Transgender men and mental healthcare services in South Africa

Jude Anjuli Daya

Student number: DYXANJ002

Supervisor: Professor Floretta Boonzaier

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Declaration

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Abstract

The mental healthcare needs of transgender men in South Africa are not being met. Transgender people face disproportionately high rates of mental illness, yet struggle to find mental healthcare that is sensitive to their needs. Transgender men remain an unseen, underserved subset of this already marginalised group. This research aimed to provide a platform for trans men to share their narratives about accessing mental healthcare. The researcher, a trans man, brings an insider perspective to trans mental health. Individual semi-structured interviews were conducted with 17 adult transgender men and transmasculine individuals who had used mental healthcare services in South Africa. The interview transcripts were analysed using thematic narrative analysis, informed by queer theory and gender minority stress theory. Participants described ongoing challenges, which included everyday and medical discrimination, feelings of invisibility, imposed expectations of transness and masculinity, and the distress of gender dysphoria. This study highlights the significant maltreatment and transphobia that trans men experience from most mental healthcare services. Participant narratives indicate that most healthcare providers were misinformed about transness and treated patients as educators. This research provides insights into the challenges trans men navigate with mental healthcare, and offers recommendations for appropriate, sensitive care for this population.

Contents

Glossary

- **AFAB**: assigned female at birth
- **AMAB**: assigned male at birth
- **Binding**: the use of materials such as tightly-wrapped bandages or a binder (a type of compression vest) to flatten one's chest
- **Cisgender**: someone whose gender identity aligns with their sex assigned at birth; the opposite of transgender
- **Cishet**: someone who is both cisgender and heterosexual
- **Deadname/deadnaming**: using a trans person's birth name instead of their chosen name
- **Female-to-male (FTM)**: older term for a trans man, not commonly used today
- **GAHC**: gender-affirming healthcare
- **Gender dysphoria**: distress caused by a mismatch between one's gender identity and birth-assigned sex
- **Gender euphoria**: the opposite of gender dysphoria; the joy of having one's gender identity affirmed
- **Gender identity**: an innate sense of gender (e.g. man, woman, nonbinary, genderqueer), or a lack thereof (e.g. agender)
- **Gender expression**: how someone expresses their gender identity through their appearance and mannerisms
- **HCP**: healthcare provider
- **HRT**: hormone replacement therapy
- **LGBTQIA+**: lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/aromantic/agender
- **MHCP**: mental healthcare provider

- **Misgendering**: deliberately using incorrectly gendered language for a trans person
- **Packer/packing**: the use of penile prosthetics or other materials to create the appearance of a bulge in one's underwear
- **Passing**: being correctly perceived by others as the gender one identifies as
- **SA**: South Africa
- **Sex assigned at birth**: "the classification of an individual as male, female, or intersex, typically made by medical professionals at the time of birth based on physical characteristics, such as external genitalia" (PsySSA, 2025, p. 95)
- **Stealth:** trans individuals who live and pass as the gender they identify with and do not disclose their trans status publicly
- **T:** testosterone
- **TGNC**: transgender and gender nonconforming
- **Top surgery**: chest surgery - for AFAB people, a double mastectomy
- **Trans**: shorthand for transgender; umbrella category that includes anyone who is not cisgender
- **Transgender**: someone whose gender identity does not align with their birth-assigned sex; opposite of cisgender
- **Transfeminine/transfemme**: an umbrella category that includes trans women and nonbinary trans people who identify primarily with femininity
- **Transition**: medical, social, and/or legal changes made by a trans person to better align their body and/or how they are perceived by others with their gender identity
- **Transmasculine/transmasc**: an umbrella category that includes trans men and nonbinary trans people who identify primarily with masculinity
- **Transsexual**: older term for transgender, generally seen as a slur today; sometimes used to describe trans people who have medically transitioned

Chapter One: Introduction

1.1 Background

Transgender men form a subset of a marginalised population with diverse mental healthcare needs, yet there is very little research on how they experience seeking out and utilising mental healthcare services. Trans people face discrimination in arenas ranging from the social and familial to the legal, medical, and structural. Being transgender is no longer classified as a mental illness (American Psychological Association [APA], 2013), but the combination of discrimination and gender dysphoria contributes to the "distress and dysfunction" many trans people experience (Campbell et al., 2018, p. 168). Thus, while trans people may experience psychological distress related to their trans status, these difficulties are more attributable to social factors (including minority stress) than to being trans itself (Hendricks & Testa, 2012).

Despite the South African Constitution being renowned for its protection of LGBTQIA+[1] rights, the rights of trans individuals are still violated in multiple contexts including healthcare access (Zambezi & Viljoen, 2024). A progressive Constitution has also not made the general public fully accepting of trans people (Sutherland et al., 2016). As a result, a trans man seeking psychological help in South Africa (SA) cannot be guaranteed that health care providers (HCPs) will understand his trans identity (PsySSA, 2025; Seelman & Poteat, 2020). They may pathologize his identity, misunderstand, dismiss or maltreat him (Husain, 2022; Müller et al., 2019; Outright International, 2024).

Research on trans people in SA thus far has almost exclusively focused on trans women in the context of HIV, with minimal attention paid to trans men. It is only in the last five years that a handful of researchers have focused on this population, in the contexts of trans masculinities (Monakali, 2020; Monakali & Francis, 2020), inclusion in higher education (Buthelezi, 2022; Buthelezi & Brown, 2023), intimate partner violence (Rogers,

[1] Lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual/aromantic/agender

2021), and T (testosterone) as a technical object (Camminga & Lubinsky, 2021; Lubinsky, 2024). The mental healthcare experiences of trans men in this country have not been addressed in any academic literature.

A note on language: I use 'trans' as shorthand for 'transgender' throughout this thesis as an umbrella term for anyone who is not cisgender. This is because 'trans' is currently the term we use most commonly in this community to describe ourselves. However, terminology changes rapidly among trans people, and it is quite likely that this will become dated within the next few years. Please see the **Glossary** (p.viii) for more information about terms used by and about the trans community, both historically and currently.

1.2 Aims and Research Questions

This study aimed to explore trans men's experiences of seeking out and accessing mental healthcare services in SA, through providing them with a space to speak with a fellow trans man about these experiences. It also examined whether there is one general 'trans male experience' of accessing these services or whether other intersecting aspects of identity influence their experiences. Lastly, based on participants' experiences and recommendations, it aimed to make suggestions for mental healthcare providers (MHCPs) on the most appropriate, sensitive ways of engaging with this population.

The research questions are as follows:

1. How do transgender men speak about their lived experiences of their gender identity in the South African context?
2. What narratives do transgender men tell about their experiences of public and/or private mental healthcare services in SA?
3. How do they speak about whether (or not) their needs as transgender men are being met by the healthcare system?

a. What narratives do they tell about the changes they wish to see made in the system?

1.3 Significance of the Study

The study contributes to a small but growing body of literature on the experiences and needs of trans persons in the Global South. The vast majority of research about trans men has been conducted in the Global North. Although there are some commonalities between these findings and those of the current study, other research cannot be directly applied to the South African context. This research explores factors that shape the experiences of trans men in SA. It is not possible to rectify the issues trans men are facing within South African mental healthcare systems without first establishing what these issues are. Equally, trans men's positive experiences can inform HCPs as to what constitutes a good healthcare experience for this population. This research also benefits from its emic approach, drawing from my experiences and observations as a trans man who has used mental healthcare in SA.

1.4 Thesis Structure

Chapter Two reviews different aspects of the available literature on this topic. Chapter Three covers my approach to research and how I collected and analysed the data. Chapters Four, Five and Six contain the analysis, with findings and discussion combined. Through participants' narratives about their lived experience of their gender, Chapter Four provides context about what it is like being a trans man in SA. Chapter Five looks at participants' experiences of seeking out and accessing mental healthcare and some of the challenges they faced. In Chapter Six, participants speak about whether their healthcare needs are being met and what changes they want to see made to existing healthcare systems. Finally, Chapter Seven details the significance and limitations of the current research, what other areas still need to be studied, and gives some practical recommendations for HCPs.

Chapter Two: Review of Transgender Mental Health(care) Literature

2.1. Introduction and Context

This chapter reviews the available literature on different aspects of the topic of trans men and mental healthcare in South Africa: general South African trans experiences; trans people and healthcare (local and global); mental healthcare in SA; and trans mental health.

2.1.1 Being Transgender in South Africa

Prejudice against trans people is widespread in SA (Sutherland et al., 2016). Macheso (2020) observes that trans people are marginalised in general society in SA as well as within the LGBTQIA+ community, which is reflected by the "dearth of scholarship on transgenderism [sic] in African literature" (p.1). Trans people are frequent targets of harassment and violence, particularly gender nonconforming people and those who do not pass as the gender they identify with (Ramphele, 2016). Transphobic violence needs to be understood within the broader context of pervasive sexual and gender-based violence (SGBV) in SA (Boonzaier, 2018; Human Rights Watch, 2011). Campbell et al. (2018) argue that the high prevalence of SGBV in SA may "normalise" the "violence and aggression [that] are everyday experiences for trans individuals" (p.173).

Being trans and/or queer is often framed as 'un-African' and this perception is still prevalent in SA (Berry, 2021; Monakali & Francis, 2020), despite constitutional protections for LGBTQIA+ individuals. However, Collins (2017) highlights that Africa has a lengthy history of gender nonconformity, and that much of this history was suppressed and erased by European colonization. As Beemyn (2013) notes, there has not historically been one cross-culturally stable definition of the term 'transgender.' Thus, there are people from previous decades and from cultures pre-colonisation who would currently be understood as trans, but may not have described themselves as such (Elnaiem, 2021; Mehra et al., 2019). Trans activists in Africa face significant challenges finding suitable vernacular terms in local

languages for discussing trans identities (Kolanyane-Kesupile & McAllister, 2021), without directly importing "Eurocentric definitions" from the Global North (Moloi, 2013, p. 9).

Particularly in the South African context, it is crucial to consider how race and class intersect with gender and influence how people experience being trans (Strand et al., 2020). Theron and Kgositau (2015) highlight that there is "no singular trans experience or definition, not in the global North and definitely not in English-speaking sub-Saharan African countries" (p.579). Medical and legal transition remain financially inaccessible for many trans people, meaning that class and income directly impact how they are able to express their gender. Van der Merwe (2017) argues that the intersections of "race, geography, class, education and economic status" make it "virtually impossible for trans persons of colour to access comprehensive gender-affirming care in South Africa" (p.93). Additionally, as de Vries (2012) asserts, "dominant cultural narratives such as whiteness influence an individual's perceived gender" (p.60). A white trans person who transitions will be perceived as shifting from one *gendered* identity to another, but a trans person of colour may also encounter shifts in how their *racial* identity is understood. For example, White et al. (2020) found that Black transmasculine individuals are often "seen as threatening" after medically transitioning and being seen as Black men (p.257). The inherent "assumption of whiteness" means that passing guides[2] for trans men essentially give advice on "how to pass as a hot normative white dude" (Pennington, 2018, p. 119), with little consideration for trans men of colour or anyone who does not identify with transnormative versions of masculinity.

2.1.2 Transnormativity

Cisnormativity is an ideology that positions being cisgender as the norm and assumes that everyone identifies with the gender they were assigned at birth (Bradford & Syed, 2019). As

[2] A *passing guide* is a set of tips and advice for trans people on how to be perceived as the gender they identify as. For trans men, this includes topics like haircuts, clothing, binding, packing, body language, and men's bathroom etiquette. However, these guides have been critiqued for relying on normative, restrictive conceptualizations of maleness and masculinity (Spade, 2006).

an ideology, transnormativity asserts that there is a singular 'correct' way to be trans, enforcing cisnormative gender standards by imposing certain criteria that trans people must fulfil to be considered 'really' transgender (Johnson, 2016; Vipond, 2015). This creates a "*trans enough* hierarchy" in which individuals are compared to each other (Johnson, 2016, pp. 466, emphasis in original), resulting in some being viewed as more trans or more valid than others.

Transnormativity views trans identities through a medical lens. Thus, to be recognised as transgender one must be diagnosed with gender dysphoria as a mental illness and subsequently receive medical treatment (both hormone replacement treatment [HRT] and gender-affirming surgery) for this 'illness' (Johnson, 2016). The medical model necessitates diagnosis, thereby allowing healthcare providers to control and regulate access to medical transition (Riggs et al., 2019). Another aspect of this is the "medico-legal" model of transness (Camminga, 2017, p. 11), wherein gender and sex are defined by the medical profession and legitimized through legal systems of documentation. This model also demands medical transition in order for transgender people to achieve legal recognition as their true gender (Camminga, 2017).

Johnson (2016) outlines how transnormativity relies on a "binary medical model" (p.466), suggesting that norms associated with the gender binary and medicalization of trans people are inextricably linked. Those who do not or cannot abide by binary gender norms and/or reject medical transition are often subjected to heightened visibility (Vipond, 2015). Trans people are expected to strive to conform to the "ideal of binary gender" (Bruns, 2023, p. 53), despite the inherent unattainability of this envisioned 'ideal.' This excludes non-binary and gender nonconforming individuals from being recognized as transgender (Anzani et al., 2022). Nonconformity to societal expectations draws attention, as others struggle to comprehend one's gender expression which hinders their ability to understand the person

overall (Garrison, 2018). Furthermore, transnormativity perpetuates heteronormative standards, thereby also excluding queer trans individuals from recognition (Bruns, 2023; Vipond, 2015).

There is a prevailing assumption that all transgender people not only want to be recognized as the correct gender but also to be seen as cisgender (Riggs et al., 2019). Thus, a trans man cannot desire to be seen as a *transgender man*: he should only wish to be seen as a *man* and assumed cisgender by default (Bruns, 2023). The concept of passing is closely related to transnormativity, serving as both an aspect of it and a parallel concept. According to LaValley (2021), some trans people perceive the pressure to pass as damaging, while for others passing functions as a tool for navigating a society that does not fully understand or accept transgender people. However, there is a paradox within transnormative notions of passing. If trans people must be perceived as cisgender to pass, then being seen as trans means one has failed at being trans (Vipond, 2015). In other words, belonging to the trans community means that one's trans status must be invisible. As explained in the following section, being visibly trans also poses significant challenges in healthcare contexts.

2.2 Healthcare

This section looks at three aspects of healthcare: the discrimination trans people encounter in this context, the education of HCPs about trans people and their healthcare needs, and a broad overview of mental health and healthcare in South Africa.

2.2.1 Discrimination in Healthcare Contexts

Trans people experience active discrimination in healthcare settings, including verbal and physical violence, hostility and stigma, and conversion practices. There is also passive discrimination, such as gendered healthcare spaces not accommodating trans people, the lack of facilities providing trans-affirming healthcare, and the exclusion of trans people from

healthcare administration and policies. One of the results of this discrimination is that some trans people avoid accessing healthcare as they fear encountering further transphobia.

Transgender Experiences of Medical Discrimination. Stigma against trans people is rife in medical settings, globally and in SA. It is well-established that trans people face significant discrimination in healthcare contexts when HCPs are aware of their trans status (Cicero et al., 2019). As a result, many LGBTQIA+ individuals hide their gender identity and/or sexual orientation from HCPs because they fear mistreatment (Müller, 2017; Müller et al., 2019). Transphobic violence perpetrated by HCPs ranges from "doctors making inappropriate jokes" to "abuse and physical violence" (Abelson, 2019, p. 182). These experiences of prejudice are especially troubling considering that discrimination in healthcare and other structural contexts can contribute to suicidality for trans individuals (Herman et al., 2019). Some HCPs justify poor treatment of LGBTQIA+ patients due to their "political, moral or religious beliefs" (Luvuno et al., 2019, p. 2). Similarly, Müller (2017) notes the role of religion in trans healthcare discrimination, through "forced subjection of patients to religious practices" (p. 1). The weaponisation of religion is a core element of conversion practices, which are associated with worse mental health and quality of life for LGBTQIA+ people (Outright International, 2024).

Trans people experience multiple forms of violence in healthcare settings (da Luz Scherf et al., 2021). Verbal violence is evident in how HCPs speak to and about trans patients. One such language issue is misgendering, which worsens trans mental health and make trans patients feel unsafe and unwelcome in healthcare spaces (Dolan et al., 2020; Holt et al., 2021). Other discrimination issues include "health care worker voyeurism" and trans patients "being made a spectacle to other patients and health care workers" (Luvuno, Ncama, et al., 2019, p. 6). This type of mistreatment disregards the patient's right to privacy and dignity.

Particularly in mental healthcare contexts, the trans patient's gender identity often becomes the focus of the appointment even if this is not what they have sought help for (Holt et al., 2021; Luvuno, Ncama, et al., 2019). Yet a review by White and Fontenot (2019) found that when trans people do wish to discuss trans-related mental health difficulties, HCPs are not always willing or able to discuss these issues.

Lack of Transgender Inclusion in Healthcare Spaces. The lack of trans-specific facilities and services in both public and private healthcare sectors in SA is a serious issue (Jessani et al., 2024; Zambezi & Viljoen, 2024). There are very few public healthcare facilities in SA that provide trans-affirming healthcare (Wilson, 2021). Although gender-affirming healthcare (GAHC) can be accessed in private healthcare, this is costly, and medical aid schemes do not pay for this care as it is deemed "cosmetic" and therefore "not medically necessary" (Deyi, 2017, p. 159).

Placing trans individuals in hospital or inpatient psychiatric wards that do not align with their gender identity is humiliating and threatens their safety (Dasso et al., 2025; Dolan et al., 2020). Allocating people to gendered wards based solely on the gender on their official identification is problematic, as a trans person's legal gender will often not match their gender identity. Not all trans individuals wish to legally change their gender marker, however, partly because it is a notoriously difficult process in SA (Iranti, 2022). Nonbinary individuals are particularly unlikely to have an ID that matches their gender since despite a proposed third gender marker option (Department of Home Affairs, 2023), South African IDs still only code for male or female.

Another issue in hospital and inpatient psychiatric facilities is gendered bathrooms, which are a major source of stress and safety concerns for trans people in many contexts (Abelson, 2019; Dolan et al., 2020). The Southern African HIV Clinicians' Society's GAHC guidelines recommend that trans patients have access to bathrooms that correspond to their

gender identity, “including fully private, non-binary or gender-neutral bathrooms” (Tomson et al., 2021, p. 12).

Dolan et al. (2020) raise the issue of official medical correspondence having the wrong gender or title on it, potentially outing people, and that this invasion of privacy can put trans people in danger. There are issues around medical intake forms, where only having binary gender options excludes many trans people, especially nonbinary individuals. Hope et al. (2022) recommend having a “blank space for specifying gender and the name you wish to be called” (p. 10). The phrasing here is also important; it is better to say, ‘What do you want to be called?’ than ‘preferred name,’ which makes using this name seem optional. People may still wish to be addressed by their birth name for safety reasons or if they are not out as trans. The medical exclusion trans people experience can contribute to their being reluctant to be in these discriminatory contexts.

Transgender Healthcare Avoidance. Given that many trans people experience medical discrimination, it is no surprise that some avoid seeking out healthcare altogether. This is a long-standing issue, with Singh et al. (2014) finding over a decade ago that some trans people avoided seeking healthcare because they were afraid of experiencing transphobia due to previous negative healthcare experiences. More recently, a UK study about experiences of transphobia found that almost 80% of participants had avoided healthcare because of transphobia, and close to half had “received incorrect medical treatment due to transphobia” (Bradley, 2020, p. 17). In mental healthcare settings, having negative experiences or knowing a trans peer who has contributes to trans people avoiding or ceasing to access this care (Cicero et al., 2019; White & Fontenot, 2019).

There are several consequences of this healthcare avoidance. Findings from a review of literature on trans access to healthcare in Africa indicate that trans people may avoid seeking healthcare even in medical emergencies (Jessani et al., 2024). Additionally, if trans

people are not having regular medical checkups, they are at "increased risk of morbidity and mortality from preventable infections and cancers" (Luvuno, Mchunu, et al., 2019, p. 2). Another issue is that people may self-medicate instead of seeking medical treatment (Dasso et al., 2025), which can in itself cause other health issues (Luvuno et al., 2017). One way of ameliorating these effects of healthcare discrimination is through the education of HCPs.

2.2.2 Education of Healthcare Providers

HCPs need to be informed about trans people and their healthcare needs in order to provide suitable care, yet most healthcare training does not cover trans healthcare. In the absence of formal education about trans people, the responsibility falls to HCPs to self-educate. If HCPs are uninformed about transness, trans patients often have to educate them. In recent years, guidelines have been created for HCPs working with trans patients in SA. Nevertheless, it is still the responsibility of individual HCPs to read and apply these guidelines.

Healthcare Curricula Excluding Transgender Care. Globally, HCPs are not receiving adequate education about trans people or trans healthcare. Forshee (2006) highlighted that trans men were excluded from healthcare training. Yet nearly 20 years later, Dasso et al. (2025) note that HCPs "seemed unaware of research into trans health" (p. 568). This is concerning because the amount of research on trans health has increased significantly in the last 10-15 years. However, if HCPs are not aware of this research, they will not be able to put it into practice. This lack of education has also been an issue for a long time in SA, with Theron (2008) noting a dearth of information about trans people in "medical, mental health and legal professions training curriculums" (p. 7).

Research from the last decade has highlighted the issue of HCPs in SA not receiving formal education about LGBTQIA+ people in general, let alone trans-affirming healthcare or GAHC. Luvuno et al. (2017) interviewed HCPs in KwaZulu-Natal and found that none of them had been trained about LGBTQIA+ health. However, the HCPs interviewed felt that

they needed this training, which was a "positive indication of willingness to care for the transgender patients" (Luvuno et al., 2017, p. 8699). Similarly, Spencer et al. (2017) noted the conspicuous absence of trans healthcare from healthcare curricula, particularly GAHC. If HCPs are not receiving formal training about trans people and trans healthcare needs, the result is that the only ones who do have this knowledge are those who have taken "individual interest and initiative" to educate themselves (Spencer et al., 2017, p. 12).

Luvuno, Mchunu, et al. (2019) highlight another important factor: HCPs having experience and awareness of LGBTQIA+ patients. Given that HCPs have not generally been trained on how to work with these populations, and that trans people are a minority group, it can be easy for them to be unaware of trans-specific healthcare needs. The authors also discovered that if HCPs receive exposure to LGBTQIA+ patients early on in their careers, this "increases clinical confidence" and improves those patients' experiences (Luvuno, Mchunu, et al., 2019, p. 8). Other research conducted with HCPs in South Africa indicates that "inadequate training and inexperience" was a significant reason that HCPs avoid providing GAHC (de Beer-Procter, 2022, p. 2). Without training, HCPs are less likely to gain experience, and experience is crucial for working with trans patients.

There is significant body of research strongly recommending that trans healthcare be included in healthcare curricula (Kattari et al., 2020; Meer & Müller, 2017; Spencer et al., 2017; Strand et al., 2020). It is clear that solely relying on HCPs to do self-study is insufficient: medical training needs to include trans and gender-diverse people from the start, rather than HCPs only doing additional education after their formal education (Hope et al., 2022). Worryingly recent research with final year medical students in South Africa found that there is "no stipulated teaching regarding LGBT mental health in the formal academic rotation" (Badat et al., 2023, p. 3). McLachlan (2024) notes that many current HCPs "did not

receive formal education on sexually and gender diverse topics during [their] studies" (p. 2), and emphasizes the necessity of HCPs continuing their education.

Transgender Patients Educating Healthcare Providers. HCPs being unfamiliar with trans healthcare needs does not stop trans people from needing healthcare. If HCPs are not receiving formal education or doing self-study about trans care, the burden of education ends up falling on the trans patient (Kattari et al., 2020). This has been found to be the case in general healthcare contexts (Dasso et al., 2025; Seelman et al., 2020), and is detrimental to trans patients in mental healthcare as well (Holt et al., 2021). White et al. (2020) found that Black trans men in the US seeking mental healthcare had to educate their counsellors about different intersecting aspects of their lived experiences, and that this "led to unhelpful therapeutic relationships" (p. 259). Having to educate HCPs about transness and trans healthcare causes significant frustration for trans patients, which is worsened when they put in that effort and the HCPs are unwilling to learn (Hope et al., 2022). In the South African context, it has also been found that trans patients are having to educate HCPs about their healthcare needs as well as basic information about transness (Luvuno et al., 2017; Strand et al., 2020).

Guidelines for Healthcare Providers. The systemic barriers trans people encounter in healthcare contexts also include passive forms of erasure. This results in a "lack of knowledge, data, policies and practice guidelines" about trans healthcare needs (Luvuno, Ncama, et al., 2019, p. 2). Without guidelines, it is harder for HCPs to know what constitutes appropriate healthcare for trans individuals and therefore how to provide it. Until quite recently, there were no guidelines in SA for MHCPs or HCPs in general regarding working with trans clients. Research from before the guidelines came out highlights how much they are needed (Wilson, 2021). It was difficult to know how individual HCPs who provided

GAHC could "make clinical decisions about eligibility and treatment options" (Spencer et al., 2017, p. 1), because there were no guidelines to act as a benchmark for appropriate care.

There are now several South African guidelines for HCPs working with trans patients. The "Southern African HIV Clinicians' Society Gender-Affirming Healthcare Guideline for South Africa" was published in 2021, and aimed to "provide evidence-informed best practice recommendations in order to enable South African healthcare providers, including psychosocial and allied healthcare professionals, to offer quality, affirming services to TGD[3] clients" (Tomson et al., 2021, p. 3). For MHCPs, the first edition of the *Practice Guidelines for Psychology Professionals Working with Sexually and Gender-Diverse People* by the Psychological Society of South Africa (PsySSA) came out in 2017, and the updated second edition this year (PsySSA, 2025). It is vital for HCPs to have local guidelines; however, it is not yet clear how much these guidelines are being implemented. Additionally, since the guidelines are not currently enforceable, the onus is still on individual HCPs to put them into practice.

2.2.3 Mental Healthcare in South Africa

There is limited data available regarding the prevalence of mental illnesses in South Africa (Shisana et al., 2024); however, the information we do possess indicates that a significant number of South Africans are experiencing challenges related to mental health. Data gathered from the South African Stress and Health Study in the early 2000s revealed that the lifetime prevalence of any mental illness was 30.3% (Stein et al., 2008). More recently, Benjamin et al. (2021) reported that the 12-month prevalence of common mental disorders, which include mood disorders, anxiety, substance use disorders, and PTSD, was 16.5% (p.366). Furthermore, Craig et al. (2022) found that between 14.7% and 38.8% of South Africans are experiencing moderate to severe symptoms of probable depression.

[3] Transgender and gender diverse

However, most individuals with mental health conditions are not receiving the necessary support. Only 24% of those with a common mental disorder actually receive treatment (Baker & Naidu, 2021, p. 1). When individuals with severe mental illnesses are factored in, it is estimated that less than 10% of people in South Africa access treatment for their mental health conditions (Sorsdahl et al., 2023, p. 2). Several factors contribute to this lack of access to treatment. A significant concern is that many individuals are not well-informed about mental health issues. This knowledge gap affects not only those seeking assistance for their own mental illnesses (Bila & Carbonatto, 2022), but also their caregivers (Monnapula-Mazabane & Petersen, 2023). Furthermore, this limited understanding of mental illness is linked to the considerable social stigma that still surrounds it. Benjamin et al. (2021) suggest that educating broader communities could improve acceptance and understanding around mental health, facilitate earlier identification of illnesses, and encourage people to seek out help.

When people do seek mental healthcare, though, their options are often quite limited. Only 15.7% of all South Africans have access to medical aid (StatsSA, 2023, p. 20), without which private healthcare is generally unaffordable. With an unemployment rate of 32.1% (StatsSA, 2024, p. 1), it is not surprising that over 80% of South Africans rely on public healthcare (Sorsdahl et al., 2023, p. 2). Additionally, the distribution of MHCPs raises concerns. Janse van Rensburg et al. (2021) found that nearly 80% of psychiatrists are employed full-time in private practice, and only about 20% work full-time in public healthcare (p.2). For people living in rural areas, access to mental healthcare is further complicated by a shortage of local resources and the costs associated with transport to healthcare facilities in metropolitan areas (Bila & Carbonatto, 2022). It has also been reported that only half of public hospitals with mental healthcare services employ a psychiatrist, and a third do not have any clinical psychologists on staff (Nguse & Wassenaar, 2021).

Despite the clear need for publicly accessible mental healthcare, only 5% of the total public health budget is allocated to these services (Docrat et al., 2019). This funding is significantly skewed towards inpatient treatment, which receives 86% of total expenditure, while just 14% is directed towards outpatient care (Docrat et al., 2019, p. 707). Furthermore, only 8% of overall mental healthcare spending is designated for primary healthcare services (Sorsdahl et al., 2023), which is also intended to cover medication costs for individuals with severe mental illnesses. Docrat et al. (2019) highlight that medications for conditions such as depression, bipolar disorder, and psychosis are frequently out of stock in public healthcare facilities. Additionally, Siyothula (2022) found that 72.4% of clinical psychologists working in non-urban areas of KwaZulu-Natal reported a lack of essential resources, including assessment tools, phone and Internet access, and computer equipment. These kinds of resource constraints have a detrimental impact on the quality of care that HCPs working in the public healthcare system are able to provide.

2.3 Mental Health of Transgender Individuals

This section focuses on elements that can harm or help trans people's mental health. It starts by contextualising the high prevalence of mental illness among this group. It then explores some factors that improve mental wellbeing, both internal factors like resilience and external factors such as social support. Lastly, it looks at what constitutes trans-affirming healthcare and how healthcare can be more inclusive of trans people.

2.3.1 Mental Illness in Transgender Populations

Several factors contribute to the higher rates of mental illness found in trans populations, including social stigma, physical violence, and harassment. It can be dangerous for people to be openly trans due to societal prejudice against visibly gender-nonconforming people. As a result, it is often safer for trans people to be perceived as cisgender and heterosexual,

particularly in high-risk contexts such as gendered public bathrooms. The trans population is at a much higher risk of experiencing mental illness, with suicidality being a major concern.

Contributing Factors. As the minority stress model makes clear, mental illness does not occur in a vacuum: people of marginalized groups are more likely to experience mental illness symptoms due to the stigma they experience, not because they are inherently more mentally ill (Helsen et al., 2022; Hendricks & Testa, 2012). It is therefore important to understand trans mental health issues in context, as many of these issues can be understood as a "normative response to pervasive discrimination, violence, and exclusion" (Valentine & Shipherd, 2018, p. 35).

Trans people experience disproportionately high rates of violence, which has a serious impact on their mental health. A UK study on transphobia found that in the last 12 months, 17% of participants had experienced or been threatened with sexual assault, and 26% had experienced or been threatened with physical assault (Bradley, 2020, p. 6). A large survey on LGBTI people and mental health in SA had similar findings for past-year experiences: 56% of gender minority[4] participants had experienced verbal harassment, 29% had experienced sexual assault, and 27% had experienced physical violence (Müller et al., 2019, p. 41). These numbers are even higher when looking at lifetime experiences of violence: 79% for verbal harassment, 62% for sexual assault, and 61% for physical violence (Müller et al., 2019, p. 45).

Being visibly trans or gender-nonconforming can be very dangerous, particularly in SA. Müller (2016) notes that it is not only actually being LGBTQIA+ but that "even the perception of homosexuality or transgender identity puts people at risk" (p.196). The largest nationally representative survey of South Africans to date found that although nearly 90% of

[4] People who are not cisgender, which includes transgender, gender-nonconforming, nonbinary, and intersex individuals (Müller et al., 2019).

respondents said that they had not and would never be physically violent against gender-nonconforming people, 6.2-7.4% felt that they might be in the future (Sutherland et al., 2016, p. 22). This violence needs to be understood in the broader context of gender-based violence that is prevalent in South Africa.

For many trans people, leaving the house can be very difficult. One major source of concern is around gendered public bathrooms, which are very unsafe spaces to be visibly gender nonconforming or queer. Not being able to use a public bathroom limits how long someone can be out of the house, and means that trans people must make decisions about where they go based on the availability of safe bathrooms (Bradley, 2020). Passing is particularly important for trans people in this context. Rogers (2019) found that when trans men have fears around safety, passing provides a degree of protection. Yet to use public bathrooms safely, in addition to not being visibly trans, trans men also cannot be seen as queer. As Abelson (2019) highlights, avoiding violence in these spaces requires trans men to demonstrate "appropriate behaviour that mark[s] them as properly heterosexual" (p.166).

Mental Illness Prevalence. Although sources vary on the exact rates of mental illnesses among trans populations, it is clear that the overall prevalence is much higher than among cisgender people (Pampati et al., 2023). Trans people are at elevated risk for depression, anxiety, suicidality, non-suicidal self-injury (NSSI), substance abuse disorders, PTSD, and eating disorders (Tebbe & Budge, 2022; Valentine & Shipherd, 2018). Depression and anxiety are common issues, with Hajek et al. (2023) finding in a German sample that the rate of "probable depression" and anxiety were 33.3% and 29% respectively (p.6). In general, trans people with less social support have worse mental health. For example, Puckett et al. (2019) found that the prevalence of severe depression was 42.6% among trans individuals with overall low levels of social support, compared to 5.1% among those with high levels of

support (p.9). There was also a marked prevalence of anxiety, with 44.7-59% of all participants reporting moderate anxiety symptoms (Puckett et al., 2019, p. 9).

Rates of NSSI are very high among trans people. Research by Lefevor et al. (2019) demonstrated that 57% of binary-gendered trans people and 62% of nonbinary people had experience with NSSI, compared to 16% of cisgender men and 29% of cisgender women (p.390). Risk factors for NSSI include gender dysphoria, eating disorders, and diagnosed comorbid mental illnesses (Vigny-Pau et al., 2021).

It is well-established that there is a suicide crisis in the trans community. Data collected in 1997 from research on HIV prevalence among trans populations in San Francisco by Clements-Nolle et al. (2001) also discovered that 32% of the 515 trans individuals interviewed had attempted suicide (Clements-Nolle et al., 2006, p. 59). Research from the past two decades has demonstrated continued elevated rates of suicidality in trans populations. Among a Canadian sample of trans adults, lifetime suicidal ideation was nearly 45% and 26% had had at least one suicide attempt (Moody et al., 2015, p. 269). The 2015 United States Transgender Survey (USTS), the largest survey of trans people in the US, found that 81.7% of trans individuals had experienced suicidal ideation and 40.4% had attempted suicide at some point in their lives (Herman et al., 2019, p. 1). A Swedish study found that among trans participants, lifetime suicidal ideation and suicide attempts were 36.1% and 15.5% respectively; among cisgender participants, 12.5% and 3.6% respectively (Bränström et al., 2022, p. 405).

There is very little data available about mental illness prevalence in SA, and even less about trans populations. Nevertheless, the available research indicates similarly high prevalence of suicidality in trans populations. Müller et al. (2019) found that although lifetime suicidal ideation prevalence was similar for trans people (67%) and for LGBQ[5]

[5] Lesbian, gay, bisexual, and queer

cisgender people (60%), lifetime suicide attempts were significantly higher for trans participants (46%) than their cisgender peers (35%) (p.61). For trans men specifically, lifetime suicidal ideation and suicide attempt were 66% and 41% respectively; additionally, 23% had attempted suicide in the past 12 months (Müller et al., 2019, p. 88). Since trans people face significant mental health challenges, it is important to also look at ways of improving their mental health.

2.3.2 Transgender Mental Wellbeing

Resilience and social support are two crucial elements of trans mental wellbeing. Although resilience is typically considered to be an individual trait, it can also be developed at the community level. Different types of social support have been shown to protect against mental health issues, including depression, anxiety, NSSI, and especially suicidality (Dickey & Budge, 2020; Puckett et al., 2019). Support from family has emerged as a key contributor to trans mental wellbeing, yet many trans individuals experience familial rejection. Peer and community support are therefore vital forms of social support for trans people.

Resilience. Resilience is well-established in trans literature as a powerful protective factor against mental health issues (Matsuno & Israel, 2018), and can be defined as "one's ability to overcome or bounce back from adversities" (Puckett et al., 2019, p. 956). As trans people experience significant adversities, it is vital for them to be able to respond to and manage these adversities in a healthy way.

Although resilience has often been understood as an individual characteristic, Singh et al. (2014) note that this conceptualization originates in a Western, individualist context and that marginalised groups "may experience resilience within a more collectivist environment" (p. 209). It is thus important to understand resilience both in terms of individual coping and in community contexts. Another issue with viewing resilience as a personal characteristic is that this can put too much responsibility on the individual while ignoring structural barriers. As

Meyer (2015) highlights, “not everyone has the same opportunity for resilience when the underlying social structures are unequal” (p. 211). For people who experience multiple, intersecting forms of marginalization, it can be more challenging to be resilient in the face of these adversities. Additionally, focusing too heavily on resilience at the individual level risks putting most of the attention on the “individual response to stress rather than the stressor itself” (Meyer, 2015, p. 211). It is undoubtedly important for trans people to be able to manage the effects of living in a transphobic society. However, the societal oppression itself needs to be addressed and not only how the trans individual copes with this prejudice.

Familial Support. Many trans individuals experience rejection from their families of origin. This rejection can take different forms, including physical violence, kicking the trans individual out of the family home, not allowing them to express their gender identity, and conversion practices (Herman et al., 2019; Singh & McKleroy, 2011). While familial rejection has been shown to significantly worsen trans mental health, familial support alone is not sufficient to completely protect against discrimination-related psychological distress (Valente et al., 2020). Nevertheless, support from family members plays a highly significant role for improving the overall mental wellbeing of trans individuals.

When trans people’s families support their gender identity, this can significantly improve trans resilience (Matsuno & Israel, 2018). Singh et al. (2014) found that “messages of support” from family members contributed to resilience for trans youths, even if these messages “were not completely consistent” (p. 213). This demonstrates the powerful role of familial support; evidently, some support is better than none at all. Familial support is also a significant protective factor against suicidality. In the USTS, trans people whose families supported their transness had half the prevalence of suicide attempts in the past year compared to people who were rejected by their family of origin (5.1% vs. 10.5%) (Herman et

al., 2019, p. 2). Similarly, a systematic review of literature on suicidality and NSSI found that familial rejection was linked to higher rates of suicide attempts (Vigny-Pau et al., 2021).

Peer and Community Support. Given that trans people often cannot rely on their families of origin for support, community support is particularly important for trans mental wellbeing (Gorman et al., 2022). Vigny-Pau et al. (2021) found that peer support reduces the risk of suicidal ideation and attempts. A scoping review by Kia et al. (2021) discovered that peer support serves the dual role of "validating trans identity" and "constructing trans community" (p. 114031), the combination of which helps protect against suicidality. Similarly, Singh (2013) found that "resilience strategies" used by trans youth of colour were frequently "relational in nature," and that it was important for these youth to connect with other trans people of colour to "affirm their identities" (p. 699). Among Canadian trans adults, Moody et al. (2015) found that another significant protective factor against suicidality was simply knowing that other trans people exist and that they were not alone in their experiences.

It is not always straightforward for trans people to find and belong to communities, though (Singh & McKleroy, 2011). One issue is that openly belonging to a trans community or group may out someone as trans (Puckett et al., 2019). However, Singh et al. (2014) found that for trans youth, the benefits of being part of a trans-affirming community outweighed these concerns. Another factor that can contribute to resilience is participating in trans community events (Dickey & Budge, 2020), such as marches or international trans days of awareness (e.g., Transgender Day of Visibility, Transgender Day of Remembrance). However, it is worth noting being involved in activism can worsen psychological distress for trans people. Higher levels of collective action might expose trans people to more transphobia, which can also worsen internalized transphobia (Breslow et al., 2015). According to Valente et al. (2020), while activism may focus on changes to structural issues in society, resilience focuses more on coping within unequal societal contexts. Attempting to

and not being able to bring about social change "may further lead to hopelessness among TGNB[6] individuals" (Valente et al., 2020, p. 2657).

There have been conflicting findings about community connectedness and resilience. It is undoubtedly important for trans people to have a supportive community and peer support. For example, when developing the Gender Minority Stress and Resilience Measure, Testa et al. (2015) included "community connectedness" as a factor that contributes to resilience (p. 68). In terms of trans experiences of discrimination, Bockting et al. (2013) found peer support to be a resilience factor, as it "significantly moderated the relationship between enacted stigma and psychological distress" (p. 6). However, more recent research has not found community connectedness to reduce this psychological distress to a significant extent. In a meta-analysis exploring the links between gender minority stressors and resilience, Wilson et al. (2024) found that pride and community connectedness did not have as strong of an effect as expected. Likewise, Helsen et al. (2022) discovered that in the context of trans mental health and proximal minority stressors, community connectedness was not a source of resilience. Social support and internal factors like resilience play a significant role in the mental wellbeing of trans individuals, and so does having affirming healthcare that is sensitive to trans needs.

2.3.3 Trans-Affirming Healthcare

Trans-affirming healthcare is not limited to medical transition or the patient's interactions with the HCP, but extends to every aspect of the healthcare experience (Forshee, 2006; McLachlan, 2024). This includes making sure that every member of staff the patient interacts with is also trans-friendly and uses the correct gendered language. Hope et al. (2022) note that it is important for staff not to make "comments on changes in clients' appearances" (p. 10). Even if this is well-intentioned and staff are trying to be affirming of progress in the

[6] Transgender and gender nonbinary

trans client's medical transition, these kinds of comments are inappropriate and can make trans people very uncomfortable. Another aspect of the healthcare experience that can be made more trans-friendly is intake forms and interviews, with Singh et al. (2011) emphasizing that it is better for trans patients to self-define their gender rather than only having a male/female checkbox.

The baseline expectation is that HCPs have a 'trans 101' understanding: knowing what it means to be trans, basic terminology, and understanding what kinds of questions are invasive or inappropriate. However, as Moody et al. (2015) highlight, a "culturally competent" MHCP will have a deeper understanding of transness (p. 277), including the intersections of the trans patient's other identities and the influence of minority stress on their mental health. Singh and McKleroy (2011) emphasize that "'social locations' (e.g., racial/ethnic, gender, socioeconomic status)" influence how trans people of colour in particular experience and respond to "traumatic life events" (p. 35). White et al. (2020) found that Black trans men had better experiences with MHCPs who understood intersectionality and would "inquir[e] about [their] lived experiences within oppressive systems" (p. 260). In South Africa, Strand et al. (2020) recommend that the Department of Health provide "thorough and intersectional training and sensitization" for (M)HCPs regarding trans individuals' healthcare needs (p. 71). The second edition of PsySSA's guidelines for working with trans clients recommends that MHCPs should be "sensitised to the influence of multiple and intersecting forms of discrimination against sexually and gender-diverse people" (PsySSA, 2025, p. 17).

Forshee (2006) found that it was important for trans men that HCPs have a "genuine sense of respect" for them (p.148). Similarly, Dasso et al. (2025) note that "it is necessary to respect the transgender person and build a relationship of trust" (p.567) in order for trans people to have positive healthcare experiences. When MHCPs misgender trans patients,

patients do not feel respected or able to trust them, which negatively impacts the therapeutic relationship (Dasso et al., 2025).

For some trans people, it is important to share their identity with a MHCP. A review by White and Fontenot (2019) indicated that for some trans people, it was important that their MHCP was LGBTQIA+, but for others, this was a less significant factor than "an overall openness to and knowledge of TGNC care" (p.204). Snow et al. (2022) also found that although participants in a large trans mental health survey in the US had felt "comfortable" with trans-friendly HCPs, they only described feeling "safe" with HCPs who were also trans (p.156). Regardless of whether HCPs are LGBTQIA+ themselves, however, a degree of self-awareness is important. Moody et al. (2015) note the significance of reflexivity in establishing competency, and that MHCPs need to be conscious of their own beliefs and attitudes about trans people.

2.4 Conclusion

Given the limited availability of literature at present directly addressing the topic of this thesis, this chapter has examined the topic from several different angles. Trans people in SA face significant transphobia in their daily lives and in healthcare contexts. Some of the key issues affecting the mental health of trans people have been discussed, as well as the difficulties they encounter when seeking mental and general healthcare services. It is clear that in SA, not only are trans people struggling to access healthcare, the population overall is also experiencing many mental health challenges for which they are not receiving help. Although there are numerous factors contributing to worse mental health among trans people, the effects of these factors can be alleviated through social support and access to healthcare that is sensitive to their needs.

Chapter Three: Research Methodology

In this chapter, I explain the approach I took to conducting this research, including an outline of the narrative approach informed by minority stress theory and queer theory. I outline the steps involved in recruiting participants, what the final sample looked like, the process of collecting data, and how I analysed the data.

3.1 Qualitative Research

There is still pressure within academia for students to justify not using quantitative methods, even when a qualitative approach is clearly more appropriate for the research topic and questions. Rudestam and Newton (2015) note the often "long-winded explanations" for this epistemological decision, and that "after all, a quantitative dissertation doesn't require a treatise on logical positivism" (p.138). I will therefore not allocate much space to offering definitions of qualitative research and its limitations and will instead focus on its strengths and suitability for this study.

From the outset, I aimed for a smaller sample size to allow for the collection of more in-depth data. This is particularly appropriate for use with a hidden population, who have at the time of writing been the focus of very little research (Monakali & Francis, 2020). The current social climate in South Africa means that transgender people live "precarious lives" (Macheso, 2020, p. 1), as safety is destabilised if one's trans status is known by others. Since so much of the quantitative research on trans people results in trans "enfleshment [being] lost to statistics" (Macharia, 2016, p. 38), the richness and heterogeneity of our lived experiences as individuals is often lost, overlooked, or entirely ignored. My aim was to re-humanise participants (Butler, 1999) by showing that trans people are unique individuals whose lives cannot be neatly simplified and summarised. A qualitative approach was therefore most appropriate for answering my research questions, as it allowed for a nuanced exploration of trans men's experiences.

In this research, I prioritised and valued subjectivity over objectivity. Riessman's (1993) observation that subjectivity was "deeply distrusted in mainstream social science" in favour of "context-free laws and generalized explanations" (p.5) still seems to hold true today. But part of the value of qualitative research is that it *does* take context into account. Generalisability becomes less relevant when, in studies such as this, one is looking at a small population with unique experiences. The value of research is not decreased by subjectivity if "data gathering procedures and values are both made explicit" (Zinn, 1979, p. 213), and I have aimed to do that in this chapter. Another reason I did not aim for a completely objective approach is that objectivity in itself is "usually white male subjectivity" claiming to be "non-racial [and] non-gendered", the detached "authoritative universal voice" that researchers sometimes claim to possess (Crenshaw, 1989, p. 154). Given my insider status in this population, it would feel inauthentic to attempt to write in a "detached impersonal style" (Davies, 2012, p. 746).

I view my shared intersubjectivity with participants as a strength that added value to the research, not as a weakness that detracts from its 'validity,' if that is defined as "the accuracy and truthfulness of scientific findings" (Cypress, 2017, p. 256). My focus is not the 'accuracy' of participants' narratives, or how a neutral observer would have related the same events. I believe they gave representations of their stories that accurately captured how *they* had experienced them, and that spoke to their personal truths and values, in alignment with the narrative qualitative approach undertaken in this work.

3.2 Narrative Research

While there is "no single definition of narrative" (Riessman, 2008a, p. 155), one possible definition is an "organized interpretation of a sequence of events" (Murray, 2008, p. 113). The events that people experience are not necessarily organised, linear, or logical in nature; therefore as humans, we need to make sense of these events (Bamberg, 2012). The terms

'narrative' and 'story' are often used interchangeably. However, Ntinda (2019) emphasises that although narrative research is not synonymous with 'storytelling,' it utilizes storytelling to "uncover nuances around people's lived experiences" (p.420).

Taking a narrative approach to research requires reimagining the roles of both the researcher and the participant, viewing both as possessing "narrative agency" (Gubrium & Holstein, 2012, p. 33). Researchers cannot expect to obtain neatly packaged narratives from a participant while paying no attention to their own role in the process. The research interview is not a neutral space where narratives simply emerge fully formed from participants. Instead, it is a specific context in which the researcher and interviewee collaboratively construct meaning (Salmon, 2008). The participant is still, however, understood as the "expert on [their] own life" (Carless & Douglas, 2017, p. 2), and the focus remains on how they have made sense of their experiences through narration (Anderson & Kirkpatrick, 2016).

Bamberg (2012) distinguishes between research *with* narrative and research *on* narrative: the former explores the meanings narrators make of their experiences, while the latter explores the narrative techniques used to make these meanings. Thus, the current research can be categorized as research *with* narrative, as my focus is on what participants' experiences meant to them rather than the construction of their narratives. My interest was less in obtaining a "factual record" of what participants have experienced and more in exploring their "narrative truth" (Josselson, 2011, p. 239). For instance, there were several cases in which two participants had seen the same healthcare provider. My aim was not to find out whether that provider was 'objectively' helpful or not, but rather to understand how each individual participant perceived and interpreted those experiences. A narrative approach gave participants the space to share the aspects of their mental healthcare experiences that mattered the most to them individually.

3.3 Theoretical Frameworks

I drew from two theoretical frameworks to inform my research approach: queer theory, and (gender) minority stress theory. The multifaceted and interdisciplinary nature of queer theory allows for different elements of it to be used in a variety of contexts. The application of minority stress theory to transgender populations renders it suitable for contextualising psychological distress experienced by trans individuals.

3.3.1 Queer Theory

Although queer theory cannot be defined as a "singular…methodological framework" (Spargo, 1999, p. 9), since every person who writes about it defines it differently, there are common threads. It primarily explores gender, sexual orientation, and sexuality: how they are interrelated, how people are expected to "do their gender right" (Butler, 1999, p. 178), and the power dynamics that categorise people into "normal and deviant" (Dilley, 1999, p. 458). Societal perceptions of gender only render individuals intelligible if they fit into narrow dichotomous norms of gender expression and identity (Butler, 1999). Trans people do not always "live their genders in intelligible ways" (Butler, 2009, p. ii) – whether through deliberate gender nonconformity, through any form of transitioning, or otherwise. Queer theory is not simply a "rejection of binary contrasts" (Marinucci, 2010, p. 34), which would invalidate any gender identities that fall within the male/female binary. Instead, it critically examines how meaning is socially constructed through apparent binaries like gender.

Broader principles of queer theory informed the current research, but particularly the concept of transnormativity. This "regulatory normative ideology" (Johnson, 2016, p. 466) medicalises trans people and pressures them to conform to binary gender roles. It legitimises narratives of transness that align with "gender normative practices and identities" (Vipond, 2015, p. 24), based on the underlying assumption that all trans individuals desire to assimilate into 'normal' cisgender society. Gender identities and narratives that deviate from these

norms are “discredited or obscured” (Garrison, 2018, p. 1), resulting in many trans people not being perceived as ‘really’ transgender. Transnormativity demands that all trans people must want to medically transition, experience significant gender dysphoria, know they are trans since childhood (Bradford & Syed, 2019), and identify firmly within the gender binary. Consequently, trans people who do not meet these criteria are seen as failing at being trans. This concept helps to contextualise the expectations that are placed on trans people, as well as those they place on themselves.

3.3.2 Gender Minority Stress Theory

Brooks (1981) states that the origins of minority stress lie in minority identities being “categorically ascribed [as] inferior” and notes that minority individuals undergo “critical and potentially stressful experiences” related to this socially defined inferior status (p.74). Meyer (2003) identified three key elements of minority stress: it is “unique”, in that it is experienced by members of minority groups in addition to average ordinary stressors; it is “chronic” in that it is ongoing as it stems from deep-rooted “underlying social and cultural structures”; and it is “socially based”, in that it exists in the broader societal context and not only an individual level (p.676).

Minority stress theory positions stressors on a distal-proximal continuum (Meyer, 2003). External (distal) stressors include “experiences of discrimination, rejection, or violence” linked to one’s minority identity (Testa et al., 2015, p. 65). Proximal (internal) stressors can be understood as the minority individual’s internal responses to these distal stressors, and include expectations of rejection (Rood et al., 2016), the vigilance required to avoid experiencing this rejection (Brooks, 1981), and internalised stigma. In Meyer’s (1995) work with gay men, this was defined as ‘internalised homophobia’; for trans populations, Hendricks and Testa (2012) adapted this to ‘internalized transphobia.’ It is important to recognise, however, that trans individuals’ experiences of minority stress differ from those of

LGBQ individuals (Tan et al., 2020). They may encounter additional stressors such as issues around legal documentation, healthcare access, and public bathrooms (Testa et al., 2015). The type of minority stress specific to trans people is referred to as "gender minority stress" (Tan et al., 2020, p. 1474).

Brooks (1981) highlights that the "focus of intervention" in healthcare contexts is influenced by how the presenting issue is conceptualised (p.82). The minority stress model is therefore useful when exploring mental health issues that trans people experience because it shifts from locating pathology solely within the trans individual, and instead situates this distress in a broader societal context.

3.4 Recruitment and Sampling

Please see **Appendix A** for the study advertisement I distributed. I specified the eligibility criteria in this advert. I asked for participation from anyone who is a "trans man," which I defined as "Anyone who falls under the trans masculine umbrella, regardless of your past/current/planned social or medical transition." This definition was included to make it clear that in terms of gender, my main concern was how potential participants *identified* since the transition process itself was not the focus of the study. The advertisement also specified that potential participants had to be aged 18 and older.

The other main eligibility criterion related to my research questions was that they had used mental healthcare services in South Africa. As 'mental healthcare services' is quite a broad term, and I did not want to only interview people who had seen clinical psychologists or psychiatrists, I articulated mental health use as: "These include government or private psychiatrists, psychologists, counsellors, social workers, occupational therapists, support groups and can be in-patient treatment and rehabilitation as well as out-patient care." It was not specified that participants had to currently live in South Africa, only that they had accessed services in the country.

I used purposive sampling, which is a "deliberate selection of individuals […] because of the crucial information they can provide, which cannot be obtained as adequately through other channels" (Liamputtong, 2019, p. 18). There were two ways in which I recruited participants: through emailing NGOs, and through posts in transgender Facebook groups I am in. Some of the organisations I had planned on approaching for assistance with recruitment had closed or changed names. The organisations I contacted in the end were: *Gender DynamiX, Iranti, My Sexual Health, the Other Foundation, OUT, Trans University Forum, Trans Wellness Forum, Transgender, Intersex Africa*, and the *Triangle Project*. I emailed them all variations on the same email, and attached the advertisement poster (**Appendix A**), ethical approval letter (**Appendix B**), and informed consent form (**Appendix C**). Although I tried to find the most appropriate/recent email address for each organisation, there was minimal response. The only one who agreed to assist with participant recruitment was the *Triangle Project*. From what I can tell, over the course of a few months, six participants found out about the study through this organisation.

Most participants, however, came from a private Facebook group for the transmasculine community in SA. I shared the advert poster there on 22 April 2021 and updated the post on 17 May 2021 to state that the study was open for participants again. Quite a few people expressed interest in the comments on the post, and several people also messaged me directly in response. In total, 11 of the final 17 participants found out about the study this way. This included one participant referring another group member.

I have provided some information about the overall sample rather than individual participants, as this would undermine confidentiality. The gender identity question was multiple choice, plus an option to self-define. The sexual orientation question was also multiple choice and self-definition. Some participants selected multiple options, hence the total being over 100%. The race/ethnicity question was entirely self-defined.

Table 1: Demographic characteristics of participants

Characteristic	N	%
Age		
18-20	3	18
21-29	8	47
30-39	4	26
40-49	1	6
50-59	1	6
Gender identity		
Transgender man	17	100
Non-binary	2	12
Transmasculine	1	6
Genderqueer butch of trans masculine experience	1	6
Intersex/transman	1	6
Sexual orientation		
Bisexual/pansexual	9	53
Heterosexual	4	26
Demisexual	2	12
Homosexual	1	6
Aromantic	1	6
I don't know	1	6
Race or ethnicity		
White	10	59
Mixed race	3	18
African/Black	3	18
Coloured	1	6

3.5 Data Collection

Once they had expressed interest in the study, potential participants were sent a link to a Google Forms questionnaire (**Appendix D**). The purpose of the questionnaire was to see if people met the participation criteria, make sure they understood what participation would involve, obtain (initial) informed consent, and to capture their contact details. I also sent each potential participant a copy of the informed consent form (**Appendix C**). As several participants had practical issues with signing this form, such as not being able to print it out, some signed it digitally instead. I also obtained verbal consent at the start of each interview. The video conferencing platform Zoom was used to conduct all interviews. Due to the COVID-19 pandemic, it was safest for both participants and I not to conduct interviews in person. Additionally, doing the interviews online meant that I was able to interview participants from across South Africa, not only Cape Town (where I live). Nevertheless, quite a few participants did come from Cape Town. The final sample consisted of eight (47%) people from the Western Cape, five (29%) from Gauteng, and one (6%) each from the Eastern Cape, Free State, KwaZulu-Natal, and Limpopo.

There were several advantages of using Zoom specifically. Zoom is quite simple to use and became a very widely used platform throughout the COVID-19 pandemic (during which I conducted the interviews). The main technological issue was occasional unreliable internet connection, on my side and for participants. For each interview, I set up the interview 'meeting' on Zoom so that only someone who had its unique link and password could access it. To increase security, I used the 'waiting room' feature so that I had to manually admit each participant to their specific 'meeting.' This removed the possibility of anyone else joining. I used Zoom's built-in recording feature to record both the participant's and my audio and video, and these recordings saved locally to my computer (which is password-protected and nobody else has access to).

I conducted individual semi-structured interviews with each participant. I chose this approach to ensure that I could focus on specific topics, while providing flexibility for participants to discuss the aspects of those topics that were most important to them (Nathan et al., 2019). Although narrative interviews are more typically unstructured, a semi-structured narrative approach can be quite effective in research related to health (Anderson & Kirkpatrick, 2016).

At the start of each interview, after ensuring that participants had given consent to be recorded, I gave them some idea of what the interview would *not* involve. This varied somewhat, based on the individual participant, what kind of communication we had had prior to the interview, and how nervous they seemed to me. The basic message was the same, however: I was not going to ask about topics such as when they knew they were trans, or about medical transition. I added that while I would not ask specifically about transitioning, they were welcome to talk about it if they chose to. After several interviews where participants seemed somewhat bemused by this, I started to wonder if I needed to include this disclaimer. Nevertheless, I felt it was important to mention. So much research done *on* trans people focuses heavily on medical transition, and in research as well as everyday life we are often asked invasive and inappropriate questions about it. Therefore, I wanted to reassure participants that this study *with* and *for* trans people would be different. I tried to balance this, though, with not wanting to make them feel that they were not allowed to talk about transition if it was relevant or important to them.

I will outline the interview questions below, but please see **Appendix E** for the full interview schedule. My first interview question centred on participants' experiences as trans men in South Africa, which helped me gain insights into how they understood their trans identities within their specific contexts. This also facilitated developing rapport, through allowing me to demonstrate to participants that I could relate to their lived experiences.

Furthermore, it helped establish context for their healthcare interactions. Given the broad nature of the question, I provided prompts of factors that might have influenced their experiences of being trans, such as their sexual orientation, race, or family context. Additionally, I asked if they felt that their experiences would have differed if they have lived elsewhere, either within South Africa or in another country. This helped establish whether they perceived their experiences as trans men to be universal, or more specific to the South African context.

Next, I sought to understand their experiences of accessing mental healthcare services. I started by exploring their first encounters with these services. It was necessary to ask about both *accessing* and *trying to access* healthcare as I knew that not everyone would have received the care they needed. I discussed with participants what their expectations were of this initial mental healthcare usage, and whether these expectations were met. Subsequently, I inquired about their best and worst experiences, as well as the reasons that these had been more positive or negative. For participants who had used both government and private healthcare, I asked if they observed any differences between the two systems. For those who had only used one system, I asked if they felt their experiences would have differed had they used the other. My final question explored any changes they felt were needed regarding the treatment of trans men by mental healthcare providers. Each interview concluded with checking in and debriefing.

The interviews ranged in length from 20–77 minutes, with a mean length of 43 minutes. The first interview was on 20 April 2021, and the next eight were from 26 April to 1 May 2021 – in total, nine interviews for the first round of data collection. The second round of eight interviews were between 21-30 May 2021.

3.6 Data Analysis

In this section, I outline my approach to utilising narrative analysis, followed by the steps I took in analysing the data.

3.6.1 Narrative Analysis

Following Riessman's (2008a) description of narrative analysis as "a 'family' of analytic approaches" (p.151), I combined a variety of analytical and theoretical elements. There are three main approaches to narrative analysis: *structural analysis*; *interactional-performative* analysis (Esin, 2011); and *thematic narrative analysis*. These approaches differ in two primary overlapping areas, both of which relate to how one defines a narrative. Firstly, the unit of analysis is generally "categorical" or "holistic" (Josselson, 2011, p. 240). Categorical approaches examine all examples of that category in the interview(s), while holistic approaches explore each narrative in its entirety. Secondly, the analysis may focus either on the content or the structure of the narrative (Earthy & Cronin, 2008).

The approach I used, *thematic narrative analysis*, looks mainly at the content of the text (Bengtsson & Andersen, 2020), rather than the structure or specific language used. Shukla et al. (2014) note that the combination of thematic and narrative methods enables researchers to explore both general and specific contexts by considering "historical and societal" as well as "personal and subjective" factors (p.22). This approach is also well-suited to working with larger numbers of interviews (Bryda, 2020), as it does not require examining elements such as phrasing, tone of voice, body language, or narrative structure (Riessman, 2008b).

3.6.2 Process of Data Analysis

I had planned on using the voice-to-text software *Otter.ai* to transcribe the interviews. However, when I started editing the transcript it produced for the first interview, it turned out to be far more inaccurate than expected, so I spent a long time editing that transcript. Another

issue was that I was attempting verbatim transcription, which I had never done before – and I had not realised that I would actually do thematic narrative analysis, which does not require including paralinguistic features. My supervisor recommended hiring a professional service to do (clean verbatim) transcription instead, and very kindly assisted with funding half of this cost.

I started analysing data by manually coding the first round of interviews. To familiarise myself with the data, I read through all the transcripts. I had also planned to watch all the Zoom video recordings. This proved very challenging, as I found it deeply uncomfortable watching myself conduct the interviews and therefore struggled to focus properly on the interview itself. I did not read much about how to do manual coding since I was not aware of any specific resources I could or should consult. The manual coding initially consisted of me simply jotting down observations as I went through the transcripts line by line, without any a priori codes or a codebook. I started noticing recurring topics throughout each individual interview, and later across multiple interviews. This was essentially descriptive coding, which "assigns labels to data to summarize in a word or short phrase […] the basic topic of a passage of qualitative data" (Saldaña, 2015, p. 315).

After establishing initial themes and patterns, I coded the transcripts using the qualitative data analysis software NVivo. I assigned codes based on the themes I had discovered during manual coding; minority stress theory; anything directly related to my research questions; and any other recurring topics that I noticed. As demonstrated in the coding schedule (**Appendix F**), I included far more detail than was necessary. After completing this process, I created theme tables – essentially, spreadsheets organising shorter quotes from salient codes. This approach enabled me to gain a broader picture of the data, and to consolidate themes/narratives.

I only used about a third of the codebook in the final analysis. However, as this is still around 20 codes, there is insufficient space to detail how every code mapped onto the final themes. I will therefore instead illustrate the process using one example. I started with a category in NVivo, *3.4 Access to MHC*[7] (**Appendix F**), which included the codes *Accessibility*, *Barriers to access*, and *Govt vs private*. This category contained quotes about the difficulties participants experienced accessing mental healthcare, and which challenges were related to the healthcare system used. In the theme tables (**Appendix G**), I defined this theme as *Accessing mental healthcare: challenges*. Its sub-themes focused on two issues specific to public healthcare (*difficulties accessing* and *not knowing government healthcare*), and two related to private healthcare (*cost* and *medical aid*). Each sub-theme is illustrated by one quote in the example theme table (**Appendix G**), but the original theme tables contain two to eight examples per sub-theme. These quotes became the analysis section **6.1 Accessing Public and Private Mental Healthcare**, which focuses on challenges in the public and private healthcare systems.

Additionally, I used digital mind-maps to visualise the data and explore the connections between different ideas. The writing process was not linear: I revisited and revised the NVivo coding, the theme tables, and the mind-maps, adding to each as the analysis developed.

3.7 Ethical Considerations

3.7.1 Informed Consent

The study advertisement and informed consent form notified participants that they would remain anonymous and would not be identifiable either from the thesis or from any other work that came out of the study. They were told that they could stop participating at any point with no consequences, and that if they did, all their data would be destroyed – this included

[7] MHC = mental healthcare

the interview recording, the transcript, and the answers they had given in the Google Forms questionnaire. Additionally, my supervisor would be the only other person who could access their raw data. This last point was based on the assumption that I would be transcribing the interviews myself using Otter.ai. As aforementioned, a professional transcribing service was used instead. This service had previously signed confidentiality agreements for transcribing work for the *Unsettling Knowledges on Gendered and Sexual Violence* project, which I was involved in as part of the broader *Hub for Decolonial Psychologies in Africa* project at UCT. Additionally, the transcription service only had access to the interview recordings and none of the participants' identifying information.

Participants were given the opportunity to ask questions about the study. The advertisement and the informed consent form also gave contact details for my supervisor, as well as information about who to contact if they had any concerns about the ethics of the study. I also checked with each participant at the start of their interview that they were comfortable with it being recorded. Since not all participants were able to sign the consent form, this ensured that I at least had a recording of their verbal consent.

3.7.2 Confidentiality and Privacy

Since I am quoting participants' words in the thesis (and any resulting literature), total confidentiality of data could not be ensured. The informed consent form made this clear. However, I have anonymised participants as much as possible so that they are not identifiable from these quotes. I am the only person with access to all the raw data, which includes the interview video and audio recordings, completed demographics forms, and any text-based communication – and without which, one cannot fully identify any participant. The interview recordings have been deleted from the Zoom platform. Although in my proposal I stated that I would store the recordings on an external hard drive, this did not work out in practice. I realised the risks of having all my data stored on one physical item and instead stored the

files in my personal OneDrive account. This meant that I had a local copy of each file to work with directly on my laptop, which then synchronised online with the Cloud as a backup. My laptop and OneDrive account are both password-protected and nobody else has access to them.

Most of the information I have about participants is only what they chose to share with me or what is publicly available (for example, their display names on Facebook). The question around names in the questionnaire was phrased as follows: "What name would you like me to address you as, and what name should I use to refer to you in the research?" I avoided using the dreaded 'preferred name' phrasing, which implies that a person's chosen name is merely a preference rather than the actual name they use. Since only a few participants listed a pseudonym, I assigned pseudonyms to the rest of the participants myself in the interest of maintaining confidentiality.

3.7.3 Risks and Benefits for Participants

Since the research involved a vulnerable population and explored sensitive topics, ensuring the safety and comfort of participants was particularly important. As participation only involved the single Zoom interview, there was no direct risk of physical harm. The most pressing potential risk was if participants had been 'outed' (had their trans status disclosed without permission) or if they were identifiable, since this could have made them targets of transphobia. I took great care to ensure that this is not the case.

Every participant was given ZAR100 as a compensation for any mobile data costs incurred from doing the video interview, through a bank transfer or eWallet. This was theirs to keep even if they chose to withdraw from the study. I chose this approach as it allowed the participants agency over what they did with the money. I learned some participants' deadnames or old names when obtaining their bank account details, and others' in their email addresses. I did not save this information anywhere. Research ethics aside, it is standard

practice in trans communities to try to forget each other's deadnames and only use them if strictly necessary.

There were no additional direct benefits for participants. However, when I enquired about their reasons for participating, many participants expressed a desire to contribute to initiatives that would benefit the trans community. Several had participated in other research about LGBTQIA+ people, and some were involved in trans advocacy and research. Others mentioned wanting to share their stories, as they felt their perspectives as trans men had not been represented much elsewhere.

3.7.4 Debriefing and Counselling

At the end of the interview, I tried to make sure I asked each participant how they were doing. There is the possibility that they did not share their emotional state with me in full, but overall, the interviews did not seem to cause much distress to the participants. Nevertheless, with most participants I checked that they had psychological support available if they were struggling since I could not personally offer counselling services. I had prepared a list of free/inexpensive mental healthcare services to give to all participants (see **Appendix H**), which I mentioned in most of the interviews but only actually sent to a handful of them. Some participants already had mental healthcare support, and others had said they did not need it at all. In the end, I only sent the list to the few participants who were struggling to find resources for themselves or other trans friends.

3.8 Reflexivity

Reflexivity is undoubtedly necessary to include in a thesis. However, "simply revealing biographical facts about ourselves as producers of knowledge" (Riessman, 2015, p. 223) and our differences and/or similarities to participants, is insufficient without critical analysis of what that means in context. I agree with England (1994) that "we need to locate ourselves in our work" (p.88), and I have attempted to accomplish this by weaving reflexivity throughout

my thesis rather than limiting it to a self-contained sub-section. It is still useful to use this section to discuss certain relevant aspects of my identity and experiences, though, while bearing in mind that "making positions transparent does not make them unproblematic" (Spivak, 1988, as cited in Pillow, 2003, p. 183).

Like Meadow (2013), during data collection it became evident to me that "it mattered to my research subjects just who and what I am" (p. 473). I expected that disclosing my trans identity (and therefore insider status) would make other trans men feel more comfortable participating in my research, since most research about transgender people is conducted by people who are not part of the trans community. Participant Owen directly addressed this, stating that, "stud[ies] done by a trans person […] those are the only types I'm actually willing to participate in." Nevertheless, insider status "does not automatically yield the research egalitarian" (Pillow, 2003, p. 182). Having a similar gender identity to my participants certainly did not mean that we had the same lived experiences, and it also did not erase the power differential inherent in the researcher-researched relationship.

Several major privileges have had a significant influence on my experience as a trans man in South Africa. Firstly, my socioeconomic status: being (upper) middle-class, and particularly having financial access to private healthcare. Secondly, my race: although I am both white and Indian, I am read as white and experience white privilege. Thirdly, my family situation: both of my parents are supportive, with regards to my trans identity and in general. For example, the fact that I was able to get top surgery done privately with my parents' financial backing places me in an extremely small minority of trans men in South Africa. I am aware that my experiences are not universal, so I tried to avoid making assumptions about other participants' lives based on my own. Thus, while my experiences will undoubtedly have shaped the interpretations I have made, my analysis of the data has been led by the participants and their narratives.

I encountered some challenges with doing the interviews. With no experience or training in qualitative interviewing, let alone narrative interviews, I was very nervous. I had not anticipated how emotionally draining it would be. Additionally, I had gender-affirming surgery (top surgery, i.e., a double mastectomy) on 3 May 2021, the date for which was only confirmed a month beforehand. I was also mentally preparing myself for this, which was a massive milestone in my transition. The first week of interviews (26 April to 1 May) was very pressured because I wanted to complete data collection before surgery as I did not know how long I would need to recover. There were two days in a row where I did two interviews in one day, which was exhausting. I felt like I was drowning. By the fourth interview, I was already writing in my research journal to "look up interviewer fatigue stuff" (fieldnotes, 28 April 2021).

Fortunately, I had recovered enough to do the second round of interviews (21–30 May). Again, though, I did two interviews per day for two days in a row, which was a mistake. After the 14th interview, I started feeling like I cared less about the individual participant and just wanted to get it over with. In my research journal entry after the 15th interview (one of the shortest) I wrote, "I feel like I could have tried harder as an interviewer but also it was like I didn't really care enough" (fieldnotes, 29 May 2021). The problem was more that I cared too much: carrying around the heavy feelings and experiences each participant had brought to their interview had left me experiencing compassion fatigue. I felt guilty about not trying hard enough to help every participant tell their story. It was therefore helpful to learn that a strong sense of responsibility towards participants and emotional fatigue are common phenomena among researchers studying sensitive topics (Dickson-Swift et al., 2007; van der Merwe & Hunt, 2019), and that I was not weak for feeling this way. I also realised that I was experiencing secondary trauma from participants' stories, particularly since I personally related to some of their mental healthcare experiences. Therapy provided

me with a confidential space to process these issues, but it has been a process of learning to manage the feelings rather than trying to completely detach from them.

3.9 Data Quality and Trustworthiness

According to Lincoln and Guba (1985), four factors enhance the quality and "trustworthiness" of qualitative research (p. 290): credibility, transferability, dependability, and confirmability. These correspond to the quantitative concepts of internal validity, external validity, reliability, and objectivity. I will outline below how these factors were applied in this study.

Credibility relates to the truthfulness of research findings, and their believability for the reader (Nassaji, 2020). To ensure credibility, I used the techniques of "prolonged engagement" and "persistent observation" (Lincoln & Guba, 1985, p. 301). This drew on observations from my lived experience as a trans man and engagement with the local trans community for over 15 years. This speaks to "credibility in the eyes of the information sources" (Lincoln & Guba, 1985, p. 213), which also relates to participants trusting me enough to feel comfortable sharing personal experiences. I demonstrated credibility to the participants through shared trans identity as well as my identity as a researcher. Triangulation strengthened credibility through the large sample allowing for a wider variety of data sources to be compared against each other. Additionally, I used a research journal to record my thoughts immediately after each interview and reflect on the research process (Shenton, 2004). Lincoln and Guba (1985) also note that a reflexive journal can improve confirmability (see below).

Transferability addresses whether research findings can be generalised to other contexts. Nassaji (2020) notes that the small sample size and interpretive nature of qualitative research means that findings thereof are not as directly generalisable as with quantitative research. For findings to be transferable to other contexts, one needs to know both the

original context and the context it is being applied to (Lincoln and Guba, 1985). Thus, I cannot state whether the findings of the current study are applicable to, for example, trans femmes in South Africa, or trans men in other countries. However, the thick description in the analysis is hopefully sufficient to help other researchers decide whether these findings can be applied to other groups.

Dependability speaks to the issue of consistency. Lincoln and Guba (1985) note that research can only be fully replicable if what is being studied is "tangible and unchanging" (p. 298): if it is not, "noted instabilities […] are at least as much a function of what is being studied as of the process of studying" (p. 298). If the findings change when the research is repeated, it does not mean that the research is untrustworthy but may rather indicate that the topic under investigation is itself changing. Thus, the findings of the current study cannot be exactly replicated. Even with the same participants, researcher, interview schedule and setting, the ways participants felt and spoke about their experiences would vary depending on numerous intrapersonal and interpersonal factors.

Confirmability refers to how much "others confirm the researcher's interpretations and conclusions" (Nassaji, 2020, p. 428). I primarily addressed this through different forms of peer debriefing, which Ahmed (2024) states can help "authenticate interpretations and mitigate researcher bias" (p. 2). Peer debriefing also contributes to establishing credibility. Although I did not check with the participants themselves (see **7.4 Limitations**), I did obtain ongoing feedback on the analysis from other trans men and transmasc peers. This helped me assess how my interpretations of the data would be received by the community. Additionally, I gave two presentations based on my analysis for the Professional Association for Transgender Health South Africa (PATHSA), which enabled me to receive input from experts in the trans healthcare field.

In this chapter, I have detailed the epistemological, methodological, and ethical approaches I have taken to this research. Through explaining my personal beliefs about research and subjectivity, I have aimed to contextualise my position as both a researcher and a member of the transmasculine community. The following three chapters centre this community by exploring issues around identity, mental health, and healthcare needs. I will preface these chapters with a quote from participant Owen that provides some perspective on the challenges that trans men are facing: "We need to focus on the bad experiences because those are real, they need to be affirmed and addressed, actual change needs to happen and I feel like in order for that change to happen we need to have examples of what we want the outcomes to look like, so I feel like both experiences are so important."

Chapter Four: Being a Transgender Man in South Africa

In this chapter, I explore participants' narratives about their lived experiences of their gender identity in the South African context. Participants spoke about the challenges of navigating social landscapes that actively discriminate against them. The issue of being visible as a trans man emerged for participants of different races, but a lack of inclusion and representation made Black trans men especially invisible. Several participants raised the topic of physical gender dysphoria, particularly related to the desire for medical transition. However, more people talked about dysphoria in social contexts. The ways that participants could talk about their gender and how much they had to explain depended on if they were talking to trans or cisgender people.

There is no single definitive 'transgender story' that can encapsulate the heterogeneity of trans men and transmasculine people, and especially not in a country like South Africa (SA) in which the population is so diverse in every respect. It is not possible, in this thesis or otherwise, to fully represent all experiences trans men have in this country. Nevertheless, the variety in the experiences of participants in this study provide some insights into what members of the community are dealing with. In my analysis of the data, I identified certain commonalities across participants' narratives. The picture these begin to paint is quite grim – and complex.

4.1 Transphobia: Discrimination and Violence

A significant theme that emerged across all participants' narratives was that of transphobia: prejudice and discrimination related to their trans status. Regardless of individual experience with transphobia, the discrimination and violence experienced by our community forces trans people to maintain a high "degree of vigilance" (Brooks, 1981, p. 79). Every participant had dealt with transphobia in some form, but primarily they raised issues of physical violence, different types of transphobic language, and difficulties in social contexts. Although physical

transphobic violence was something that participants feared, they sometimes spoke about it with a degree of separation.

> "I often hear horror tales of people that are abused, sexually assaulted, that do get chased out by their families." (Edward, 40s, white heterosexual trans man)

Edward was aware of specific kinds of violence, but in the context of "horror tales" that happened to other people. However, Alistair's fears appeared to have significantly affected his everyday life and how he navigates the world. While he did not talk about physical violence specifically, it appears that a fear of physical violence shaped his choices and decisions about 'the outside world':

> "It's really scary you know, that's why I just like being inside and not being in the outside world because sometimes I feel like it's too dangerous for people like us as trans men, so transgender as a whole, it's a little bit dangerous, I guess many people don't accept us." (Alistair, 18, Black heterosexual trans man)

Alistair demonstrates how deeply transphobia can affect trans people's sense of safety and belonging. This was the first thing Alistair said regarding being a trans man in SA, highlighting fear as a major feature of his experience. Given the incredibly high rates of violence faced by the trans community overall, his fears are not unfounded. Black trans men like Alistair are at particular risk of violence. In a report entitled *Violence and discrimination against Black lesbians and transgender men in South Africa*, Human Rights Watch (2011) describe the fear of this violence as being "so pervasive that even those who experience it first-hand take it for granted and often do not talk about it as a specific hardship unless asked directly" (p.44). It must be noted that Black trans women are also disproportionately affected by different forms of violence (Shabalala, 2020). Lonwabo explained how many Black trans men "make themselves smaller so as not to stand out, because of the prevalent violence against masculine women" who they are often misperceived as.

Other participants also spoke about transphobia in SA compared to other parts of the world. Edward commented:

> "I know up in Africa it's still illegal, people do get killed for being trans or for being gay, so although there is certainly room for improvement in people's attitudes, [South Africa]'s not as bad as other places." (Edward, 40s, white heterosexual trans man)

I found it interesting that Edward made this distinction between SA and the rest of Africa. Additionally, his reference to places "up in Africa" was the only time any participant compared SA to anywhere else in the Global South – or indeed, mentioned the Global South at all. Although a few participants viewed the Global North as more progressive than SA or had had better experiences in that context, this perception was not entirely positive. There was some variance between countries and regions.

The sole participant who spoke about encountering physical violence had experienced it in a mental healthcare context. Ethan recounted being in a private inpatient psychiatric clinic where his bodily autonomy was clearly violated.

> "I knew that was gonna be really shit because from the first day I was just like there, in the communal area, and one of the nurses came to me and she was like can I just check something and then she tried to feel my chest, she went to feel my chest and I was like no, so I jumped back and she was like, I just wanted to check if you've still got titties." (Ethan, 30s, white trans man)

This behaviour is especially disturbing considering that people usually seek psychiatric inpatient treatment because they are already experiencing intense psychological distress. For anyone in that position, this could exacerbate their distress. Ethan described the experience as "really horrible"; this was also not his only experience with maltreatment in a psychiatric inpatient context. Although Ethan was the only participant who talked about experiencing physical transphobic violence, other invasions of privacy are not uncommon for trans

individuals. We are often asked highly personal questions regarding our transition merely to satisfy cisgender curiosity about trans bodies, with little regard for how objectifying or uncomfortable this can be.

Transphobic language was an ongoing issue for most participants. This kind of ongoing "everyday discrimination" that "accumulates over time" had a significant negative impact on participants (Meyer & Frost, 2013, p. 252). One major language issue that participants pointed to in their narratives was that of misgendering and deadnaming (see **Glossary**, p.viii). This was not limited to healthcare providers (HCPs), however, but occurred in a variety of interpersonal relationships. Some participants described difficulties around knowing how and when to correct others' language, such as Noah, whose partner misgendered him. Ethan also found that

> "…someone can be your friend and everything but then come out with really transphobic comments, with like not thinking it's a problem." (Ethan, 30s, white trans man)

Other participants had reached a point with certain people in their lives where their trans identity was so disrespected that they chose to cut contact with those people entirely. This was the case for Chris:

> "I haven't even updated my family because I don't really want to talk to them. My mom has tried contacting me in the past two years, but she still gets my name wrong, deadnames me all the time […] she has this whole like… well you're not a gender to me, you are this person. I'm like, I'm not that person actually, I am this person, this is my name, if you could get that right we could start somewhere." (Chris, 20s, mixed race bi/pansexual trans man)

Most participants discussed having had familial difficulties related to their trans identity, which remains a prevalent issue in the trans community. While some participants' families

had come to understand and accept their transness, for others, like Chris, even a basic level of tolerance seemed unreachable. Even within the broader LGBTQIA+ community, however, trans people cannot assume that they will be understood. For example, Samuel had encountered issues with people they had expected to be more respectful of transness.

> "In the suburban areas you think you feel more safe because people are very outspoken about how they're so accepting and whatever, but I found it to be evasive. Like the amount of questions I get asked that are just not appropriate when I'm with people who claim to be supportive – a lot." (Samuel, 19, white bi/pansexual genderqueer transmasc)

As Samuel highlights, no matter the contexts we are in, transphobia is a part of everyday life for trans men in SA. No participants mentioned dealing with violence in terms of physical attacks, but one cannot conclude that nobody had had this experience. Ethan's experience of being physically violated by a nurse shows that transphobic violence occurs in mental healthcare contexts as well. Additionally, transphobia manifests in other forms that are also painful and damaging. Encountering ongoing prejudiced language contributed to participants not feeling safe, comfortable, or respected. Another arena where participants did not always feel included or respected was that of race and its intersections with other aspects of identity.

4.2 Narratives on Race and Privilege

There is a profound lack of representation and consideration of trans men of colour in trans spaces, discourse around trans issues, and media and popular culture. This exclusion makes it perhaps unsurprising that Lonwabo described how, "for the longest time, [he] was the only Black trans guy [he] knew." Vidal-Ortiz (2014) observes that "it is through the silences in which whiteness operates that trans* communities, representations, and thus visibility retain a white homogeneous perception" (p.264). Thus, while white trans men can be simply 'trans

men' since their whiteness is seen as the default, Black trans men must always be 'Black trans men.'

Pennington (2018) points out that "the patriarchal dividend is designed for white men, and men of colour have a necessarily different relationship to the white heteropatriarchal state, something too often overlooked in analysis of a 'general' (i.e., white) trans masculinity" (p.120). It is beyond the scope of this thesis to explore in-depth the complex relationship between race and transition among trans men. Nevertheless, it can be said that white trans men who pass as white cisgender men will gain particular forms of male privilege. De Vries (2012) observes that for trans men of colour, "an increase in visibility is related to male privilege and others' perceptions of them as exotic, sexually threatening, and/or criminal" (p.62). Although Black trans men may gain male privilege after medically transitioning, they may also have to deal with other broader prejudice against Black men (White et al., 2020).

When participants talked about physical transphobic violence, this violence was often described (sometimes indirectly) as occurring in Black communities. Interestingly, it was primarily – but not exclusively – white participants who brought up this idea. When describing how their race and socioeconomic background influenced their experiences of being trans in SA, River (who is white) explained:

> "I was in a very good, a super privileged position with respect to race and class and a lot of other things. I don't feel like any of those things really made it more negative if that makes sense, I think it was as good as it was going to get." (River, 20s, white bi/pansexual nonbinary trans man)

River's comment that "it was as good as it was going to get" speaks to the advantages of privilege and suggests that not being white or middle class will always make it harder to be trans. Other white participants stated that their experiences as trans men were not universal.

For example, Ethan seemed hesitant to generalise from his experiences of being a trans man in SA.

> "I don't know about the 'in South Africa' bit because I know my experience would be 100 times different from someone living like in Khayelitsha or something." (Ethan, 30s, white trans man)

Doubtless, Ethan's experience living in the suburbs of a major city would be quite different to someone living in a township. Ethan did not seem to see his own experience as being typical for the average South African. While Ethan may not face certain difficulties because of his privileges, there is also an underlying implication that life in a Black township is inherently more difficult for trans people. A similar idea appears in how Oliver spoke about a trans support group in Cape Town.

> "I went to a Triangle [Project] group meeting once, and there's quite a lot of black people and they were telling stories about like their experiences of being trans, like being in the communities or whatever and being attacked and all that stuff. So that made me think that okay, as a white person that stuff doesn't really happen to me. So that's different." (Oliver, 30s, white bi/pansexual trans man)

Oliver's acknowledgment that "as a white person that stuff doesn't really happen to [him]" speaks to his racial privilege. Even though he is trans, being white reduces his likelihood of experiencing violence: if he passes as male, he will simply be seen as a white man. His comment that hearing Black trans individuals' stories of violence "made [him] think" suggests that this is not something he had previously considered. This is not unique to Oliver, though. Due to the "nonconscious nature of race privilege" (Hurtado, 2019, p. 91), white people may think that race does not impact them because they do not experience racism. This perspective does not consider that being white is itself a racial identity, or that privilege

includes not only the advantages one gains because of an identity but also the obstacles one does not have to face.

While all participants in this study shared similar gender identities, they differed in other ways. Yet one cannot separate aspects of their experiences into exclusively 'trans experiences' or 'Black experiences' or any other 'minority experiences,' as the interactions between these "multiple interlocking identities" (Parent et al., 2013, p. 640) form unique and specific experiences. In my case, I have experienced quite different intersections of race, gender, and sexual orientation throughout my life. I am Indian and white, but white-passing. In my childhood, I was seen as an Indian girl half of the time and as a white girl with a 'tan' the other half. As a young adult, I was seen as a feminine queer white woman, although I was nonbinary. Now I am typically seen as a gay white man, despite being a queer, mixed-race, genderqueer trans man. I cannot distinguish between the different components of my identity, as each is interwoven with the other. Regardless, how I am perceived by others means that I experience white male privilege.

Below, Lonwabo explains the importance of having all the elements of one's identity properly understood.

> "The issues that someone would deal with, as being a Xhosa trans man […] when you're focused on the core issues there, it's such a specific issue that one of the male typical mental help doesn't really cover it. So you go maybe because you need, maybe emotional support or whatever with this aspect of your life which is a very small part of it, but that one small part is something that no-one else can really understand except maybe like five, or twenty other people who... when you boil it all down to like your core identities, match, and that's a trans Xhosa male etc. etc. And then because there's such a few number of people that can relate to that, and I don't think any that I've met personally who would have the kind of skills like artillery to be able to assist

> in a professional capacity, in mental health or anything. It's kind of like everyone else therefore is like a...no, no. You go there for 99% of other things or whatever, but then *this one thing that would actually be most beneficial for you is the one thing that they can't really understand*." (Lonwabo, 20s, Black heterosexual trans man) (emphasis added)

Lonwabo highlights how MHCPs cannot ignore the intersecting aspects of their clients' identities. If he sees a cisgender Xhosa male MHCP, he cannot expect an understanding of what it is like being trans. But equally, if he managed to find a trans MHCP (in itself, very difficult), if they are not Black, being trans alone does not mean that they could fully understand his experiences either.

Trans men's race influences the male privilege they may gain if they are read as male. For some, this may intersect with other privileges they already possess; for others, the ways that others perceive them may bring new difficulties. Some white participants located transphobic violence as primarily occurring in Black communities. The intersections between multiple identities result in "novel experiences that are distinctive and not necessarily divisible into their component identities or experiences" (Parent et al., 2013, p. 640). Additionally, if these identities shift over time, it may influence the individual's experiences. Another factor that influenced participants' experiences of their gender was the degree to which gender dysphoria affected them.

4.3 Narratives of Dysphoria

The APA (2024) defines gender dysphoria as "psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity" (para. 1). Although this distress is no longer always seen as a prerequisite for being transgender, it is still something that many trans people identify with. While some participants referred to dysphoria directly, many did not use this specific term. This is quite common for those in the

trans community when we speak to other trans people: it is unnecessary to label dysphoria as such, because we can generally assume that the other person will know what we are referring to. When speaking to cisgender people, though, it can be necessary to specify something as dysphoria, since they will not be personally familiar with that experience.

A significant number of participants used variations on the term "uncomfortable" to describe their relationship with or feelings about their body with regards to gender. For example, Asher stated that he had "been like very uncomfortable with [his] body," particularly regarding romantic relationships, since there would be "an expectation of [him] being a typical girlfriend." Ethan described "always feeling very uncomfortable then after discovering [he] was transgender."

I wondered whether participants' language would have been different if they had read me as a cisgender man, which I thought about more after one participant only realised that I am trans near the end of the interview. It is possible that there was an assumption from most of the participants that as I am also trans, even though I was specifically asking about their experiences of transness, there was a certain amount that they did not need to say. That we both understood the 'trans man experience.' This raises questions about what kind of dominant narratives about trans male experiences exist – and about the universality of these experiences, especially in a country where it seems like so much of our understanding and information about trans maleness and masculinity is a direct import from the Global North. With every interview, I tried to be mindful of what I – and the participants – took for granted as shared understanding. If participants generally assumed that they did not need to explain everything in detail, they could have felt that words like "uncomfortable" encapsulated their feelings of dysphoria. But as I asked about their experience of being a *trans man* or *trans person*, not *gender dysphoria* specifically, dysphoria may simply not have been a salient aspect of their experience.

However, several participants did discuss gender dysphoria. Varying in their narratives was the intensity of the distress it had caused them. For Samuel, who is transmasculine, context significantly influenced their social dysphoria.

> "I'd say in suburban spaces I find being trans quite dehumanising while in more inner-city spaces I'd say being trans is just a bit uncomfortable sometimes. You know, sometimes you can't bind and you just have to go around looking like a woman, but then you have to correct people, and like you're fine if nobody makes a big deal out of it – just uncomfortable." (Samuel, 19, white bi/pansexual genderqueer transmasc)

In *inner-city* spaces in Cape Town, where Samuel felt that people understood their gender identity better, a potential issue such as not being able to bind their chest and being misread as a woman was "just uncomfortable" – but not unsafe. In *suburban* spaces, however, the element of safety/comfort was not present. Samuel also described being treated "like a sideshow" in suburban spaces once people realised that they were trans. This othering was in stark contrast to inner-city spaces, where they felt being trans was not seen as different or strange.

Edward and Sawyer, two white trans men in their 40s and late 50s, respectively, used more evocative language to describe their experiences. Both men had spent decades knowing that they were trans but also being aware that although HRT and gender-affirming surgeries were technical possibilities, medical transition was not practically accessible or feasible at the time. Edward described this state of limbo, and feeling intense distress but not being able to do anything about it.

> "It took 20 years for me to realise and somebody was writing online that they were transitioning through the state and I went like what? Where? Huh? But they told me they're not doing it anymore, and that was 20 years of special, special kind of hell,

> because I can't die evidently, and there's no way of making peace with my body, so that was a cruel, cruel 20 years." (Edward, 40s, white heterosexual trans man)

One major difference between Edward and Sawyer is that Edward has been able to access medical and social transition, which has greatly improved his quality of life. The dominant narrative throughout his entire interview was that his life as it should have been only started once he started transitioning in his 40s. Once he had undergone most of the physical changes he desired, and crucially, once he started *passing*, his life could properly begin. For Sawyer, it seems that social transition was more important – medical transition being inaccessible partly for health reasons, and partly because it was simply not a priority. He has also dealt with schizophrenia and other mental health challenges for most of his life. But the mental healthcare he had used the most had suppressed his gender identity:

> "…for 30 years I've had a psychologist try and change my gender identity from male to female."
>
> "…if only I had known about being a trans kid now. Different. Life would be different and maybe I wouldn't have had to be so psychotic and that schizophrenic." (Sawyer, 57, white heterosexual trans man)

Sawyer postulated direct causal links between undergoing what is essentially a form of conversion therapy and his psychological distress, particularly psychosis. Sawyer's overall narrative has a 'what if?' quality to it. What if he had been taken seriously as a young trans man? What if he had been able to transition in any way? What if he hadn't had negative mental healthcare experiences that "stifled" his transness – what then?

Although medical transition may not have been a magic bullet for mental wellbeing or quality of life for either Edward or Sawyer, their narratives highlight the importance of hope for trans people. While dysphoria does not define the trans experience, it is still a significant part of it. For those who desire to medically or socially transition, being able to access this

care is crucial for alleviating the distress that dysphoria can cause. It is important to note, though, that the way trans people speak about dysphoria differs based on who they are talking to. We may discuss our experiences differently with cisgender people to how we would with other trans people, where our shared understanding makes explanations less necessary. The need to explain gender identity also varies in the disclosure process.

4.4 Coming-Out Narratives

As trans people are a minority, other people do not generally expect our transness, which often necessitates explaining this identity. This is particularly true for trans men in South Africa, where there seems to be very limited awareness of trans men as a concept. Coming out as trans, i.e. disclosing one's trans status, is an undeniably important element of the trans experience. However, its significance varies across individuals. Participants only talked about coming out if they felt it was a significant aspect of their trans narrative. Additionally, since LGBTQIA+ people – especially trans individuals – are always expected to provide their coming out story to cisgender/heterosexual society, they may not have wanted to tell the same story again. The way participants spoke about coming out did sometimes seem as if they had told the story so many times it almost felt rehearsed, or like they were just mentioning a minor detail to get it out of the way.

Depending on where one is in any kind of transition process, coming out can look quite different (Hendricks & Testa, 2012). However, mainstream trans narratives predominantly reflect only two types of coming out. The first type of coming out occurs once a trans individual has realised that they are trans, at which point they come out to friends and family. A significant reason for this is to prepare loved ones for the changes that will come with the apparently inevitable medical transition. Said medical transition takes place, and the trans individual immediately starts passing (assuming that they identify with a binary gender or can pass as one). Following this would come the second kind of coming out. Once the

trans person passes full-time and is *stealth*[8], they may have to come out to reveal the 'previous life' they had as their birth-assigned sex.

One of the many problems with this mainstream trans narrative is that it fails to consider that transitioning can involve several processes that do not take place overnight – and which may happen simultaneously. The physical appearance of trans men on testosterone will become increasingly masculine over a period of approximately five years (Mayo Clinic, 2021), although there is significant individual variability in this. During this time, the gender that others perceive them to be tends to change at the same time. Therefore, trans men do not typically experience the rapid binary transition from being read as women to being read as men that is assumed in the mainstream transition narrative. This, combined with the inaccessibility of gender-affirming surgery, as well as the difficulties trans people in SA experience with legal name and gender marker changes, means that trans men may find themselves in a state of gender-nonconforming limbo. When people cannot easily categorise you as either binary gender, there may be "no choice but to be visible" as trans (Nicolazzo, 2020, p. 123); consequently, your gender identity is frequently questioned. This often necessitates coming out several times or constructing alternative narratives to 'explain away' one's transness (Vipond, 2015).

Another problem with the mainstream transition narrative is that it does not acknowledge those who choose not to or are not able to transition at all, and especially so for older individuals who may consequently continue to be perceived as their birth-assigned gender for decades. For example, at the time of our interview, Sawyer was 57 but in the early stages of coming out to people around him.

[8] *Stealth* refers to trans individuals who live and pass as the gender they identify with and do not disclose their trans status publicly.

Most participants discussed coming out as trans to their families, particularly their parents. Participants described variation in how their families reacted to their transness, but several common threads emerged. Coming out – or wanting to do so – had posed significant difficulties for some participants, with tensions often remaining unresolved. For example, Avery had come out to his mother four years prior to our interview, which lead to continued conflict between them as she "was not happy about it and she still is not happy about it." Chris was estranged from his family, who disowned him when he came out aged 16. Sawyer had a strained relationship with his mother, and did not expect support if he came out to her:

> "People don't think it's okay… my sister's okay, my one sister, my father and mother I'm not sure, but my mother won't be okay. She won't understand. She hasn't got a clue." (Sawyer, 57, white heterosexual trans man)

Several participants struggled initially with their families but had seen improvements in these relationships. Lin experienced initial rejection from his foster mother when he came out aged 16. He noted, though, that she was his only family member who did not understand his trans identity.

> "I told her that I'm done being groomed to be a girl. I want to be a boy and that is who I am. I think for three weeks, literally for a month she didn't actually talk to me." (Lin, 20s, mixed race bi/pansexual intersex trans man)

After they could talk about it, though, she came to accept his transness.

> "I told her the difference between everything and I explained to her how I feel inside. And then she just slowly accepted it back." (Lin, 20s, mixed race bi/pansexual intersex trans man)

Sebastian described his experience of coming out as comparatively easy.

> "At first no-one like really believed that I was a trans guy. But it was fine, I had patience with it. My parents took... they didn't take a long time, so for me it was fairly

> easy compared to a lot of other guys. But in the beginning, they just completely denied it." (Sebastian, 18, Coloured demisexual trans man)

Even though Sebastian's parents completely rejected his trans identity initially, he did not see this as a great difficulty. Sebastian saw the challenges other trans men dealt with when coming out to loved ones as a common experience. Ethan also compared the situation with his family to that of other trans people, saying "they weren't going to like chuck me out the house." Nevertheless, his experience of coming out had not been entirely smooth sailing.

> "At the beginning, like my family was very not accepting, but I was also so miserable, now they're much better, although still with… the initial experience, it's like it's permanently kind of broken something, not broken something but…so my family will forget all the stuff that was said kind of thing, but I can't forget." (Ethan, 30s, white trans man)

Ethan's narrative above illustrates the complexity of coming out to one's family. Unfortunately, the pain he experienced is not unique. For many participants, even those whose families and loved ones eventually came to accept their trans identities, rejection was a core aspect of coming out. Few participants spoke specifically about coming out, but quite a few talked about how their interpersonal relationships had changed afterwards. The difficulties seem to lie more in how things unfold after disclosure than in the act of disclosure itself. Trans people generally have to come out multiple times in different contexts and in different ways, and there is no set way of how that can or should happen. One factor that also influences the process of coming out is how visible we wish to be as trans people.

4.5 (In)visibility

> "As soon as I'm in a non-safe space I'm like…I just don't even mention it […] sometimes, depending on the situation, if people misgender me, I just leave it because I don't want them to question me more because I get very people pleasey, very

> anxious, I can't really be myself most of the time." (Owen, 20s, mixed race bi/pansexual transmasc)

Owen's attempts at avoiding transphobia by hiding his identity or trying not to draw attention to himself speak to a broader issue that affected participants: visibility. Participants had quite different experiences with and feelings about disclosing their trans status. A rhetorical question from Owen – "If you don't look trans then are you even trans?" – speaks directly to this issue. If a trans person passes enough to be stealth, does this take away from their trans status? Moreover, is being trans always a major part of trans men's identities? In some cases, it is: someone may identify and wish to be seen specifically as a *transgender man*. But others only identify as *men*, with transness sometimes seen as a problem that becomes irrelevant once one has 'fully' transitioned. Several participants discussed passing and trans visibility:

> "… the effects of T, it kind of goes on… it's way more powerful I feel and way more instant so it's so much easier to be stealth and then just now know that we kind of exist right, or kind of pass a lot easier, *we don't stand up as much*." (Owen, 20s, mixed race bi/pansexual transmasc) (emphasis added)

I interpreted Owen's statement as a comparison to the experiences of trans women: that the changes trans men go through on testosterone happen noticeably faster and to a greater extent than for trans women on HRT.

Do trans men always want to be visible, and what are the consequences of this visibility? Rogers (2019) discusses the "continued importance of trans men passing in order to protect their well-being and gain privileges" (p.658). It is important to discuss the kinds of male privilege afforded trans men who pass. However, I argue that, for my research participants at least, one of the privileges that was sought out most keenly was the ability to simply exist without being questioned or invalidated because of one's trans status.

But there are two sides to visibility. Trans women and AMAB[9] trans femmes often experience a level of "hypervisibility" (Pitcher & Boonzaier, 2023) that results in "increased vulnerability to hostility and discrimination" (Shabalala, 2020, p. 19). The staggering levels of violence that trans women face are well-documented (Arayasirikul et al., 2022; Shabalala, 2020). That is one end of the visibility spectrum, where one's trans status becomes constantly visible and it is hard to simply exist without facing hostility. However, several of the participants lay at the other end of the spectrum. Chris and Morgan, two participants who are medically transitioning and are generally read as male, had similar experiences in this regard.

> "I've obviously transitioned, to the point where now nobody really knows, so they treat me like a cis man, and that's been okay, it has its ups and downs because you get to see some of the worst of some of the cis men in South Africa, who just blab whatever they want to out of their mouth." (Chris, 20s, mixed race bi/pansexual trans man)

The invisibility of his transness affords Chris a "kind of access to the world that is often blocked by being perceived as trans or labelled as such" (Stryker, 2017, xi, as cited in Rogers, 2019). However, the world that he gained access to is that of *cisgender* men, which also includes unwanted access to toxic masculinity and openly expressed misogyny. Similarly, Morgan is not heterosexual but is perceived as a cishet man:

> "I present like I'm dead ordinary you know, like nobody clocks me as any kind of queer, I am queer but nobody thinks I am." (Morgan, 20s, white heterosexual trans man)

[9] Assigned Male At Birth

From my own experience, the issue of passing is still one much debated within trans communities. Leaving theoretical discourse[10] about the validity of the concept aside, it remains something that many trans people have to engage with, regardless of their own opinions about it. Trans people can choose to be stealth, wish to pass in some contexts but not others, or deliberately use gender expression to disrupt or reject the concept of passing altogether – but we must make decisions about how we deal with it.

4.6 "Being Nonbinary Was Just Too Complicated"

As aforementioned, transnormativity demands that trans people strictly adhere to binary gender norms. It also medicalises and pathologizes trans identities. Through this lens, being a 'true' trans man requires debilitating physical gender dysphoria, desire for medical transition, strong identification with hegemonic masculinity, and rejection of anything deemed too feminine or 'female.' This delegitimises any kind of gender-nonconformity or queerness, which makes it difficult for nonbinary transmasculine people to express their gender identity as anything other than 'male.' However, as Samuel highlights below, social context can influence trans individuals' level of comfort with sharing their full identities.

> "There's a really big difference between how I identify within the queer community and how I identify in public. I came out as a trans man as far as any cis person I talk to where I'm concerned, I'm a binary trans man. I would have all of the surgeries if I had the money for it… But with other trans people I add a bit of nuance." (Samuel, 19, white bi/pansexual genderqueer transmasc)

Samuel illustrates the necessity of describing one's gender in ways that are intelligible to others (Butler, 1999) – and how context-specific this intelligibility can be. It can be less complicated for trans people who do not fit entirely inside the gender binary to instead

[10] There is significant debate within trans communities regarding passing, including about if it should be a goal we should aim to achieve (Billard, 2019), the privileges afforded those who can pass (Duck-Chong, 2023), the protection against transphobia and harassment it may provide (Smit, 2024), or if passing is a cisnormative imposition that should be ignored.

express their gender in binary terms in broader society. Cisgender people might still not understand what it means to be a trans man, but *man* is at least understood in a way that *transmasculine* or *nonbinary* is not. In addition to binary terms requiring less explanation, there is also the element of safety when disclosing one's trans identity. Coming out to someone as trans requires trusting that that person will respond with understanding and acceptance, which cannot be assumed of society at large.

It is worth noting that in addition to trans individuals sharing different aspects of their gender identity in different contexts, their gender itself can also change repeatedly and over time. This can be in terms of actual gender identity shifting, exploring and discovering different elements of one's gender, or becoming more at ease with gender expressions that feel more comfortable and authentic.

> "Initially I wasn't going to do anything medically because when I originally came out, I came out as nonbinary." (Chris, 20s, mixed race bi/pansexual trans man)
>
> "At the time I was trying to present as a binary trans person, because being nonbinary was just too complicated." (River, 20s, white bi/pansexual nonbinary trans man)

These two participants seem to have had almost opposite narratives dealing with the gender binary. Chris went from identifying as nonbinary to identifying as a trans man; River, the reverse. It is unclear whether it was meant as a general comment about nonbinary people or only applied to his experience specifically, but there is a strong implication in Chris's statement that nonbinary people do not typically medically transition. Perhaps for him, coming out as nonbinary was easier precisely because then there was no expectation of medical transition from other people – and possibly less chance of transphobic backlash from the people in his life.

Conversely, River found it easier initially to try to be seen as a binary trans man than to express their nonbinary identity. River did not go into much detail about their own

transition, and I did not ask. Chris, however, discussed some of the hurdles in accessing HRT during our interview, and the difficulties he had faced early in his transition when other people could not easily determine his gender. It was clear that starting HRT had significantly improved his quality of life.

I could relate to Chris's experience of coming out as nonbinary being a kind of stepping stone towards identifying and coming out as a trans man. In my context, as an AFAB[11] person, it was easier to come out as nonbinary. There is a significant issue, however, with both cis and trans people treating nonbinary genders as a kind of "woman-lite" (Hearne, 2020, para. 1) – that being nonbinary is confined to AFAB people who do not want to medically transition, so they are 'basically' women but not quite. This narrative, as well as being inaccurate, completely excludes AMAB nonbinary people (LaValley, 2021) and anyone who wishes to medically transition but does not identify as strictly male or female. In my experience, before I started testosterone, whenever I came out as nonbinary, I was still essentially seen as and treated as a woman. However, my more recent experiences of disclosing my gender identity are more like River's. I usually say that I am a transgender man and leave it at that, because that alone often requires significant explanation. If I were to be accurate, I would say that I am a genderqueer trans man, that I identify more with maleness than masculinity, that my gender is in a constant state of flux. But, as River says, it is more complicated trying to explain all that.

4.7 Concluding Remarks

It is evident from participants' narratives that trans men in SA experience significant discrimination, from general society as well as from family and friends. Multiple intersecting factors influenced how participants experienced their gender, including their race, location, levels of social support, gender dysphoria, transition status, and whether they were seen by

[11] Assigned Female At Birth

others as men. Participants spoke about the influence of social context on their feelings of safety and comfort, their gender expression, and how they explained their gender to others. With the experiences of trans men in SA contextualised, the following chapter explores their interactions with mental healthcare services.

Chapter Five: Transgender Men's Narratives about Mental Healthcare Services in South Africa

As previously established, there are a number of intersecting complexities that shape transgender men's lived experiences of their gender identity in South Africa. In this chapter, I explore the narratives transgender men shared about their experiences of accessing mental healthcare services in South Africa. I start by looking at the reasons that participants needed mental healthcare in the first place. A distinction is made between mental healthcare needed in relation to being trans, and help needed regarding mental health difficulties. I distinguish between the two partly to emphasise that being trans is not a mental illness, but also to highlight how many participants had needed mental healthcare primarily because GAHC remains gatekept by the mental healthcare profession. The severity of the psychological distress many participants spoke about is emphasised. Following this, I explore some of the issues created when HCPs lack fundamental knowledge about trans people and/or experience working with trans patients. I then examine the different forms that gatekeeping can take, drawing from participants' narratives about the narrow definitions of trans masculinity imposed upon them – and the consequences this had for their ability to access GAHC. Lastly, I focus on ethical violations that participants discussed, and the effects of having their identities disregarded and suppressed.

5.1 Reasons for Needing Mental Healthcare Services

Participants narrated a variety of reasons for using mental healthcare. These have been broadly categorised into reasons related to being trans, and reasons related to general psychological distress. While being trans added layers of complexity to some participants' mental health difficulties, direct causal links between transness and mental illness cannot be claimed. Nevertheless, many participants narrated MHCPs assuming that the two *are* directly connected, thereby pathologizing their transness. Nearly half of all participants discussed

needing mental healthcare to access GAHC. Several participants expressed that they had little need for mental healthcare besides accessing medical transition. While the overwhelming majority of participants spoke about experiencing depression at some point in their lives, not all of them had wanted to or been able to seek treatment for it. Many participants' narratives about mental illness indicated severe psychological distress. This included various mental health crises, self-injury, psychosis, substance abuse, and eating disorders. Of particular concern was the fact that several participants had dealt with suicidality – and that help was not always readily available for this issue.

5.1.1 Trans-related: Gender Identity and Transition

Twelve participants (71%) talked about using mental healthcare specifically because they needed help exploring being trans and/or gaining access to GAHC. For several of them, part of figuring out their trans identity involved diagnosis – three were diagnosed with gender identity disorder (GID), and one with gender dysphoria. Only one participant, Morgan, self-diagnosed with GID.

> "I remember when I was 15, I searched on the internet, I tried to find out what was wrong and I found the term Gender Identity Disorder, I don't think I even knew the term transgender at the time, I think that's the only one that I found and I told my mum, I think I have Gender Identity Disorder and I asked to see a psychologist, so you know, I did see a psychologist, but she didn't seem to think that I was really trans, she got out the DSM and we had a look through that." (Morgan, 20s, white heterosexual trans man)

When Morgan was looking online in the mid to late 2000s for information what it means to be trans, there were far fewer resources available than there are today. I was also figuring out my trans identity around this time, and most of what I could find online either pathologized trans people or perpetuated transnormative ideas of how trans men 'should' be. It would not

have necessarily been a good thing for Morgan to be diagnosed with GID, since being trans is not a mental illness. However, at that point it may have been helpful to have someone acknowledge the distress he was experiencing and put a name to it. As Morgan narrates, he "wasn't dissuaded" from being trans, but he also spoke about how

> "…it just felt like nobody was taking me seriously and that there was nothing that I could do about it, so I just tried to put it to the back of my mind and just move on really, and ja, that feeling of not being able to express it and not being able to do anything with it, it just felt like something that I'd have to carry forever." (Morgan, 20s, white heterosexual trans man)

Another participant, however, seemed quite relieved to have been diagnosed:

> "So recently I saw a psychologist, or a psychiatrist […] and that is when they *finally* diagnosed me with gender dysphoria." (Sebastian, 18, Coloured demisexual trans man) (emphasis added)

Unlike Morgan, Sebastian's experiences and identity were being recognised for what they were. Sebastian did not state this directly, but another likely purpose of the diagnosis was facilitating access to the GAHC he desired, i.e., starting HRT. Needing help with starting medical transition was a common reason for participants to seek mental healthcare. Eight participants (47.1%) discussed how they had to see a MHCP to be allowed to start HRT. This was the primary reason for Sanele, and the only reason for Lonwabo. Besides an initial psychological assessment, Sanele spoke about seeing a doctor (either a psychologist or psychiatrist) every three weeks for six months.

> "Because with my doctor, she is being changed every now and then, that obviously have like a psychological impact on me. So I have to go back there and make sure that I am okay mentally." (Sanele, 20s, Black bi/pansexual trans man)

However, he also said,

> "The thing about me was I already knew what I wanted. So I felt like I didn't need that many sessions. I just wanted the referral letter." (Sanele, 20s, Black bi/pansexual trans man)

For Lonwabo, it was quite clear-cut:

> "The psychiatric medical help that I had to seek out, it was only because a letter from a psychiatrist was required." (Lonwabo, 20s, Black heterosexual trans man)

The 'letter' Sanele and Lonwabo refer to is a MHCP's "written recommendation for gender affirming medical intervention" and is commonly known among trans people simply as 'the letter' (Johnson & Rogers, 2020, p. 279). Although this has been replaced by the informed consent model in current medical guidelines for GAHC (PsySSA, 2025), it is evident from these narratives that the letter is still required by many HCPs in SA. In a similar manner, Chris discussed gatekeeping of medical transition:

> "I had to see a psychologist and I had to see a psychiatrist and they all had to confirm before I started any hormones and stuff." (Chris, 20s, mixed race bi/pansexual trans man)

However, Chris had not been able to access actual ongoing mental healthcare. He had battled mental health issues but struggled to get the help he needed, trying for three years at his local government hospital to see a psychologist with no success. There was therefore no MHCP who really knew Chris, his current mental state, his psychiatric history, or any other potentially relevant information. Nevertheless, his access to HRT was still determined by the mental health profession. As Ashley (2019) notes, "because they don't see self-reported desire for medical transition as sufficient a justification to obtain a HRT prescription, mental health referral requirements fail to recognise the value of trans self-actualisation" (p.481).

Thus, Chris being required to see MHCPs to be allowed to start HRT can be seen as a denial of his agency over be(com)ing who he was meant to be.

The majority of participants had needed mental healthcare for reasons related to being trans: figuring out their transness and/or needing 'the letter' to be allowed to start HRT. Almost half of all participants had seen a MHCP in order to access GAHC, since this was a requirement even for those who had no other mental healthcare needs. Most participants had not been diagnosed with GID, and it is unclear how many had received a gender dysphoria diagnosis. In addition to needing help with trans-related matters, most participants also needed help with general mental health difficulties.

5.1.2 Mental Health Issues

The theme of mental health issues as a reason for needing mental healthcare emerged from the majority of participants' narratives. Many discussed having struggled with depression and anxiety, although not all of them had chosen to or been able to seek help with these issues. Of particular concern is that severe psychological distress such as suicidality also emerged as a notable theme. Additionally, several people narrated experiencing other difficulties, including psychosis, eating disorders, and substance abuse.

Although anxiety and depression are not the same disorder, there is substantial comorbidity between the two in the general population as well as in trans populations (Chen, 2022; Hajek et al., 2023). In this study, they overlapped in almost all cases. Seven people had sought help for anxiety and/or depression – however, there were also several others who had experienced depression and not looked for help for it. Oliver was the only participant who mentioned anxiety but not depression. All other participants who talked about having anxiety referred to it in relation to their depression.

> "I've got problems with depression, anxiety [...] stuff like that for a long time."
>
> (Ethan, 30s, white trans man)

Several participants described their depression as being quite severe or difficult to treat, both in the past and currently. For example, Morgan stated that he had "had quite a few years of very, very bad depression." Seven participants had used mental healthcare due to some kind of mental health crisis or breakdown. This is close to half (41%) of all participants, which is alarming but sadly not surprising considering previous research findings about rates of severe mental illness in trans populations (Lefevor et al., 2019). Based on the literature and what I knew from others in the trans community, I expected people to talk about quite distressing experiences. But I was not prepared for just how distressing things had been:

> "I really started going off the rails and by the time I was 15 I was expelled from school, never did go back to formal schooling, did my matric 13 years later so that's when all the suicide attempts and everything started. Now I know that I shouldn't be here after 38 tries and it's very damn clear I can't even do that right." (Edward, 40s, white heterosexual trans man)

Yet during Edward's interview and when thinking about it afterwards, I was struck by how positive he seemed despite all the challenges he had faced. I got this impression from other participants, too: despite the struggles, trauma, and prejudice they had experienced, even those who were still currently struggling with their mental health demonstrated noteworthy resilience. Suicidality emerged as a strong theme in several other participants' narratives about their experiences with severe depression and other psychological distress. Chris and Avery both spoke about their attempts at getting help through calling a suicide prevention hotline, but neither participant had found this service helpful.

The narratives of a handful of participants revealed that they had struggled with other mental health difficulties, including psychosis, schizophrenia, self-harm, substance abuse, and eating disorders. Edward had used self-injury to cope with psychosis in the past, but he narrated that his mental health had improved considerably in recent years.

> "I haven't self-harmed in about… 7 years. It only really occurred to me now while I'm chatting to you, damn! You're actually really not doing too bad on that score." (Edward, 40s, white heterosexual trans man)

Edward described his experiences with mental illness and mental healthcare as, "I don't want to say illustrious, but it pretty much sums up my mental health history." It was evident from Edward's narratives that he had a long history with quite severe mental illness, so it was especially significant that he was no longer battling with self-harm or psychosis.

Participants' narratives reveal that many of them had dealt with intense psychological distress, over many years. While 41% of participants spoke about specifically seeking mental healthcare due to depression and/or anxiety, the narratives of several other participants indicated that they had struggled with these issues but not necessarily sought help for them. Suicidality, breakdowns, and mental health crises emerged as a significant theme in participants' narratives.

5.2 Damage Caused by Lacking 'Trans 101'

Participants' narratives reveal that many HCPs lacked basic 'trans 101' knowledge and experience with trans healthcare. For several participants, being a HCP's first trans patient meant they had to educate them about transness. However, some MHCPs who did have experience generalised across trans clients, deeming the validity of participants' transness lacking compared to other clients. Participants' narratives indicated that some HCPs had fundamental misconceptions, such as assuming transness is a result of trauma or family issues. Participants also highlighted MHCPs using incorrect and offensive terminology as a problem.

Trans people are often expected by HCPs to educate them about their needs. This does not seem to focus on their specific needs as individuals, but rather on education about trans healthcare and transgender identities in general. The extent of this medical knowledge is

beyond what can reasonably be expected of the average patient. Several participants talked about being the first trans patient a HCP had treated, while others were the first trans person the HCP had ever met. Lonwabo talked about how being a HCP's first trans patient meant he was used to further their knowledge.

> "And now it's not only about you, but it's about you being this token trans person that they have now known, met, treated for lack of a better term, and then now it's something that they can use to build like a profile." (Lonwabo, 20s, Black heterosexual trans man)

Similarly, Asher was the first person his MHCP had met, and he expressed that he "felt weird about it" as he did not want to be a "case study" for them. For both Lonwabo and Asher, being a HCP's first trans patient meant that they were treated as a learning experience. The "token trans person" becomes something the HCP can use to generalise from to future trans patients, but the current patient's needs receive far less consideration. In my experience of being the first trans person a HCP has encountered, my transness becomes the most interesting thing about me because it seems so unusual to them. I feel like an interesting specimen, not a person, and it is deeply dehumanising. The focus of the appointment shifts from the healthcare needs that brought me there, to essentially being a data-gathering opportunity for the HCP.

Even when the HCP does have experience with trans patients, however, this is not always beneficial for the patient. This is particularly true if this experience also relies on generalisations from previous trans patients.

> "She said that she was seeing a couple of kids who were trans you know, and because I wasn't presenting as…I don't know, I wasn't being as forceful about it, I wasn't

> putting socks down my pants[12], that was one of the things that she told me about. 'Well, this person who is trans is putting socks down his pants, you're not putting socks down your pants.'" (Morgan, 20s, white heterosexual trans man)

Morgan is an exception to this lack of HCP experience as the MHCP he saw as a teenager directly discussed other trans youth she had as patients. Yet this worked to his disadvantage, as she used these other youths' expressions of their trans identity as a yardstick. Since he was not expressing his gender identity in the same way, by her logic he was therefore not trans. Her experience working with other trans patients had not resulted in her having a better understanding of how to appropriately treat trans individuals. As participants' experiences illustrate, using a one-size-fits-all model of what it means to be trans invalidates many trans people's gender identities. This was certainly what happened for Morgan: although he still knew he was trans, not being believed by a MHCP made him feel that he would never be seen as a man.

Many HCPs seemed to lack fundamental knowledge about what it means to be transgender. Several participants saw HCPs who thought that being trans was a result of some issue with their relationship with their parents. For example, Sanele was questioned about his family situation growing up.

> "We would first have to discuss my mental state, obviously like how do I feel, my experiences from the beginning, from way, way, way back when I was a kid. And questions like have I ever been sexually molested […] They would always ask about the family structure, like how things are at home and everything, do I have a father…" (Sanele, 20s, Black bi/pansexual trans man)

[12] In other words, he was not *packing* (trying to create the look of a 'male' bulge in his underwear), which can provide gender euphoria for trans men. The MHCP's implication is that Morgan's gender dysphoria was not particularly severe since he was not doing everything possible to alleviate it.

Psychological assessment is still typically part of the process of accessing HRT. However, this HCP's approach did not appear to focus on relevant factors such as Sanele's current mental state or ability to provide informed consent. Given the misconception that people are trans due to factors like trauma or mental illness (Ashley, 2022), the questions about sexual assault and family history seem aimed at ascertaining what made Sanele 'become' trans. This raises concerns because it echoes a faulty premise of conversion practices: the idea that if transness is caused by a specific factor, then removing that factor will prevent people from becoming trans.

Participants spoke about MHCPs using inaccurate, outdated, and offensive language. Ethan had seen a MHCP who would say "transgendering" instead of 'transitioning,' despite his repeated attempts at correcting them. Even MHCPs who seemed more familiar with trans mental health needs used terminology outside what is generally accepted by trans people. River had tried seeing a MHCP whose online profile stated that she "had experience with gender variances." This phrasing seems similar to 'gender diversity,' an accepted term which includes people who identify in diverse ways outside of the gender binary. However, despite her purported experience working with trans clients, this MHCP had serious misconceptions about trans people, resulting in her coming to inappropriate conclusions about River as a person and what their specific therapeutic needs might be. River had initially been seeing her

> "…for gender stuff, because I think at that point I really kind of wanted somebody to talk to about this kind of thing, I didn't know any trans people at the time and it was a very new concept to me and I was like how do you be trans, what do you do, how do you do it, and so I wanted that support as well, and that was definitely not offered." (River, 20s, white bi/pansexual nonbinary trans man)

River was in the early stages of exploring their trans identity and was seeking help understanding what being trans could mean for them. Moody et al. (2015) state that becoming

aware of trans peers and connecting with them helps individuals who are new to exploring their gender identity to normalise their experiences and feel less alone. River also mentioned that this therapist had not provided them with any other resources such as trans support groups. This is an oversight, since connecting with trans peers "moderates the effects of stigma and discrimination and enhances mental health for trans people" (Johnson & Rogers, 2020, p. 287).

Participants' narratives indicate that some HCPs who did not possess basic knowledge about trans people treated them as educators. Some participants narrated that being a HCP's first trans patient resulted in their being treated as a learning experience. However, the few participants who saw MHCPs who did have experience with trans clients narrated generalisations and comparisons being made across all trans clients. Incorrect, offensive language used by HCPs about transness emerged as an issue for participants. From participants' narratives, it seems that HCPs sometimes looked for causes for or doubted the validity of their transness.

5.3 Gatekeeping

The narratives of participants suggest that being transgender in itself is often gatekept by MHCPs, in addition to the gatekeeping of GAHC access. Participants narrated being expected to perform masculinity and enact transness in transnormative ways, or risk not being considered 'really' trans. Pathologisation of transness was evident, with HCPs often misattributing participants' mental health challenges to their trans status. Although the focus of the current research is not medical transition per se, it was evident from participants' narratives that being able to access medical transition significantly improved their wellbeing. In other words, the impact of GAHC on trans mental health warrants considering it a form of mental healthcare in itself.

5.3.1 The Single Trans Story

The theme of a universal 'transgender experience' emerged from participants' narratives as a perspective perpetuated by MHCPs. Participants' narratives reflected a belief among some HCPs that all trans people experience their gender in the same way, with an implication that there is a single correct way to be trans. While parts of this singular narrative – such as having gender dysphoria or wanting to medically transition – applied to many participants, their narratives indicated that these experiences were not uniform.

The single 'trans experience' narrative relies heavily on transnormative ideas about what it means to be transgender. AFAB trans people are expected to identify strictly as men, only be attracted to women, express traditional forms of masculinity, never display femininity, and aim to pass as cishet men. No space is allowed for transmasculine and/or nonbinary people who do not identify solely as women or men, who are queer, trans men who still enjoy feminine gender expression, do not desire medical transition or have mixed feelings about it, or who are openly trans.

Certain elements of this transnormative narrative persist because they ring true for some trans people. All participants in this study discussed experiencing some form of gender dysphoria at different points in their lives – but how, why, and when that dysphoria manifested differed greatly. They all met the only real 'criteria' for being trans, which is that they did not identify with the sex assigned to them at birth. Most of them identified as men, but others did not. Only four (23.5%) participants identified as heterosexual. Sixteen (94.1%) participants were on HRT or wanted to be, and three (17.6%) had had top surgery, but gender-affirming surgery was not a goal or a pressing issue for all participants.

Although being trans looks different for every individual, several participants discussed pressure to conform to certain expectations of what it means to be a trans man. For

example, Ethan identified as male and wanted to be perceived as such, yet while he was in one inpatient facility, he was made to feel like he wasn't performing maleness correctly:

> "…they asked me whether I was wearing men's pants or women's pants, not jeans and whatever, but I thought like because you know the one buttons up the one way and the other buttons up the other way, apparently, but they asked it in the kind of way that was like well you know if you're transgender, you should be doing that kind of thing, that was the impression I got." (Ethan, 30s, white trans man)

The idea that people "should be" doing certain things if they are 'really' transgender assumes that all trans people express their gender in the same ways. It also assumes that people experience dysphoria about the same things, and that there are prescribed ways of dealing with this dysphoria. It is not inaccurate to say that many trans men feel more comfortable wearing men's clothing. However, men's clothing does not always fit AFAB bodies. For example, most men's jeans do not fit if one has bigger hips, and shirts are often too tight around the chest. Thus, a transmasculine person may want to present as masculine but do so wearing 'female' clothing. Asher also discussed the expectations placed on trans men in terms of presenting as masculine:

> "…in terms of masculinity and you know, being male, I think I do sort of fill most of the stereotypes. So in that sense it's been easier for me […] I don't have to choose between performing gender and people questioning you because you're not masculine enough to be trans." (Asher, 30s, white bi/pansexual trans man)

Here, Asher illustrates the consequences of not performing gender in ways that conform to gender norms. To be perceived as male, it is necessary to present a specific version of maleness and masculinity that others can understand – thus avoiding one's gender being questioned (West & Zimmerman, 1987). Psychology and psychiatry have also played a significant role in requiring trans people to conform to "normative gender roles and

stereotypes, thereby effectively policing both transsexual identity and limiting the scope of imagined possibility" (Riggs et al., 2019, p. 919). When Asher names these expectations as stereotypes, this highlights that narrow, transnormative definitions of masculinity can impose restrictions on the gender expression of trans men. Nevertheless, he still identifies with certain aspects of normative masculinity. This suggests that it is not masculinity in itself that is problematic, but rather the expectation that all trans men should perform masculinity in the same way.

Participants' narratives reveal that transnormativity imposes strict expectations of gender performance on trans men, which limit the ways in which they are 'allowed' to express their gender. Even those who aligned with societal expectations of trans men, such as identifying solely as a man and being masculine, narrated these expectations as quite restrictive. Although most participants did speak about aspects that are expected of trans narratives, including gender dysphoria and medical transition, each individual's experiences of these aspects differed.

5.3.2 Pathologisation and Access to Gender-Affirming Healthcare

Participants' narratives reveal that despite transness no longer being classified as a mental illness, an unfortunate number of HCPs still treat it as one. As the data illustrates, MHCPs typically play the role of gatekeeper for trans people trying to access GAHC. Participants who had mental health challenges narrated difficulties in getting MHCPs to understand the difference between their gender identity and mental illness. It is troubling that GAHC access is so restricted, considering the major positive impact that transitioning can have on trans individuals' mental health (Wu & Keuroghlian, 2023).

As previously outlined, knowing the basic facts about trans people is vital for any HCP. However, having an entirely abstract understanding of what it means to be trans is not always enough. In order to fully assist trans patients, River felt that it was key for MHCPs to

"understand gender on a level that is deeper than an academic level." Similarly, Sebastian demonstrates the importance of MHCPs having experience working with trans patients.

> "[the MHCP] told me she has 30 years of experience working with trans teenagers. So I don't have to feel worried, she is not going to judge anything I have to say because she has a lot of experience, and that calmed me immediately." (Sebastian, 18, Coloured demisexual trans man)

The MHCP's experience working with patients like Sebastian seems to have been quite reassuring. By contrast, the MHCP Morgan had seen in his teens had also worked with trans youths but judged the validity of his trans identity in comparison to these other patients. Experience with trans clients is not necessarily sufficient to ensure a MHCP will treat other trans individuals well. As Sebastian illustrates, it is also important that the client feels that the MHCP accepts their gender identity.

Some participants talked about HCP reluctance to provide GAHC, including denial of access to this care. Psychiatrists still play a major role in gatekeeping trans access to GAHC, but some are more trans-friendly than others. Ethan had struggled with some HCPs who made the process of starting HRT particularly challenging, but finally managed to find a psychiatrist who had a more trans-affirming approach.

> "…he was very helpful in eventually not *allowing* but *facilitating* me to start transitioning. That was the time when other professionals were very gatekeeping like you have to do x, y, z before you can start testosterone." (Ethan, 30s, white trans man) (emphasis added)

The help Ethan received from his psychiatrist is unfortunately not the norm, however. As Ethan's word choice illustrates, for many trans people, it is a struggle finding a psychiatrist who will *allow* them to start HRT – let alone one who will actively assist with the process.

If one follows current medical guidelines such the SOC-8[13] (Coleman et al., 2022) or the DSM-V-TR (APA, 2022) – or if one simply takes trans people at their word – it is obvious that being trans is not a mental illness. Yet this has not always been the case. Sawyer, who was in his late 50s at the time of the interview, described just how different things had been in the past. He explained how, "at 18 [he] was, more or less, openly trans," but that being trans

> "…was just not accepted in that time. And being trans was viewed as a psychiatric illness. The treatment was to change the person." (Sawyer, 57, white heterosexual trans man)

Given the history of Sawyer's gender identity being pathologized and suppressed by MHCPs, it is unsurprising that he had strong feelings about the continued pathologisation of trans individuals.

> "I even have a problem with gender dysphoria being in the DSM. […] I understand it exists, that we have it, and that's that. But to view this...I don't know who should be giving out the hormones. I don't think a psychiatrist... dysphoria, I don't think it's a mental thing. I think it's just as physical as anything else. […] It looks like a mental disorder and it's not." (Sawyer, 57, white heterosexual trans man)

Similarly, Chris talked about his frustration with MHCPs conflating transness with mental illness.

> "It's always like okay, so you're trans and you have an issue with being trans, it's like no, that's not the issue, I'm trans and I have psychological issues on top of it and I need to get that sorted out and they're always trying to fall back onto okay, but it's

[13] Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. Created by the World Professional Association for Transgender Health (WPATH)

definitely because you're trans, that's why you have mental health issues right?" (Chris, 20s, mixed race bi/pansexual trans man)

Hendricks and Testa (2012) emphasise that "minority stress factors (rather than gender variance itself) result in higher occurrence of psychological problems in trans people" (p.461). In other words, the different forms of prejudice that trans people experience contribute to poor mental health. But as Chris demonstrates, trans people can also have mental health difficulties entirely unrelated to being trans. Pathologising transness can result in MHCPs blaming any psychological distress that trans people experience on their gender identity, rather than treating the actual issues.

From participants' narratives, it is evident that the long history of pathologisation of transness by the medical field has not entirely come to an end. Their narratives highlight that MHCPs having first-hand experience of working with trans individuals can reassure clients and that experience is equally as important as having theoretical understandings of trans needs. Participants narrated that access to GAHC was still gatekept by MHCPs, particularly psychiatrists.

5.4 Ethical Violations: Conversion Practices

Multiple participants spoke about experiencing misconduct in mental healthcare contexts. This included general unethical behaviour such as violations of confidentiality, and ethical issues related to being trans; the latter will be explored here. A theme emerged of transness being suppressed through conversion practices. I explore participants' narratives about these abusive practices and highlight the role of religion. It must be noted, though, that while the conversion practices occurred in religious contexts, this does not mean that religious beliefs are inherently transphobic.

I refer to conversion 'practices' and not conversion 'therapies' as there is nothing therapeutic about forcing someone to repress fundamental aspects of their identity. Outright

International (2024) defines conversion practices as "practices intended to suppress or change a person's sexual orientation, gender identity, or gender expression based on cisgender, heteronormative indoctrination and the incorrect assumption that such persons' orientation, identity, or expression is not normal" (p.5). At the core of these practices is a belief that everyone is truly cisgender and heterosexual, and that therefore LGBTQIA+ individuals can 'return' to this 'natural' state. This is patently false. Trying to force an LGBTQIA+ person to be cishet does nothing but cause intense suffering for that individual (Ashley, 2022; Haldeman, 2024; PsySSA, 2025; Turban et al., 2020).

One aspect of conversion practices is the idea that being LGBTQIA+ is a choice, and therefore people can choose not to have this identity. For example, River saw a MHCP who lacked basic knowledge about trans people despite having had other trans clients and seemed to view being trans as a (poor) decision.

> "I think she just didn't understand what trans people were, I don't know if that would have been the experience of her other clients or if she just didn't get my gender, but she really seemed to be in favour of not being trans unless you absolutely have to, just really trying to talk me out of it." (River, 20s, white bi/pansexual nonbinary trans man)

Although River had seen this MHCP voluntarily (ironically, to help with exploring their gender identity), her attempts at repressing their trans identity can still be classified as a form of conversion practice. It is possible that this MHCP would have been even less likely to understand that River did "absolutely have to" be trans given that they are nonbinary, and nonbinary individuals are often taken less seriously or viewed as not really trans (Matsuno, 2019).

For another participant, the conversion practices he endured were involuntary and practically inescapable. Noah experienced medical and psychological maltreatment at a

religious mental healthcare inpatient facility. His family had sent him there ostensibly to treat his substance abuse issues, but really to 'fix' his transness through religious methods. Noah does not share his family's religious beliefs, making this facility particularly inappropriate for his care. The facility viewed Noah (a trans man) as a lesbian woman and felt that his 'lesbianism' needed treatment.

> "…the one thing that's really traumatised me and has made me even more terrified to come out is obviously when I was at this institution, it's a Christian place. They thought, okay, I'm a lesbian. And they brought a pastor in, to pray out the demon of lesbianism from me. And he came in and I got so agitated, and I'm epileptic. And I started having a seizure. And he just kept going and going and going and going in front of the entire woman's facility." (Noah, 30s, white bi/pansexual trans man)

This facility had stopped not only Noah's psychiatric medication but also his anti-epileptic medication. Research from Canada (Kinitz et al., 2022) and South Africa (Brown & Njoko, 2019) has also found that religion-based conversion practices sometimes frame homosexuality as resulting from demonic possession. Noah's contact with the outside world was also extremely limited, even more so than seems common in substance rehabilitation programs. This lack of contact was a particular problem since nobody besides his family knew that he was in this facility, making it harder to leave. Noah was eventually able to leave this facility, but it evidently caused long-lasting harm. It also did not make him any less trans, only more afraid to be open about his trans identity.

Although Owen did not personally undergo conversion practices, he was very aware of them through the church he attended growing up.

> "I was not going to getting myself into any conversion therapy, I had been through that in church enough, not in actual conversion therapy programmes but they would

> show previews for the big institutions and stuff in church." (Owen, 20s, mixed race bi/pansexual transmasc)

Owen has since left that church but still described himself as "spiritual." He described how this brought its own challenges when looking for a therapist.

> "I'm still very much a spiritual person, although not religious anymore, so it's difficult sometimes to find someone who can cope with my queerness and my spirituality at the same time, usually they kind of are like mortal enemies and they hate each other, and I'm like no, I'm one person with both." (Owen, 20s, mixed race bi/pansexual transmasc)

It is beyond the scope of this thesis to explore trans people's relationship with religion with the depth it deserves. Nevertheless, it is worth noting that both participants who encountered conversion practices did so in a religious context. Yet, as Owen points out, spirituality is not incompatible with being trans. Similarly, Lin's faith did not conflict with his trans identity.

> "I do believe in God, like a normal Christian would. I know that most people would say that it's not the right thing, it's against God's rules and stuff like that. But in my head, God accepts everyone for who they are, as they are." (Lin, 20s, mixed race bi/pansexual intersex trans man)

Although Lin did not feel that religion should be used as a reason to discriminate, it sounded like he had experienced that "most people" would weaponize their beliefs against trans people. This was certainly the case for Noah and his experiences in the Christian facility. Tillewein and and Kruse-Diehr (2023) found that for trans people who do have religious beliefs, undergoing religion-based conversion practices caused many to "lose their personal sense of faith or religion" (p.682). It is clear from participants' narratives that conversion practices cause undoubted harm to trans individuals, whether they are conducted through a religious lens or otherwise. Kinitz et al. (2022) note that these practices are "embedded in a

deeper contemporary social structure that insidiously permits cisheteronormative interventions inclusive of conversion therapy" (p.450).

5.5 Concluding Remarks

Many trans men are experiencing significant psychological distress, which is exacerbated by factors including discrimination, being misunderstood, not being taken seriously, and not getting the support they need. Many MHCPs still conflate being trans with being mentally ill, but even trans people who do have mental illnesses are not receiving adequate treatment. Multiple participants would have benefited from help with exploring their gender identities, yet some of the 'help' they received tried to discourage them from being trans at all. Both transness and medical transition are frequently gatekept, which is harmful for trans men's wellbeing. In the following chapter, I explore whether trans men's mental healthcare needs are being met by South African healthcare systems.

Chapter 6: Are Transgender Men's Mental Healthcare Needs Being Met by the System?

This chapter shows that trans men are overall not receiving adequate mental healthcare that is sensitive to their needs, and that there is significant room for improvement. It looks at the challenges participants narrated around trying to access mental healthcare, such as the lack of resources in public healthcare, and the unaffordability of private healthcare. Participants highlighted the importance of the therapeutic relationship, particularly regarding feeling affirmed and taken seriously by MHCPs. The chapter concludes with the changes participants narrated that needed to be made to South African healthcare. These narratives focused on the education of HCPs, as well as systemic changes that could make healthcare environments more trans-inclusive.

6.1 Accessing Public and Private Mental Healthcare

In this section, I compare some of the experiences participants spoke about regarding using public and private mental healthcare. Participants described the quality of public mental healthcare services as being quite low, particularly in comparison to private healthcare. A significant issue that emerged from participants' narratives about public healthcare was an overall lack of resources, which resulted in this care being less beneficial than it could have been. Participants narrated stark contrasts between the two systems regarding inpatient psychiatric facilities, with a paucity of care provided in public facilities and a variety of therapies in private ones. However, financial barriers limited access to private healthcare for many participants.

6.1.1 Public Mental Healthcare Services

This section explores the significant issues that participants narrated regarding the public mental healthcare system. These issues were consistent with those described in literature on public healthcare in South Africa, and included HCPs being overburdened, public facilities

lacking resources, and long waiting times for patients (Baker & Naidu, 2021; de Wet & Pretorius, 2022). Participants' narratives revealed a long history of mistreatment in public inpatient psychiatric services, in addition to minimal therapeutic treatment being provided in these facilities.

As Edward's narrative underscores, there are substantial constraints on resources at public mental healthcare facilities.

> "Trying to get hold of psychologists at clinics is damn near impossible, they have a huge workload, a waiting list of note, that's if the clinics have any medication and they have a very limited range of medication as well." (Edward, 40s, white heterosexual trans man)

The "huge workload" and waiting lists that Edward spoke about are unsurprising, given the combination of the majority of South Africans using public healthcare (StatsSA, 2023) and the serious shortage of MHCPs working in the public sector (Benjamin et al., 2021). Baker and Naidu (2021) note that the provision of public mental healthcare at the primary level is "limited by resource constraints, unequal staff distribution, low skill level, low staff motivation and managerial capacity" (p.10). It must also be noted that these issues with public healthcare do not affect all groups equally, as discriminatory healthcare policies inherited from apartheid continue to affect previously disadvantaged groups. Research by Sigamoney (2023) with people from peri-urban areas in Johannesburg found that in terms of access to healthcare services, some poor communities "had not witnessed any changes after Apartheid" (p.18). Additionally, according to StatsSA (2019), over eight in 10 Black households typically use public healthcare services, compared to one in 10 white households (p.104). Race and class thus influence who is affected by the issues with public mental healthcare services.

Despite the problems participants discussed encountering in public healthcare, a common theme in their narratives was that these issues were systemic and not the fault of individual HCPs. For example, Sanele highlighted some of the significant strain that is placed on HCPs working within the public healthcare system.

> "I feel like maybe it's a situation of lack of resources or either a situation of being burnt out. Because there's a lot of people that use the public clinics. So I feel like the doctors cannot necessarily give you the attention and they did not even put in the effort that they wished to put in because they have to see 50 more people after you, or maybe they saw 50 people before you." (Sanele, 20s, Black bi/pansexual trans man)

As Sanele's narrative illustrates, HCPs' high workload can also have a detrimental effect on the quality of care that they are able to provide patients. Several participants expressed concerns about how little time that MHCPs in public healthcare could spend with each patient, including in inpatient settings. Sawyer spoke about a lack of care from MHCPs in a public inpatient facility that he spent a lot of time in from the 1980s until the early 2000s. Although Sawyer's narrative is about mental healthcare from several decades ago, it helps to contextualise other participants' more recent experiences with similar kinds of care.

> "…you are left alone for large amounts of time without anything. You never saw a psychologist, you just saw the psychiatrist and the nurses […] sometimes you'd see a doctor once a month. You are just left to your own devices in between. It's just checking your medication all the time." (Sawyer, 57, white heterosexual trans man)

Sawyer's narrative about these experiences indicates that he received a very minimal level of care at this hospital. It is concerning that Sawyer did not feel like the inpatient program was sufficiently engaging, since he was experiencing significant mental health issues that warranted comprehensive care. Sawyer also recounted being made to "clean the floors and do all sorts of things that were really, really demeaning" in this hospital in the 2000s. In my

experience of public psychiatric inpatient facilities, nurses do expect the patients to clean up after themselves. However, when I was in a similar facility about a decade ago, the extent of the expectations was making one's bed, keeping one's personal belongings tidy, and cleaning up after meals – not cleaning floors. The rationale for getting patients to tidy/clean was that this would aid their recovery and help them get ready for the 'real world.' It must be noted, though, that this was the nurses' ideas of what would be therapeutic, not the psychologists or psychiatrists.

The shortage of psychiatrists and clinical psychologists in public mental healthcare results in much of the burden of care falling on nurses (Baker & Naidu, 2021). However, they are not always equipped to provide mental healthcare. Rall and Swartz (2025) found in a sample of healthcare workers in the Eastern Cape that only half of them had training in mental healthcare, and a mere 22.2% felt equipped to provide this care to patients (p.7). Similarly, Kigozi-Male et al. (2023) discovered that many nurses working in public primary healthcare facilities in Durban lacked knowledge about the "employment, recovery and help-seeking behaviour" of people with mental illnesses (p.5). Thus, nurses working in public psychiatric inpatient facilities may have to make decisions about what will be best for patients' recovery based on their personal understandings of mental health, rather than clinical training.

Other participants also spoke about being mistreated in public mental healthcare facilities more recently. Ethan described being in a public hospital a few years ago as "traumatic" in comparison to private facilities, and, like Sawyer, narrated a lack of a proper therapeutic program.

> "…you just sit there the whole day or you just sleep the whole day and there's a hole in the toilet door so people can see you in the bathroom and a hole in the shower door." (Ethan, 30s, white trans man)

It is understandable why Ethan narrated this experience as being "dehumanising." Not having any privacy for such basic necessities as bathroom facilities is deeply degrading. The facility Ethan speaks about here is an involuntary acute psychiatric ward. It is therefore especially concerning that the patients being treated this poorly are those experiencing severe psychological distress, and who may not be able to self-advocate for better treatment.

The systemic issues in public mental healthcare facilities that participants point to in their narratives primarily relate to a lack of resources such as medication and staff. Participants' narratives show that MHCP staff shortages and resulting high caseloads are negatively affecting the quality of care that patients receive. What emerges from participants' narratives is that in public mental health services, patients have insufficient time with MHCPs. This issue was raised particularly by participants who had used inpatient facilities, where they received almost no therapeutic treatment and were treated with very little dignity. The section that follows explores participants' experiences with private mental healthcare.

6.1.2 Private Mental Healthcare Services

In this section, I focus on participants' narratives about using private mental healthcare. As the data illustrates, the quality of these services was typically high – but so was the cost. Participants' narratives demonstrated that while being a member of a medical aid scheme had its benefits, there were still restrictions on the care they could access. The advantages of private healthcare that participants spoke about included having longer therapy sessions, having agency over choosing MHCPs, and being able to see the same MHCP consistently. Participants also described private inpatient clinics as having comprehensive therapeutic programs.

One significant stumbling block for many participants was the cost of medical aid, without which private healthcare is especially financially inaccessible. Given the severe inequality of South African society, it is unsurprising that medical aid membership is

unequally distributed along racial and class lines. According to the latest General Household Survey, 71.7% of white people have medical aid, compared to 41.3% of Indian/Asian, 19.6% of coloured, and 9.8% of Black people (StatsSA, 2023, p. 22). White households, with an average income over three times the national average and over five times that of Black households (StatsSA, 2025, p. 7), also spend more than four times the national average on healthcare and more than seven times what Black households spend (p.55). With higher income comes an increased ability to afford medical aid and therefore access higher quality healthcare. Shisana et al. (2024) highlight that healthcare access depends not only on income but also location, as most MHCPs work in urban areas which leaves people in rural areas with limited access.

Edward narrated that although he had initially used private inpatient services, "once [he] went off mom's medical aid, that was it, it was state all the way." As Asher highlights, however, those who could afford medical aid still had limitations on what mental healthcare they were able to access through it.

> "The one thing I didn't like with that, it's because you can only get the minimum benefits for things like depression. You can't say I'm transitioning that's why I kind of need [therapy sessions]." (Asher, 30s, white bi/pansexual trans man)

Asher illustrates the precarious position that medical aids put trans South Africans in regarding mental healthcare access. Since medical aid schemes in SA do not generally provide coverage for any form of GAHC, it is not possible to state on medical aid claims that mental healthcare is needed for trans-related reasons. It therefore becomes necessary to instead claim based on a mental health condition that the medical aid does recognise, such as depression. This lack of trans inclusion limits trans individuals' ability to access the mental healthcare they need.

It emerged through participants' narratives that one major advantage of private healthcare was the element of choice. For example, Ethan commented that "when you're private you can choose who you see." Below, Owen explained how selective he had to be when finding HCPs.

> "I've been so very pedantically careful with my actual care providers […] I specifically looked for therapists who were queer friendly, trans friendly, clued up on the stuff and so I didn't have to sit there explaining myself the whole time." (Owen, 20s, mixed race bi/pansexual transmasc)

Owen's comment that he had to be "pedantically careful" illustrates the difficulties trans people face when trying to find MHCPs who will respect and understand their transness. From the narratives of other participants and in my own experience, it is very frustrating having to explain one's gender identity to HCPs as this takes up valuable time that could be spent addressing the actual issues one has sought help for. Owen demonstrates that finding trans-friendly MHCPs requires effort but is crucial for receiving more effective care.

As Oliver narrates, being able to develop a consistent therapeutic relationship and having longer therapy sessions were significant benefits of private mental healthcare.

> "Privately you get your 50 minutes, one-on-one time, you build up a relationship with the therapists and it feels safer and homier." (Oliver, 30s, white bi/pansexual trans man)

Oliver illustrates that being able to see the same MHCP every time facilitates the building of rapport and contributes to feelings of safety. Overall, participants who were able to access private healthcare found it to be of high quality. For example, Edward narrated that in private inpatient clinics "there is actually treatment, it's not largely containment"; 'containment' had been much of his experience with public inpatient facilities, in which he described that "you're really just managed." Below, he describes private inpatient treatment:

> "…every single minute of the day there is an activity, you're actually getting art therapy in the morning then individual therapy just thereafter, then [Occupational Therapy] and there's continuously programmes and groups and therapies and things going on throughout the day." (Edward, 40s, white heterosexual trans man)

Edward's narrative indicates that the therapeutic program in private inpatient facilities is quite comprehensive and includes a variety of different types of therapies, both group and individual. This is in stark contrast to the lack of therapy that he – and other participants – described in their experiences of public inpatient hospitals.

In summary, this section has shown that participants who could access private mental healthcare had generally had positive experiences with it. However, participants raised the issue of high costs. They also indicated that without being a member of a medical aid scheme, private healthcare was particularly unaffordable. Medical aid membership still only provided limited mental healthcare access, though, and these limitations were reflected in the narratives of participants who had needed care for trans-related reasons. Participants spoke about the benefits of being able to choose their MHCPs, more intensive programs in inpatient facilities, and having more individual relationship with their MHCP. In the following section, I explore participants' narratives about the nuances of this therapeutic relationship.

6.2 The Therapeutic Relationship

From participants' narratives, it became clear that the quality of mental healthcare depended significantly on the relationship they were able to build with MHCPs. In this section, I explore the MHCP's role in ensuring that trans patients feel safe, validated, and understood in therapeutic contexts. Drawing from the narratives of participants, I also highlight the importance of treating trans individuals with respect and without making them feel that there is anything unusual about them. Participants' narratives demonstrated that for especially for trans youth, it is very helpful having a space to explore one's identity and be taken seriously.

6.2.1 Affirmation of Transgender Youth and Adults

This theme draws from participants' narratives of experiencing invalidation and underscores the importance of MHCPs affirming trans people's identities. I demonstrate that trans youth experience significant invalidation, and that their ability to self-identify is often doubted. This is illustrated through narratives from some of the youngest participants, as well as other participants' narratives about experiences from their youth.

Non-affirmation refers to other people not respecting a trans individual's gender identity (Testa et al., 2015). This includes refusing to acknowledge someone's trans identity, use their correct name, pronouns, or gendered language. Trans youth in particular often experience this non-affirmation, in addition to being treated as if being trans is just a 'phase' that they will grow out of (Singh et al., 2014). Morgan illustrates this dismissal of trans youths' identities.

> "…when I was younger, what would have been the most helpful thing is taking me seriously, no insinuations that maybe you're not actually trans, you're just maybe gay or just going through a gender thing because you're 15 years old. I don't think it is responsible to assume that someone definitely is trans or not trans when they don't feel entirely sure themselves, you can't try and influence that person, but you can give them the space to express their feelings and help guide them through it." (Morgan, 20s, white heterosexual trans man)

Morgan's narrative highlights how important it is for trans individuals, particularly trans youth, to be able to explore their identities without fear of judgment. I have also experienced being a teenager who knows that they are not cisgender but is treated as though they are too young to truly know their own identity, and it is very disheartening to be doubted in this way. Although some trans youths are in a space of self-discovery like Morgan was and may need guidance figuring out their gender, not all young trans people are uncertain of their identities.

For example, both Alistair and Sebastian were 18 at the time of their interviews and already knew that they were trans men. Sebastian explained how significant it was for him to have his transness taken seriously by a MHCP.

> "…out of all my experiences it was the best […] I was so happy […] finally someone just believes what I am saying and actually agrees with me. Because she was onboard, fully." (Sebastian, 18, Coloured demisexual trans man)

Sebastian's narrative about having his gender identity believed highlights the value for trans people of being treated as the authority on their own gender identity and needs. This type of acknowledgement contributes to feelings of being seen. As previously addressed, visibility is a salient issue for many trans men and transmasc individuals. The feeling of invisibility extends to mental healthcare contexts, where people may not feel that they are being seen as their true selves. Avery highlighted this issue when discussing what kind of support he had needed in his youth and his current mental healthcare needs.

> "…someone who listens and who will be able to help me get good coping mechanisms […] they don't necessarily need to understand or relate, but just to say okay, I get it." (Avery, 20s, white demisexual trans man)

The need Avery expressed for a MHCP who "gets it" speaks to the need to be recognised as one's full self. Several times during Avery's interview, he used similar phrasing to "someone who listens" to describe what constitutes helpful mental healthcare for him. This highlights how important it is for trans people to feel that they are being heard and that MHCPs are paying attention to their needs.

As the data illustrates, it is helpful for MHCPs to affirm trans individuals' explorations of their gender identity. From participants' narratives, not feeling heard and taken seriously emerged as a significant issue. This was especially true for trans youth. While some trans individuals may need assistance exploring their gender identity, others may

already be certain about this identity by the time they see a MHCP. The following theme highlights that while participants had some healthcare needs specific to being trans, they also narrated the need to not be treated any differently because of their trans status.

6.2.2 "They Just Treat You Like a Human Being"

This theme explores participants' narratives about how they had been treated compared to cisgender people, and how they had wanted to be treated. Their narratives show that it is unhelpful to make trans patients feel that their transness makes them strange or different. At the same time, trans individuals do have some healthcare needs that differ from those of their cisgender peers. One of these needs relates to medical administration, where participants' narratives highlight the value of having their chosen names respected. Some participants also narrated needing assistance from MHCPs with accessing GAHC.

As Sebastian narrates, trans individuals simply wish to be treated as normal people.

> "…they gender you correctly, they just treat you like a human being person, and it is fine. They don't make a super big deal about it." (Sebastian, 18, Coloured demisexual trans man)

Sebastian demonstrates that trans individuals do not want their trans status to be more of a "big deal" than necessary, and that it is preferable not being treated as unusual. However, it must be acknowledged that trans patients will have unique needs and face different challenges to their cisgender peers. For example, one issue many trans people encounter in medical contexts is around administration. When intake forms only allow space for one name, trans people often have no choice but to use their deadname. Owen highlights the major positive impact of HCPs using a trans person's chosen name.

> "I hadn't started any treatment, so I was very nervous about even just asking people to call me my name, and without her blinking an eye, she was like what's your name and I said my real name and just like that, she took her pen and changed all of my files

> with my new name on it, [which] immediately made me feel at ease." (Owen, 20s, mixed race bi/pansexual transmasc)

Owen's mention of not having "started any treatment" (i.e., HRT) also highlights a transnormative expectation placed on trans people: that we should medically transition in order for our identities and chosen names to be respected. Regardless of a trans individual's transition status, medical or otherwise, HCPs need to use their correct name. If a patient's legal name is required for administrative purposes, medical intake forms also need to allow people to provide the name they wish to be addressed by (Tomson et al., 2021).

Not all participants in this study spoke about wanting to medically transition, but for those who did, facilitation of access to this healthcare was highly significant. Unfortunately, GAHC is still gatekept by MHCPs, even those who do not believe this should be the case. Asher's narrative about wanting to start HRT shows that is key for MHCPs to be aware of how important this role of facilitator/gatekeeper is for trans wellbeing.

> "…she did help me, in fairness, to get a letter to get my hormones started. It wasn't all bad in that sense, but there were things that I was unhappy with, obviously which is why I stopped going to her." (Asher, 30s, white bi/pansexual trans man)

Although Asher had previously described seeing this MHCP as his worst mental healthcare experience, her support in facilitating access to HRT had still been valuable. This underscores the significance of GAHC for those who need it, and the mistreatment trans people often have to endure to access it. However, medical transition was not the only thing Asher discussed needing from mental healthcare: he also explained that "there was a lot of stuff [he] needed to talk about in therapy, other than trans stuff." It is evident that trans people do not only use mental healthcare for seeking HRT or for discussing trans-related issues.

In summary, this section indicates that while MHCPs need to have sensitivity around trans healthcare needs, it is equally important for them not to solely focus on a client's

transness and to rather treat them as a complete person. While some trans individuals require support with trans-specific issues, we also have the same general mental healthcare needs as cisgender people. In the theme that follows, I explore the changes participants narrated as being most important for mental healthcare in South Africa going forward.

6.3. Knowledge and Education

The themes of knowledge and education emerged in almost all participants' narratives about the changes they wished to see made to the South African mental healthcare system. Participants spoke about MHCPs generally lacking knowledge about trans people, and they narrated that this needs to be resolved through further education. They also emphasised that this education was necessary for all HCPs, not only those within mental healthcare. Participants discussed a number of practical changes that could make healthcare more trans-friendly and trans-inclusive.

6.3.1 Knowledgeable or Willing to Learn

It emerged from the data that MHCPs' levels of awareness, understanding, and desire to learn about trans people varied significantly. Participants narrated wanting their MHCPs to have a comprehensive understanding of what it means to be transgender. However, since they could not typically expect MHCPs to be this knowledgeable, the next best option was for MHCPs to be willing to learn about transness. Participants' narratives indicated that while knowledge about trans people was important, having experience working with trans clients was also very valuable.

As Owen narrates, it is preferable for MHCPs to be transparent about their willingness to work with trans clients.

> "…open to the fact that the person sitting in front of them may not have the same belief systems and beliefs as them, but to just be honest enough that if they're at a point where they cannot accept that person then to just say it, to be like, Hey!

> Actually, I can't help you because we're not on the same page, instead of trying to convert us or trying to do anything like that." (Owen, 20s, mixed race bi/pansexual transmasc)

Owen illustrates that while trans individuals may want MHCPs to be open to change, they do not expect that all MHCPs will be accepting of transness. Owen's comment about MHCPs "trying to convert us" is worth noting, considering the very real danger that conversion practices pose to trans people (Ashley, 2022; Outright International, 2024). Other participants' narratives indicated that MHCPs are not always aware of the extent of their ignorance regarding trans people. It was therefore quite encouraging that other MHCPs could acknowledge gaps in their knowledge and were willing to do something to address these gaps. Noah narrated that while his MHCP was aware that she did not know much about trans people, she had taken the initiative to self-educate.

> "She's the first therapist I've ever opened up to about being trans and immediately the next week was like, 'Okay, so I found this information out, and this information out and that information out. […] I don't know enough about this to guide you. So I've had to ask other people.'" (Noah, 30s, white bi/pansexual trans man)

Despite this MHCP's lack of prior knowledge about trans people, Noah had continued seeing her and narrated that he had found her to be very helpful. This demonstrates that even if MHCPs are initially unfamiliar with transness, if they are willing to learn, it is still possible for them to treat trans clients. As Morgan noted, "you can work with someone who doesn't understand trans issues but has compassion." While participants spoke about wanting MHCPs to be more knowledgeable about trans people, they also emphasized the importance of having real experience working with trans clients. It should be noted, though, that this differs from having first-hand experience of *being* trans. Asher narrates the value of this type of experience.

> "…maybe they can do some courses or something and learn a bit about us. But I don't know how helpful that's gonna be if they don't have experience with trans clients […] to have more people like yourself who understand this personally, that would be a lot more useful. Other therapists can definitely help […] but I don't expect them to understand the whole process or everything we go through." (Asher, 30s, white bi/pansexual trans man)

As Asher explains, education for MHCPs is not enough on its own: experience working with trans clients is equally valuable. The ideal, however, was MHCPs who "understood this personally," i.e. who shared lived experience of being trans. Other participants expressed that they felt more comfortable and better understood with MHCPs who were, as River put it, "at least queer," even if they were not also trans.

Participants' narratives indicated low expectations of MHCPs' level of knowledge about trans people. They also expressed not anticipating that all MHCPs would accept transness enough to treat trans clients, and that they would prefer to know this upfront. While knowledge about trans people was valued, participants also noted the necessity of MHCPs having experience with trans clients. It was encouraging when MHCPs knew that there were limits to their knowledge but actively tried to improve their understanding. The following section expands on the necessity of education for HCPs.

6.3.2 "Education, Education, Education"

The strongest theme that emerged from participants' narratives was the importance of education for MHCPs, as well as HCPs in general. Participants narrated that if HCPs had a better understanding of transness, it was possible for them to prevent trans patients experiencing such debilitating gender dysphoria. Their narratives indicated low expectations of HCPs' level of knowledge regarding not only trans individuals but also LGBTQIA+ people generally. Participants also emphasised that being trans is not a choice.

As Edward highlights, there is enormous potential for education to reduce the significant distress that many trans people experience.

> "Educating the GP's, educating the shrinks, educating the psychiatrists. If they know what they're looking at, they can definitely save a helluva lot of suffering, they can save lives because we won't be wanting to top ourselves because we can't bear living in the bodies that we are and being misgendered." (Edward, 40s, white heterosexual trans man)

Edward's narrative illustrates the suffering that gender dysphoria can cause, and that it is crucial that HCPs understand how profoundly dysphoria can affect trans individuals. Although not all trans people experience severely distressing dysphoria, Edward demonstrates that for those who do, the distress can be severe enough to make life not worth living.

Oliver spoke about the necessity of education and training for HCPs in general and suggested how this can be achieved.

> "Not just mental health people but all medical people should try to get some training in sensitivity […] You know how doctors and everyone, they all have to go for a certain amount of courses." (Oliver, 30s, white bi/pansexual trans man)

Oliver is referring to the Continuing Professional Development (CPD) program, which requires all registered HCPs to continue their education "beyond any initial training" (Health Professions Council of South Africa, 2024, p. 1). Given that HCPs are already required to pursue this further education, there is a clear opportunity for this to incorporate trans healthcare. Among other resources, courses about trans healthcare and LGBTQIA+ people are already offered by local organisations such as the Professional Association for Transgender Health South Africa (PATHSA), Gender DynamiX, and the Triangle Project.

Participants highlighted that HCPs who are not knowledgeable about LGBTQIA+ individuals can make fundamental errors. For example, Oliver described how his HCP did not know the difference between gender identity and sexual orientation.

> "She was really weird about the trans thing, because she obviously hasn't trained or anything. She never had a patient that's trans. She actually asked me like isn't it just better to just be a lesbian […] she's like, ja, I had two patients this morning. This lovely lesbian couple, they just had a baby. That could be you." (Oliver, 30s, white bi/pansexual trans man)

Oliver's comment that his doctor "*obviously* hasn't trained" (emphasis added) illustrates the low expectations trans people have of HCPs. This HCP's comments imply that if Oliver does not want to "just be a lesbian," he has made an active *choice* to be a trans man instead. As Edward narrated, "it would make a world of difference if everybody realised this is not a choice."

In this section, participants' narratives highlighted the key role that education plays in improving the healthcare that trans people receive. Participants narrated experiences of severe gender dysphoria, which they explained could be avoided if HCPs were better equipped to understand this type of suffering. They explained the necessity of further education and training for MHCPs and suggested that this could be accomplished through CPD courses. The following and final section focuses on participants' narratives about systemic, structural changes to healthcare systems.

6.3.3 Systemic and Practical Changes.

In addition to changes to the education of MHCPs, participants talked about broader changes they wanted to see made to South African healthcare services. Participants were not always aware that mechanisms existed for reporting unethical treatment and consequently could not access them. Their narratives indicate a need for nationwide services specifically for the

LGBTQIA+ community. Participants expressed discomfort about being placed in female hospital and inpatient wards, as well as concerns about specialized wards for trans patients. Gendered bathrooms emerged from participants' narratives as a safety issue and source of stress.

Although several participants narrated experiencing mistreatment from HCPs, they did not always know that they could do anything about it, as Ethan narrates:

> "I wish there was an easier way to hold professionals accountable for how they treat transgender people […] the kind of therapy that I've had, it has turned out to be really traumatic […] there is no way of holding them accountable and saying but that was really unethical." (Ethan, 30s, white trans man)

It is concerning that Ethan felt that "there is no way of holding [HCPs] accountable," since patients do have options like reporting unethical treatment to the Health Professions Council of South Africa (HPCSA). However, accessing this support is impossible if one does not know it exists. This indicates that there is a need for trans patients in particular to be made aware of their rights as patients.

Lonwabo had a practical recommendation for including LGBTQIA+ healthcare in existing services.

> "If the government wanted to, they actually would because it would be so simple to add on an LGBT mental health professional to the teams where they have set up the people who do HIV awareness. […] It's like one thing that's actually going well for them is the response to HIV in the small towns. So now to the same offices that they are already renting, just add one more professional." (Lonwabo, 20s, Black heterosexual trans man)

It is significant that Lonwabo highlighted the need for LGBTQIA+ healthcare to be available in small towns. Currently, GAHC availability is limited to a few major metropolitan areas in

SA (Wilson, 2021), resulting in trans people in rural areas having to spend significant time and money traveling to receive necessary care (Bila & Carbonatto, 2022). Having dedicated MHCPs for LGBTQIA+ individuals in public clinics has massive potential for improving mental healthcare for people across the country. Below, Samuel narrates another practical way of making healthcare more trans-inclusive.

> "I think what would be very helpful is if instead of you always having to bring it up, it's kind of a standard part of operating for people. Things like asking for pronouns, and then with that it's much easier to just slip in the fact that you're trans instead of having to bring it up at a different point." (Samuel, 19, white bi/pansexual genderqueer transmasc)

As Samuel illustrates, it is challenging for trans patients always needing to inform HCPs of their trans status. Asking all patients about their pronouns also helps counter the idea that only trans people have 'preferred' pronouns. In terms of intake forms and medical records, Tomson et al. (2021) also recommend that medical practices "practise discretion with billing information in terms of differentiating between the client's legal name and name-in-use, and consult with the client directly to avoid any breaches of confidentiality" (p.12).

Participants' narratives indicated that in existing hospitals and inpatient psychiatric facilities, they did not always feel safe or that their needs were being considered. Their narratives demonstrate that the comfort of cisgender patients was frequently prioritized over trans patients' comfort and safety. Noah commented on this issue regarding gendered wards in hospitals.

> "I'm not comfortable being in the female section, I want to be in the male section or whatever it is, but then I could be causing discomfort to the cisgender men in their section […] but then you don't want to be put like this weirdo in your special little own section of the hospital." (Noah, 30s, white bi/pansexual trans man)

As Noah illustrates, trans patients often do not feel that their need to be in a ward that corresponds with their gender identity will be respected. He also highlights that there are issues with trans patients being allocated separate rooms/wards from cisgender patients. This is certainly the case in my experience: while it was preferable to not be in a female ward, being in an individual room made me feel that I was indeed a "weirdo" who was not allowed to share rooms with the 'normal' male patients.

McGuire et al. (2022) raise a significant issue regarding gendered bathrooms: when there is only one gender-neutral bathroom, this can mean that trans people have to out themselves to be able to use it. Regardless of how bathrooms are set up or which one(s) a trans individual feels most comfortable using, trans people want to avoid "having to explain their gender identity to a complete stranger" (May et al., 2017, p. 173). In terms of access to bathrooms, Patel (2023) also notes that "binary gendered signs on bathroom doors confer visual power upon the cisgender onlooker, authorising their gaze and allowing them to confidently stare or actively bar transgender people from using the bathroom of their choice" (p. 49-50). In other words, the way that the physical space of public bathrooms is structured makes some cisgender people feel that they have the right to decide who is allowed in that space.

Some participants discussed how, in hospitals and in psychiatric inpatient settings, the use of gendered bathrooms was gatekept by both cisgender patients and medical staff. For example, Ethan narrated issues with gendered bathrooms in a public inpatient facility.

> "I was living as male, so I was using the men's bathrooms but then one of the nurses would say to me well this other guy said he's uncomfortable with you using the men's bathrooms, but I was like, so?" (Ethan, 30s, white trans man)

Ethan's narrative suggests that *his* comfort over which bathroom he used was not taken into consideration. This lack of inclusivity is a serious issue, given that gendered bathrooms are

sites of misgendering, harassment, and violence for many trans people (May et al., 2017; McGuire et al., 2022). Sanele described how the issue of gendered bathrooms had been addressed at one university through the addition of gender-neutral toilets.

> "There's multiple bathrooms. Similar to the regular ones. But instead of being closed in, they are open for everybody to walk in and out as they please, because it's unisex. It's inclusive of everyone. It's open. So there's no way that you would actually get attacked in there because it's open for everyone to see." (Sanele, 20s, Black bi/pansexual trans man)

The fact that Sanele commented that people would not "get attacked in there" emphasises how significant of a danger public bathrooms pose to trans individuals. Patel (2023) highlights that bathrooms are both gendered and racialised spaces, and found that trans people of colour experience "hostility in the bathroom space as being based on their gender and hostility also being enabled by their blackness" (p.50). For example, a genderqueer participant in their research described an incident where a white person was "awkward" about their presence in the women's bathroom; however, upon hearing their voice, (mis)read them as a woman and said, "Oh sorry, sometimes I find it hard to tell the difference between Black men and women" (Patel, 2023, p. 50). Although gendered bathrooms are difficult for most trans people, the intersection of racism and transphobia makes these spaces particularly threatening for trans people of colour.

This section illustrated the practical changes that participants narrated as necessary for improving mental healthcare for trans people in SA. Participants' narratives demonstrate that there is a strong need for dedicated nationwide mental healthcare services for LGBTQIA+ individuals, especially in small towns and rural areas. Gendered spaces, such as gendered wards and bathrooms in hospitals and inpatient facilities, emerged from participants'

narratives as being a significant issue. Participants spoke about other factors that could improve trans inclusion in healthcare contexts, including HCPs asking about pronouns.

6.4 Concluding Remarks

Participants narrated that there are significant issues in the mental healthcare that trans people receive in SA. Their narratives highlight that the quality and accessibility of healthcare varies substantially between the private and public systems. Healthcare access is also strongly linked to socioeconomic status – and, therefore, to race. It became clear from participants' narratives that since previous healthcare curricula have not sufficiently prepared MHCPs for working with trans clients, continued education is vital for improving the mental healthcare that trans individuals receive. Practical changes, such as making gendered spaces and medical administration more inclusive, were highlighted by participants as having significant potential for making them feel more welcome in healthcare contexts.

Chapter Seven: Conclusion

7.1 Introduction

This study aimed to explore transgender men's experiences of mental healthcare services in South Africa, determine if these experiences are universal or shaped by intersections of other identities, and offer recommendations for MHCPs on how best to treat this population. This chapter outlines the key findings, discusses how my identity shaped the research, addresses the implications of the findings, acknowledges the study's limitations, identifies areas for future research, and offers suggestions for MHCPs for providing more appropriate care for trans men.

7.2 Summary of Findings

This research was guided by three main research questions and one sub-question. I will discuss the findings in chapter order, as each analysis chapter addresses a separate research question. *Chapter Four: Being a Transgender Man in South Africa* addressed the first research question: "How do transgender men speak about their lived experiences of their gender identity in the South African context?" Trans men in SA face persistent everyday discrimination and prejudice across many contexts. Transphobia is insidious, affecting trans people in many more ways than most cisgender people are aware of. It includes physical violence but also more covert forms of violence such as transphobic language, exclusion, differential treatment based on trans status, and trans people's authentic selves being dismissed or not recognised. These findings are consistent with research on transphobic microaggressions (Chang & Chung, 2015; Wesselmann et al., 2022), which demonstrates that trans people encounter subtle forms of prejudice that are nevertheless highly damaging. There is minimal awareness of the existence of trans men in SA, with Black trans men being especially invisible, making it even harder to find community. Race influences trans men's experiences of their gender, including the degree of male privilege they may gain if they pass

as men. This highlights that discussions of masculinities not only need to include trans men (Aboim, 2016) and men of colour (Ratele, 2019), but also the intersections of these two identities. Coming out as trans is challenging, particularly since rejection is typically part of this process, even if family and loved ones become more accepting over time. This finding aligns with existing literature on the complex nature of trans disclosure (e.g. Brumbaugh-Johnson & Hull, 2019; Kade, 2021).

Chapter Five: Transgender Men's Narratives about Mental Healthcare Services in South Africa addressed the second research question: "What narratives do transgender men tell about their experiences of public and/or private mental healthcare services in South Africa?" Most (71%) of the participants needed mental healthcare for trans-specific reasons. Nearly half had consulted a MHCP specifically for GAHC: consistent with research by de Vries and McLachlan (2022), access to this care remains gatekept by MHCPs in SA. GAHC significantly improved the mental wellbeing of those who wanted it, while inability to access this care was profoundly distressing. MHCPs often imposed transnormative standards, thereby implying that there is a single acceptable way to be a trans man. Spade's (2006) writing on normativity notes similar gatekeeping of GAHC and transness itself. Continuing the very long-standing pathologisation of trans identities (Stryker, 1994), transness was often treated as a mental illness – in addition to the misattribution of actual mental illnesses to transness. MHCPs frequently focused on the client's gender identity even when it was irrelevant to the issue they had sought help with, confirming research by White and Fontenot (2019). Most HCPs lacked knowledge and experience working with trans patients. Being the first trans person a HCP had treated or met often resulted in patients becoming their educators. Another issue was conversion practices, which are deeply traumatic and damaging for trans people. These practices were sometimes blatant but other times less obvious, such as MHCPs discouraging people from being trans. Many trans men have experienced severe

mental health difficulties, including suicidality, with depression and anxiety as common issues.

Chapter Six: Are Transgender Men's Mental Healthcare Needs Being Met by the System? addressed the third research question: "How do they speak about whether (or not) their needs as transgender men are being met by the system?" and its sub-question "What narratives do they tell about the changes they wish to see made in the system?" There were stark contrasts between public and private mental healthcare services. Disadvantages of public healthcare include shortages of MHCPs, limited resources, brief sessions, and insufficient inpatient care. The primary issue with private mental healthcare is its high cost, making it inaccessible for most trans people. These issues align with those discussed in literature on South African mental healthcare (e.g. Baker & Naidu, 2021; Docrat et al., 2019; Sorsdahl et al., 2023). A significant finding of this research was that the quality of mental healthcare was strongly influenced by the therapeutic relationship. In public healthcare, short sessions and seeing different MHCPs every time made it harder to establish this relationship. Conversely, private healthcare allowed patients to choose their MHCP, see them consistently, and have longer sessions, all of which helped develop trust and a stronger therapeutic relationship.

The strongest theme regarding changes to mental healthcare related to the knowledge and education of MHCPs. Trans men generally have very low expectations of HCPs' knowledge about trans people and their healthcare needs. To date, healthcare curricula have not covered trans healthcare in much detail, if at all. It is therefore vital for HCPs to be proactive in learning about trans people to address these knowledge gaps. However, this should be accomplished through self-education, rather than relying on trans patients to educate HCPs. Education about transness is not only important for MHCPs or providers of GAHC, but for anyone in the healthcare field.

There are also several practical changes that can make healthcare more trans-inclusive, particularly in psychiatric inpatient facilities. Patients should generally be assigned to wards that align with their gender identity; for most trans men, it is distressing to be placed in female wards. Gendered bathrooms in healthcare contexts (and public places generally) are a major source of stress for trans individuals, largely due to fears of harassment and violence. Gender-neutral bathrooms can alleviate some of this stress. Additionally, healthcare administration can be made more trans-inclusive by updating medical intake forms to allow patients to self-define their gender, specify their legal name as well as the name they want to be called, and state their pronouns.

7.3 Reflexivity: Myself as the Researcher

Who I am as a person was a fundamental part of this research. I hoped that my being trans would make it easier for participants to trust me and feel comfortable sharing their stories, as they could expect that I would understand them better and not judge their experiences. This seems to have been the case: several participants commented on feeling more comfortable participating because the study was conducted by a trans person. As a trans man who has used mental healthcare services in SA, I am part of the community I researched. My lived experience provided me with different insights than a cisgender researcher would have, influencing the kinds of questions I asked and chose not to ask, how I engaged with participants, and how I interpreted the data.

Although this is insider research, as a researcher studying this population, I am also outside the community to some extent. As the researcher, it was unavoidable that I would hold a degree of power over the participants. I made a conscious effort to remain cognisant of this dynamic. To try address this issue, I used a certain level of self-disclosure during the interview to demonstrate to participants that I understood and could relate to them. It was also

important to allow myself to be somewhat vulnerable, to help participants feel safe to be vulnerable in the interview setting and to minimise the researcher/researched hierarchy.

7.4 Limitations

The sample was not racially representative of the South African population, as it consisted of 59% white people and 41% people of colour. However, given that much of global trans mental health research has relied on almost entirely white samples, this represents some progress. Demographic data about trans people in SA is very limited, making it difficult to know if the sample was representative in other respects, such as age, sexual orientation, religion, or marital status. Nevertheless, as qualitative research which explores people's experiences and stories, these findings are not intended to be generalisable to the entire trans male population of SA. I did not include several other factors which could have influenced participants' healthcare experiences or access, including socioeconomic status and geographical context (e.g., urban, peri-urban, rural). Additionally, participation was limited to people with access to the internet and devices capable of video calls. I tried to mitigate this by giving participants R100 which could be used to buy mobile data or transport to somewhere they could do the call. However, as the study recruitment was also conducted online via social media and mailing lists, it is likely that people without internet access may not have heard about the study in the first place.

The other major limitation related to language. Since I only speak English, I was unable to conduct the interviews in any other language. I decided not to use a translator for several reasons. The primary reason is that trans terminology often does not have direct translations, and I would not know if the translated terms had exactly the same meaning. Additionally, I feel that participants would have felt less comfortable sharing their stories through a cisgender translator, and finding a transgender translator would have been difficult.

One final limitation was that I did not obtain feedback from participants on my analysis of their data. There is a possibility, therefore, that my interpretations do not accurately reflect the meanings that the participants intended. Lincoln and Guba (1985) define this process of member checking as one where "data, analytic categories, interpretations, and conclusions are tested with *members of those stakeholding groups from whom the data were originally collected*" (p. 314, emphasis added). As explained in **3.9 Data Quality and Trustworthiness**, while I did not ask the participants directly, I did obtain input from other members of the group I collected data from.

7.5 Future Research Directions

This study focused on the mental healthcare experiences of trans men and transmasculine individuals. However, trans women, AMAB trans femmes, and nonbinary individuals have unique experiences with mental healthcare that deserve exploration. Multiple areas emerged during this research that were beyond the scope of this thesis. Some of these are specific to trans mental healthcare, while others are about broader South African trans experiences. A key issue is the relationships trans individuals have with their families (both family of origin and chosen families), and how these relationships impact their access to and usage of mental healthcare. There is a pressing need for more research into the mental healthcare needs of trans individuals in Africa who have undergone conversion practices, including how their own religious beliefs shape their experiences and the care they need. In order to make mental healthcare services in SA more trans-inclusive, more understanding is needed about how trans individuals' cultural contexts influence their experiences. Another aspect of trans healthcare that has not been addressed is how trans people in SA share information about (M)HCPs, using informal networks to recommend trans-affirming providers and avoid transphobic ones. Finally, gaining insight into the terms that trans people use to self-identify in South African languages can help others refer to them respectfully without relying on

(often derogatory) terms used by people outside the community. This awareness would be beneficial for MHCPs working with trans clients and could also potentially improve cross-cultural communication about trans identities.

7.6 Recommendations for Practice

Greater efforts are needed to ensure that trans people are included in healthcare curricula and policies. There is considerable room for improvement in making healthcare more actively trans-inclusive. This includes practical measures such as providing gender-neutral bathrooms, placing trans patients in wards where they feel most comfortable, and making medical intake forms more inclusive. It is also reassuring for trans patients if MHCPs are visibly trans-affirming through their website, practice environment, and in communication (e.g., including their pronouns in an email signature). While being tolerant of transness is a good starting point, providing truly helpful mental healthcare requires that MHCPs actively support and affirm trans individuals. Anyone working within the healthcare field has the capacity and responsibility to be trans-affirming. This is not only relevant for MHCPs, or those providing GAHC: any HCP is likely to have trans patients at some point. Additionally, it would be very helpful if all staff members in healthcare contexts underwent sensitivity training about LGBTQIA+ people. It is vital to know enough about transness to ensure that trans patients are treated with sensitivity and understanding.

7.7 Significance and Implications

The findings from this research make several contributions to the existing literature. This study is among the first to explore the mental healthcare needs of trans men in SA. The evidence from this study indicates that not only are trans men's mental health needs not being met, but that much of the mental healthcare they receive further harms their mental wellbeing. This research provides valuable insights into the experiences of this marginalised population, which has significant, unique mental healthcare needs. A major contribution of

this research is its South African focus, as very little previous research has explored the mental healthcare experiences of trans people in the Global South. Additionally, it sheds new light on the healthcare experiences of trans men, including mental and general health, as well as their broader experiences of their gender.

I would like to close with a quote from participant Lonwabo: “It was pretty cool being able to help those people in a way that maybe in another life I would have needed.” It is my hope that in this life, in this research, I have been able to help my people in the way that I myself had needed.

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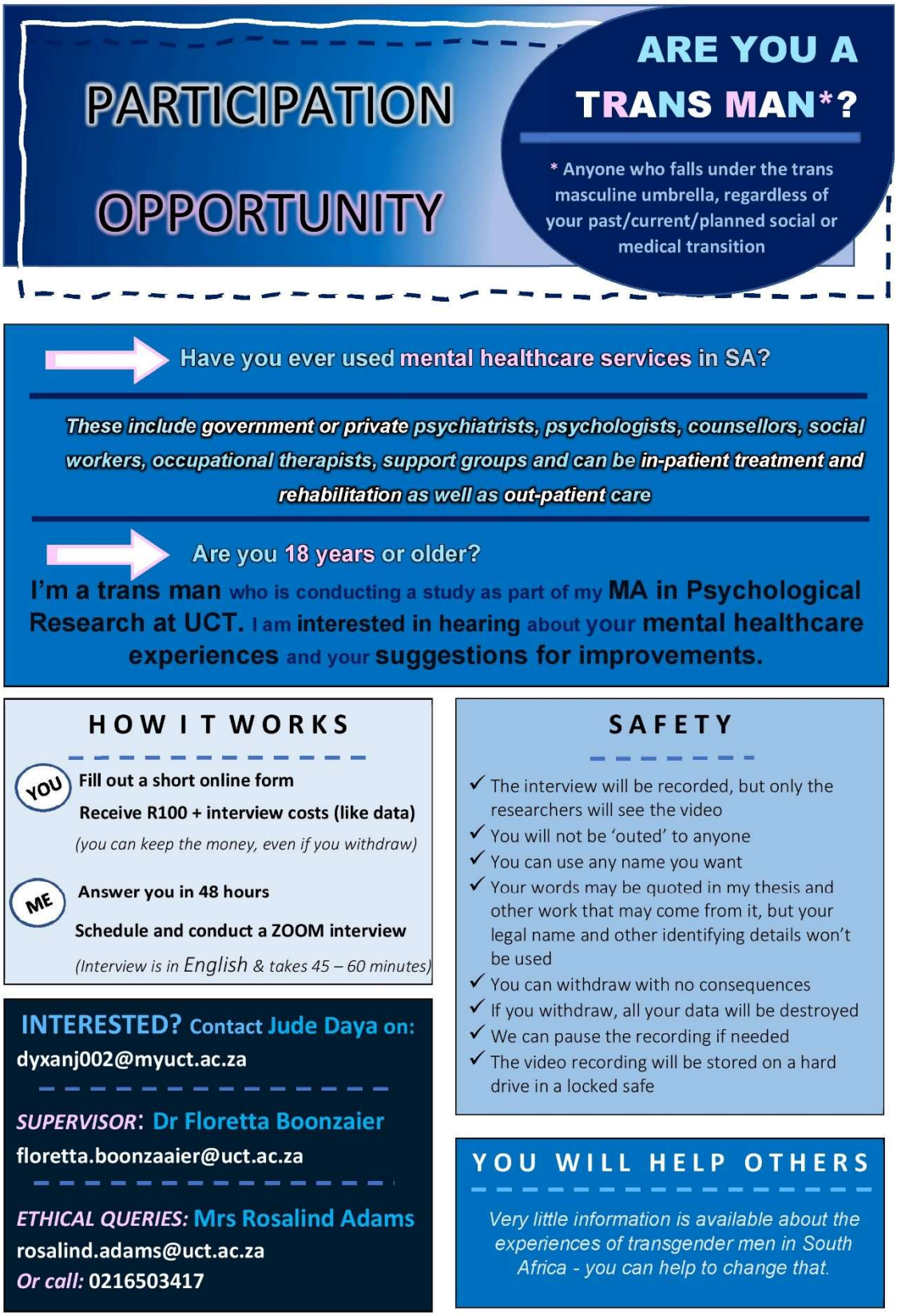
Appendix A: Advertisement/Recruitment



Appendix B: Ethical Approval

UNIVERSITY OF CAPE TOWN

Department of Psychology

University of Cape Town Rondebosch 7701 South Africa
Telephone (021) 650 3417
Fax No. (021) 650 4104

15 March 2021

Jude Daya
Department of Psychology
University of Cape Town
Rondebosch 7701

Dear Jude

I am pleased to inform you that ethical clearance has been given by an Ethics Review Committee of the Faculty of Humanities for your study, *Transgender men and mental healthcare services in South Africa*. The reference number is PSY2021-005

I wish you all the best for your study.

Yours sincerely

Lauren Wild (PhD)
Associate Professor
Chair: Ethics Review Committee

Appendix C: Informed Consent Form

Title of research project: Transgender men and mental healthcare services in South Africa

Primary researcher: Jude A. Daya. **Email:** dyxanj002@myuct.ac.za

Supervisor: Dr Floretta Boonzaier. **Email:** floretta.boonzaier@uct.ac.za

Project information: The primary researcher will conduct interviews with transgender men aged 18 and over about their experiences using any form of mental healthcare services in South Africa. You can have used these services at any time, and you do not have to be a South African citizen. The interviews will be in English, so you need to be fluent enough in the language to comfortably speak about your experiences. Interviews will be 45-60 minutes long and take place through the platform *Zoom.* Your data will be used for a Master's thesis and other academic works.

Risks: There are no risks of physical harm. Your transgender status will not be disclosed to anyone, and you can use any name you prefer. You will not be required to give your legal and/or chosen name, your ID number, or your physical address. Although your words may be quoted in the thesis and related work, nobody will be able to identify you from these quotes.

Benefits and compensation: Currently, very little information exists about transgender men in South Africa – you can help change that through sharing your experiences. You will also receive R100 (via EFT or eWallet) to thank you for your participation, and this money is yours to keep even if you withdraw from the study. Your mobile data/WiFi costs of doing the interview call will be paid for if needed.

Data security: The interview recording will be saved on an external hard drive that will be stored in a locked safe. Only the primary researcher and supervisor will have access to the

recording and transcript. If you withdraw from the study, all of this data will be permanently deleted.

If you have any concerns or questions about the ethics of the study and would like to contact the Chair of the Research Ethics Committee in Psychology, you can reach Mrs Rosalind Adams at rosalind.adams@uct.ac.za or 021 6503417

- I agree to participate in this study.
- I have read through the information about the study and understand what it involves. Any questions I may want to ask have been answered.
- I understand that I am free to stop participating at any time, with no consequences.
- I am aware that the R100 I receive is mine to use whether or not I withdraw from the study, and that the agreed participation-related costs will still be paid for.
- If I withdraw from the study, I understand that all my data will be destroyed – the interview recording, transcript, and Google Forms questionnaire submission will be permanently deleted.
- I agree to having the interview recorded, both audio and video, and understand that only the researcher and his supervisor will have access to this footage.
- I understand that I will remain anonymous and that whatever name I prefer will be used – either a pseudonym or my real name (this does not have to be my legal name).
- I agree to being quoted in the thesis and any other literature resulting from this study.

Preferred name (pseudonym) of participant:_____

Signature of participant: _____ Date:_____

Signature of primary researcher: _____ Date:_____

Appendix D: Questionnaire

The link to the Google Docs form for participants: https://forms.gle/nwGV1qnkvNVLfjVW7

Transgender men and mental healthcare services in South Africa

Thank you for your interest in this study. Please read the poster before completing the form. If there is anything you do not understand or that you have questions about, please feel free to contact me at dyxanj002@myuct.ac.za

*Required

I give permission for my information to be used in this study. I understand that my participation is voluntary and that I can withdraw from the study at any time with no consequences. I also understand that my participation is anonymous. I have read through the information about the study and understand what it involves. I agree to complete the informed consent form if I am eligible for participation. *

The informed consent form will be sent to you if you are eligible and wish to participate. You will need to read the form, sign it, and send back a scanned version or photo of it.

- ◯ Yes
- ◯ No

What is your gender? *

Please select every option you identify with. Cisgender means that you identify with the sex assigned to you at birth - the opposite of being transgender.

- ☐ Transgender man
- ☐ Transgender woman
- ☐ Cisgender man
- ☐ Cisgender woman
- ☐ Non-binary
- ☐ Other:

What is your age? *

- ○ 17 or younger
- ○ 18-20
- ○ 21-29
- ○ 30-39
- ○ 40-49
- ○ 50-59
- ○ 60 and older

Have you ever used mental healthcare services in South Africa? *

This includes both private and public healthcare. It includes, but is not limited to: psychiatrists, psychologists, counsellors, social workers, Occupational Therapists (OTs), and in-patient treatment (such as psychiatric wards, private clinics, public mental health institutions, substance abuse rehabilitation).

- ○ Yes
- ○ No

How do you identify in terms of race or ethnicity? *

Your answer

What province do you currently live in? *

- ○ Eastern Cape
- ○ Free State
- ○ Gauteng
- ○ KwaZulu-Natal
- ○ Limpopo
- ○ Mpumalanga
- ○ Northern Cape
- ○ North West
- ○ Western Cape

What is your sexual orientation? *

- ☐ Heterosexual
- ☐ Homosexual
- ☐ Bisexual/pansexual
- ☐ Asexual
- ☐ Other: _____

What is your marital status? *

- ○ Single, never married
- ○ In a relationship
- ○ Married
- ○ Divorced
- ○ Separated
- ○ Widowed

What pronouns do you currently use? *

In other words, how would you want someone else to refer to you if they're not using your name?

- ☐ He/him/his
- ☐ She/her/hers
- ☐ They/them/theirs
- ☐ Neopronouns - e.g., xe/xem/xyrs
- ☐ It/its
- ☐ Other: _____

Which of the following best describes your current employment status? *

- ☐ Working, full-time
- ☐ Working, part-time
- ☐ Currently unemployed, student
- ☐ Currently unemployed, looking for a job
- ☐ Currently unemployed, not seeking work
- ☐ Other: _____

How would you prefer to be contacted about the study? *

Under 'Other', please include your contact details and the name you want to be addressed as.

- [ ] SMS
- [ ] Whatsapp
- [ ] Telegram
- [ ] Facebook Messenger
- [ ] Email
- [ ] Other: _____

What name would you like me to address you as, and what name should I use to refer to you in the research? *

Short-answer text

That's all! Thank you for completing this form. The primary researcher will be in contact within 48 hours. Please respond with what time you would prefer to be contacted (e.g. only after 9am, late afternoon, etc.) *

Your answer

Submit

Appendix E: Interview Schedule

1) **(Establishing rapport)**
    a) (Reassure/remind them that I'm not going to ask the usual invasive questions)
    b) If at any point you want to say something 'off the record', let me know and I'll pause the recording. And you can still withdraw at any time during the interview.
    c) Why did you decide to participate in this study?
    d) Would you like to tell me a little about yourself?
2) **On a psychological level, what has it been like for you being a trans man in South Africa?**
    a) *Prompt*: What do you feel has shaped your experiences?
        i) Prompt: For example, your [race/sexual orientation/family situation/etc.]?
    b) *Prompt*: Do you feel that things would be different if you lived somewhere else?
3) **When did you first use or seek out mental healthcare?**
    a) What were you looking for or expecting, and were your expectations met?
4) **Tell me about your experiences of seeking out and using mental healthcare services.**
5) ***Prompts*:**
    a) What has been your best experience with mental healthcare?
    b) What has been your worst experience with mental healthcare?
    c) Which systems have you used – private, public/government, or both?
        i) Have you noticed any differences between the public and private systems?
    d) <u>(If they have only used one system)</u>
        i) Do you think your experiences would have been different if you used the [public/private] system?
6) **What kind of changes do you feel need to be made to how trans men are treated by mental health professionals?**

7) Debriefing and Concluding

a) We're almost at the end. I just want to check in – how are you feeling?

b) I will send you the numbers of some free helplines and links to other mental health support.

c) Is there anything else you would to add, or that we might have missed?

Appendix F: Coding Schedule

Name	Description	Files	References
1.0 Trans general	general experiences of being transgender	5	5
AGENCY	Having a sense of control over one's life	30	145
Dysphoria & pain	Difficulties associated with being trans, any kind of gender dysphoria	20	55
GENDER IDENTITY	LIVED EXPERIENCES of GENDER IDENTITY in the SOUTH AFRICAN context	34	285
Stealth & passing & out	Being stealth, being/coming out, passing	32	131
coming out	Coming out	12	15
Transphobia & violence	any and all transphobia experienced/witnessed/ heard about	29	108
Expecting rejection	anticipated or feared rejection from others due to trans identity	2	4
Context-specific	In what contexts do you expect rejection? Is it different in different contexts?	21	42
Interpersonal	rejection from other people generally	19	40
Structural & systemic	Transphobia and rejection on a systemic institutional level - at Home Affairs, hospitals, clinics, etc.	14	33

Name	Description	Files	References
Internalised transphobia	Internalised transphobia	14	26
What is trans	How do you understand transness? What does it mean to you to be a trans person? Is it identity, a medical condition, a psych illness, or just part of who you are? Why are people transgender?	2	22
1.1 Trans SA context	Experiences/ideas specifically related to the South African context	19	39
Binary & norms	To do with the gender binary and the norms around it, non-binary stuff	27	83
Gatekeeping	Gatekeeping of transition or mental healthcare by healthcare providers etc.	20	66
Practical & everyday aspects	General everyday issues you have to deal with as a trans person	10	22
Race & class & culture	Intersections with other aspects of identity - race, class, culture, ethnicity, nationality, etc.	21	82
Social	General stuff to do with other people and interpersonal aspects	19	49
2. Medical transition	Anything about medical transition	31	130
Emotional impact of transition		20	40
3.1 Reason for seeking MHC	Reason for seeking mental healthcare	17	90

Name	Description	Files	References
First time MHC	First time using mental healthcare	27	48
Mental health general	General mental health issues, reasons for needing mental healthcare	16	58
Suicide & SH	suicide and self-harm	15	33
3.2 Type of MHC	general mental health stuff, other MHC experiences (not strictly positive or negative)	0	0
Inpatient	Inpatient psychiatric care	12	73
Involuntary MHC	involuntary use of mental healthcare	7	28
Meds & psychiatrists	psychiatric medication and psychiatrists	17	45
3.3 MHC experiences	Mental healthcare experiences	0	0
Bad MHC	Negative experiences of mental healthcare	27	154
Good MHC	Positive experiences of mental healthcare	28	100
Mixed	Both good and bad experiences of mental healthcare	11	14
3.4 Access to MHC	Access to mental healthcare	0	0
Accessibility	Being able to access necessary services and help - financial, practical, location-based, etc.	19	60

Name	Description	Files	References
Barriers to access	Barriers to accessing mental healthcare	1	1
Govt vs private	Public and private mental healthcare	26	115
Govt	Experiences with public mental healthcare	23	56
Govt-pvt compare	Comparisons between public and private mental healthcare	21	34
Private	Experiences with private mental healthcare	12	25
NGOs etc	NGOs or other organisations used for help	16	35
3.5 Coping & resourcefulness		0	0
Coping group	Coping using group-level resources	0	0
Activism	any activist work, work done for the community, helping other trans people	9	22
Community & belonging	Feeling like you belong somewhere, accessing community (or not)	28	63
Ingroup compare	Comparing oneself to other trans men/transmasc people, rather than comparing with cishet norms	16	55
Coping individual	Coping strategies used in an individual capacity	0	0
Hope(less)	Having a sense of hope and optimism, or feeling hopeless	11	25

Name	Description	Files	References
Prior trans knowledge	Knowing about other trans people before realising one is trans/coming out/ transitioning (in any form)	16	34
Self-definition	How do you define yourself?	31	100
Self-worth	Self-esteem, seeing value in oneself	24	60
Privileged comparison	Feeling privileged in comparison to other trans men/trans people generally	11	25
4. Changes	Changes people want to see made to the (mental) healthcare system and how it treats trans people	30	85
5. Mention	Things to possibly mention in thesis	2	2
Family	Familial relationships and difficulties	30	145
Min research & significance	Lack of research about trans men, significance of this T4T research for the broader community	9	12
Religion	Religious beliefs (self/others)	17	48
Shared knowledge	shared between myself and participant, or participant and trans people generally	9	23
Why participate	why people wanted to participate in this study	19	23
6. TEMP	codes to use another time	0	0

Name	Description	Files	References
Age & time		26	145
Bureaucracy & admin		10	19
Exploring gender ID	exploring and discovering one's gender identity	10	24
Humour	Participant use of humour	6	17
MST codes	minority stress theory codes	0	0
(non)Disclosure	Whether or not to disclose minority identity status	21	50
Community	Having a sense of community, accessing things in a community context	20	55
Minority identity	Strongly identifying with trans maleness/masculinity	14	48
Prejudice - transphobia	Transphobia one has experienced	10	19
Language + misgendering	Use of transphobic or problematic/outdated language, being misgendered or deadnamed	19	40
Proving transness	Having to prove or justify one's trans identity	16	56

Appendix G: Example Theme Table

Theme	Subtheme	Definition	Quote/example
Accessing mental healthcare: challenges	Government: difficulties accessing	Issues when trying to use government healthcare	"trying to get hold of psychologists at clinics is damn near impossible, they have a huge workload, a waiting list of note" (Edward, 40s, white heterosexual trans man)
	Government: not knowing government healthcare	Not knowing how to use public system or what is available	"I find it really hard to find healthcare that's understanding and affirmative that isn't private. If it exists, I don't know how to access it" (Samuel, 19, white bi/pansexual genderqueer transmasc)
	Private: cost	Private mental healthcare prohibitively expensive	"I haven't seen [psychiatrist] since I think I was like 21. Because it's just too expensive. If you can get the same stuff from a GP then..." (Oliver, 30s, white bi/pansexual trans man)
	Private: medical aid	Not having medical aid, only gaining access when you have it	"In the beginning it was private as far as mental health goes but once I went off mom's medical aid, that was it, it was state all the way" (Edward, 40s, white heterosexual trans man)
	Misc. access challenges	Other access issues	"if the government wanted to they actually would because it would be so simple to add on like an LGBT mental health professional to the teams where they have setup the people who do HIV awareness" (Lonwabo, 20s, Black heterosexual trans man)

Appendix H: Resource List

For 24/7 assistance:

- **LifeLine**: All helplines are toll-free and available in all 11 official South African languages. General: 0861 322 322. Gender-based violence: 0800 150 150. AIDS: 0800 012 322. Website: lifelinesa.co.za
- **South African Depression and Anxiety Group (SADAG):** general helpline: 0800 456 789. Suicidal emergencies: 0800 567 567. Counsellors are also available 8am-8pm every day: 011 234 4837. Website: sadag.org
- **Rape Crisis:** counselling helpline: 021 447 9762. Website: rapecrisis.org.za
- **Befrienders Bloemfontein:** helpline for emotional support: 051 444 5000
- **7 Cups of Tea:** free online text-based support with volunteer 'listeners' who you can talk to about anything you may be struggling with. Website: 7cups.com

Counselling and support groups:

- **Triangle Project:** LGBTQIA+ organisation in Cape Town. Counselling available on a sliding scale. To book: call Heather Adonis 021 422 0255 or email health2@triangle.co.za . Hours: Monday-Friday 9:00am-4:30pm.
- **The Counselling Hub:** individual counselling at R50 per session, 4-6 sessions available. Based in Cape Town, but currently offering online sessions. To book: call 021 462 3902, or email info@counsellinghub.org.za . Website: counsellinghub.org.za
- **Revive:** free trauma counselling. Based in Port Elizabeth. To book an appointment: call 041 373 8882/3, office hours Monday-Thursday 8am-4pm, Friday 8am-2pm. Wednesdays 8am-3pm are open days, no appointment needed. Email: info@revive.org.za

- **JHB Parent and Child Counselling Centre:** based in Johannesburg. Phone: 011 484 1734. WhatsApp (messages only): 071 608 9361. Counselling, therapy, assessments: gaby@jpccc.org.za