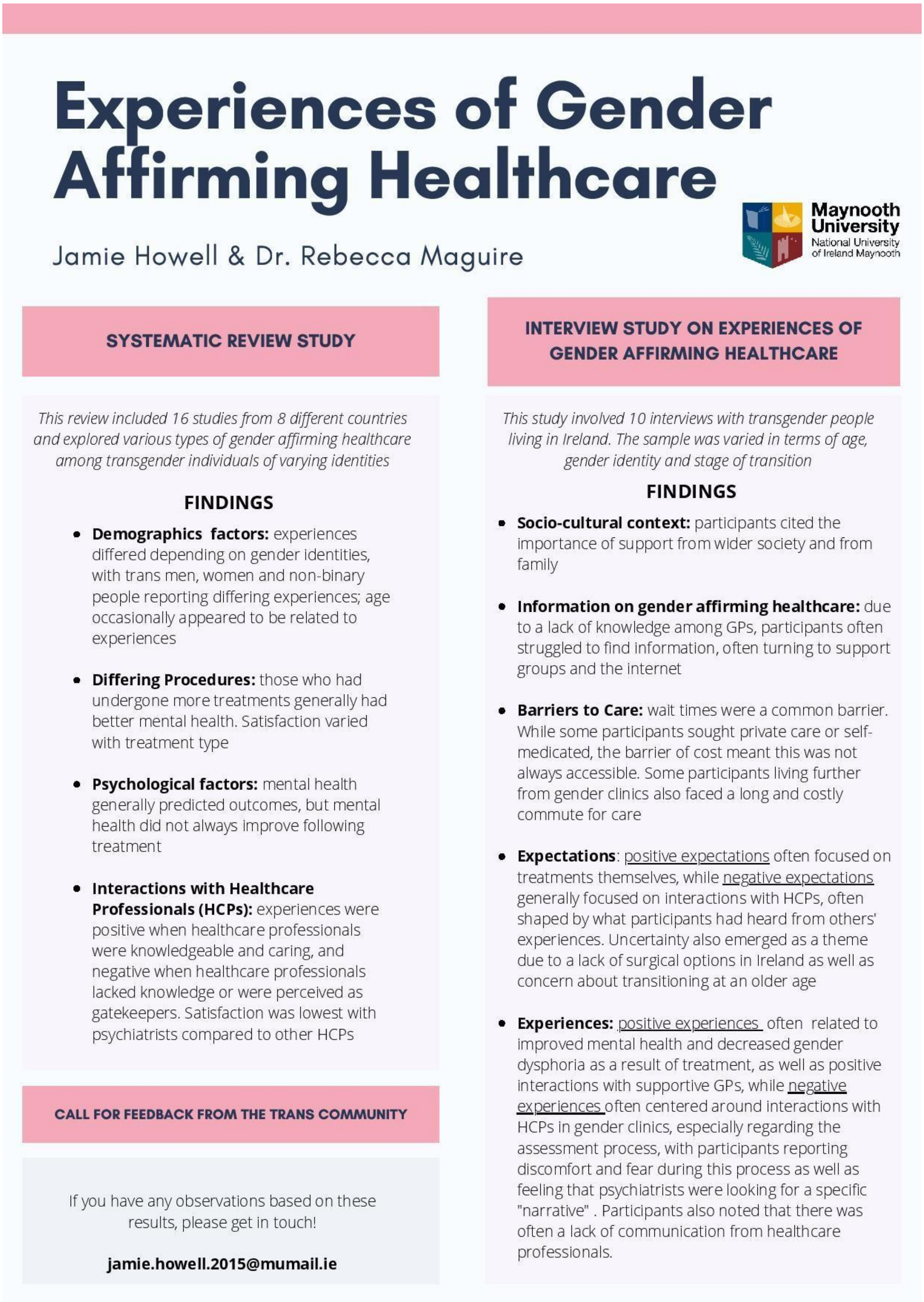
IF SO, WE WANT TO HEAR FROM YOU!

My name is Jamie Howell and I am a postgraduate student at the Department of Psychology in Maynooth University, supervised by Dr. Rebecca Maguire

As part of my MSc research, I conducted two studies investigating factors associated with experiences of gender affirming healthcare

I'm looking to present my findings to transgender patients and get some feedback or thoughts on what they mean to those undergoing gender affiriming healthcare

Get in touch: jamie.howell.2015@mumail.ie



Experiences of Gender Affirming Healthcare

Jamie Howell & Dr. Rebecca Maguire

Maynooth University
National University of Ireland Maynooth

SYSTEMATIC REVIEW STUDY

This review included 16 studies from 8 different countries and explored various types of gender affirming healthcare among transgender individuals of varying identities

FINDINGS

- **Demographics factors:** experiences differed depending on gender identities, with trans men, women and non-binary people reporting differing experiences; age occasionally appeared to be related to experiences
- **Differing Procedures:** those who had undergone more treatments generally had better mental health. Satisfaction varied with treatment type
- **Psychological factors:** mental health generally predicted outcomes, but mental health did not always improve following treatment
- **Interactions with Healthcare Professionals (HCPs):** experiences were positive when healthcare professionals were knowledgeable and caring, and negative when healthcare professionals lacked knowledge or were perceived as gatekeepers. Satisfaction was lowest with psychiatrists compared to other HCPs

CALL FOR FEEDBACK FROM THE TRANS COMMUNITY

If you have any observations based on these results, please get in touch!

jamie.howell.2015@mumail.ie

INTERVIEW STUDY ON EXPERIENCES OF GENDER AFFIRMING HEALTHCARE

This study involved 10 interviews with transgender people living in Ireland. The sample was varied in terms of age, gender identity and stage of transition

FINDINGS

- **Socio-cultural context:** participants cited the importance of support from wider society and from family
- **Information on gender affirming healthcare:** due to a lack of knowledge among GPs, participants often struggled to find information, often turning to support groups and the internet
- **Barriers to Care:** wait times were a common barrier. While some participants sought private care or self-medicated, the barrier of cost meant this was not always accessible. Some participants living further from gender clinics also faced a long and costly commute for care
- **Expectations**: positive expectations often focused on treatments themselves, while negative expectations generally focused on interactions with HCPs, often shaped by what participants had heard from others' experiences. Uncertainty also emerged as a theme due to a lack of surgical options in Ireland as well as concern about transitioning at an older age
- **Experiences:** positive experiences often related to improved mental health and decreased gender dysphoria as a result of treatment, as well as positive interactions with supportive GPs, while negative experiences often centered around interactions with HCPs in gender clinics, especially regarding the assessment process, with participants reporting discomfort and fear during this process as well as feeling that psychiatrists were looking for a specific "narrative" . Participants also noted that there was often a lack of communication from healthcare professionals.