What are causes of minority stress in transgender individuals in Sweden, and how do they cope?

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Abstract

**Aim:** To explore the causes of minority stress in trans individuals in Sweden, and how these individuals cope with such minority stress.

**Background:** Trans individuals have markedly poor mental health compared to the general population. Meyer’s Minority Stress Model has been shown to apply to trans individuals. However, causes of minority stress and methods of coping for trans individuals have not been investigated in Sweden. Previously, social support has been highlighted as a key coping mechanism of minority stress. This thesis explores the causes of minority stress on trans individuals and how they cope with this stress.

**Methods:** A qualitative study utilising semi-structured interviews with 18 trans individuals from across Sweden. A deductive approach was applied in analysis of the data, in order to explore the causes of minority stress, as detailed by the Minority Stress Model.

**Results:** The main causes of minority stress were found to be the medical investigation, discrimination and internalised stigma. The trans community was a source of social support, facilitating coping with minority stress. Other facilitative coping mechanisms used by participants were the support of family. Discrimination and internalised stigma led to avoidant coping mechanisms, such as avoidance of social environments.

**Conclusion:** This study reinforces previous findings that discrimination and internalised stigma cause minority stress for trans individuals. The structure of the medical investigation in Sweden should be reviewed, to reduce the stress it causes. The visibility of the trans community should be improved to increase the use of the community as a source of social support and facilitative coping.
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Abbreviations and terms

Transgender: individuals who identify as a gender other than the gender they were assigned at birth (1).

MtF: Male to female; trans individuals whose gender identity changed from male to female (2).

FtM: Female to male; trans individuals whose gender identity changed from female to male (2).

Non-binary/gender non-conforming: Trans individuals who do not identify as neither female or male, may choose to use gender neutral pronouns, such as “they” in English (2).

Gender: In terms of transgender research, gender refers to the gender identity of the individual. That is to say an individual’s sense of self-awareness of their identity as a defined point on the gender spectrum (3).

LGBTQ+: lesbian, gay, bisexual, trans, queer/questioning is an overarching label to describe the community and population of gender and sexual minority individuals. The ‘+’ signifies the inclusion of other identities such as intersex, asexual and pansexual1.

Cis-gender: people who identify as their birth gender are referred to as cis-gender, or simply cis (4).

Cis-normativity the affirmation of cis-gender identity as the norm, and other gender minority identities as ‘other’, and is informed by a basis of patriarchal authoritarianism and traditional, conservative values of masculinity and femininity (5). It also encompasses the assumptions that gender identity matches the sex they were assigned at birth (4)

Queer: an umbrella term for non-cis-hetero identities (6).

Gender dysphoria: the distress resulting from incongruence between assigned and experienced gender identity (7).

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1 Intersex: persons born with sex characteristics that do not fit typical binary definitions of male and female bodies; asexual: little to no sexual interest in any gender; pansexual: sexual attraction to all genders (89,90).
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Introduction

Transgender health has become a growing focus in LGBTQ+ health. In 2019, transgender identity has become more visible in society, within Sweden and many other high-income countries. The conversation around transgender rights in politics and mainstream society has become heightened in recent years. In January 2017, National Geographic published a special issue titled the ‘Gender Revolution’, detailing the shifting landscape, perspectives and science on gender, including the nature of medical transition. This increased focus on transgender identity and the issues trans individuals face, has ultimately increased the quantity of research on trans health. A search analysis of PubMed publications showed 1025 results for ‘transgender’ in 2018, versus just 79 in 2010. Despite this increase in research, and a changing perception in society toward trans identity, trans health is still notably inequitable.

Trans individuals are a marginalised group who experience health inequity compared to the cis-gendered population and their LGB counterparts. Trans health research has long utilised a disease-based model with which to investigate trans health. With progress away from this model toward that of an identity-based model, there is need to investigate how social factors impact and influence the health of trans individuals. There is limited trans health research in a Scandinavian context, and much of the broader literature focuses on the experiences of healthcare professionals providing care to trans individuals. This thesis aims to address gaps in the literature on why such health disparities exist between trans persons and cis-gendered persons. The study draws upon literature of coping, minority stress and cis-normativity to investigate the causes of minority stress in trans individuals’ in Sweden, and how they cope. Acquiring a better understanding of coping, social support and community support and empowerment, may allow for new strategies to be developed aimed at reducing the inequalities frequently seen in the trans population compared to that of the cis-gendered population. The need for greater understanding of the social factors that underpin and influence trans health were highlighted in a review paper of 116 trans studies.

Lesbian, gay, bisexual, trans and questioning/queer
Lesbian, gay, bisexual
The assumption that all people are cisgender, that their gender identity matches the sex they were assigned at birth.
published in the Lancet in 2016 (15). Therefore, the present thesis aims to answer the following question: what are causes of minority stress for trans individuals in Sweden, and how do they cope with such stressors?

1.1 Health inequity and discrimination

To understand the need for trans health research, it is important to describe the disparity in health between the trans population and LGB/cis-hetero individuals. Whilst LGBTQ+ health and healthcare has improved over the last several decades in higher and middle income countries, coinciding with improved public attitudes, the health of trans individuals lacks far behind that of their sexual minority contemporaries, and trans individuals are significantly lacking quality care compared to that of the cis-hetero population (16). The National Transgender Discrimination Survey in the US, highlighted some of the major health disparities of trans people in a study published in 2010 (10). The study included 7000+ trans and GNC individuals as participants, recruited through 800 trans community organisations across the US. Grant et al. found 19% of the sample reported being refused care due to their gender identity, with higher numbers of trans people of colour being refused care than other ethnic groups. Moreover, Grant et al found that over 25% of respondents reported as using drugs or alcohol to cope with gender-based discrimination. HIV prevalence in the study population was four times higher than the average for the USA. 41% of respondents reported attempting suicide, compared to 1.6% in the general population. Suicide ideation in the trans population is markedly higher, with studies reporting suicide ideation prevalence around 45-77%, whilst suicide ideation in the general population is just 13.5% (17). Healthcare providers themselves have detailed receiving poor LGBTQ+ health education, particularly when it comes to trans-specific services. A study of medical students in 176 medical schools across the US and Canada, with over 9000 respondents, found only 26% of respondents felt prepared discussing surgical gender confirmation treatment and only 28% felt prepared discussing gender transition (18). A study in the UK from 2017, found similar results, with participants reporting they would not ask, by default, for clarification on a patient’s pronouns or gender identity in mental health or reproductive health consultations (19). The lack of trans inclusivity of healthcare services has been found to be significantly associated with depression and suicide
ideation (20). Therefore, the lack of knowledge of trans health by healthcare professionals has the possibility to negatively impact mental health in trans individuals.

Studies have shown the trans population to have a much higher prevalence of mental health morbidity than that of LGB persons (15, 21). Prevalence of depressive symptomology is around 50% in the trans population (22). The disparity in the prevalence of mental health morbidity in trans individuals is a clear sign that the improvements that have been made in LGB health since the HIV/AIDS epidemic, have not occurred in trans health. This disparity has been confirmed to be present in a Swedish context, with 36% of respondents reported as seriously considering suicide in the past 12 months, in a large sample across the whole of Sweden, compared to 6% suicide ideation over 12 months in the general population (23). While few studies exist that investigate health disparities of trans individuals in Sweden, studies that have been conducted indicate that the same trans health disparities that exist in other countries are also present in Sweden (24–26).

Discrimination, violence and harassment toward trans individuals have been reported in a wide variety of settings including healthcare, workplace and education (10, 27). Trans individuals face greater barriers finding both suitable quality housing and employment (28). Discrimination occurs in a wide variety of settings, and toward all ages of trans persons, but the impact of discrimination has been shown to lessen in older MtF, in a large sample study of MtF life-course discrimination (29). Transgender youth are more likely to experience discrimination in a school setting than LGB students (30). Discrimination, violence and harassment all act as stressors that negatively impact health and wellbeing in trans individuals.

1.2 The Minority Stress Model and cis-normativity

The Minority Stress Model, first put forth by Meyer in a paper from 1995, is a model that has emerged from generating a better understanding of the cause behind the high prevalence of mental health morbidity in sexual and gender minority groups (31, 32). Whilst some of the poor mental health outcomes experienced by trans individuals is attributable to gender dysphoria; as discussed above, trans exclusionary and discriminatory spaces that trans individuals occupy influence these mental health outcomes. Research on the impact of a

5 The distress resulting from incongruence between assigned and experienced gender identity (7).
combative, exclusionary environment on sexual and gender minorities is informed largely by Meyer’s framework of Minority Stress (31). Meyer originally developed the framework in the mid-90’s to describe the high prevalence of mental health morbidity seen in gay men. Since then, this framework has been adapted to explain the effects of discrimination and stigma of gender minorities (13). Minority stress can be divided into two key groups of stressors: distal and proximal (32). Distal stressors are prejudice events or discrimination that occurs to an individual, such as verbal abuse based on gender identity. Proximal stressors originate from the individual themselves; an example of self-stigma can be expectation of rejection. Proximal stressors are negative societal attitudes that have been internalised and result in negative coping behaviours, in an effort to avoid encountering distal stressors. However, concealment, hypervigilance and avoidance are described as having a negative impact upon long-term mental health of the individual (33). Figure 1 details the current model of minority stress within trans individuals. In the figure, minority status and minority identity can be seen as the source of proximal and distal stressors. Proximal and distal stressors can interact. For example, discrimination may lead to internalised stigma. Proximal and distal minority stress cause poor mental health. Social support is seen as the key buffer of mitigating mental health outcomes in this model.

Figure 1. Meyer’s Minority Stress Model in the context of trans minority stress (16)

Minority stress in sexual and gender minority persons is the product of a cis-normative and heteronormative society, which actively and passively reinforces sexual and gender norms.
Cis-normativity is the affirmation of cis identity as the norm, and other gender minority identities as ‘other’, and is informed by a basis of patriarchal authoritarianism and traditional, conservative values of masculinity and femininity (5). The existence of trans individuals challenges the stability of gender and sexual categories present in society (34). Trans persons may encounter cis-normativity in a wide variety of ways, from lack of trans-inclusivity, such as lack of gender-neutral bathrooms, to verbal harassment in public. The exploration of minority stress in trans persons allows development of strategies and interventions targeted at reducing proximal and distal stressors. The minority stress framework has been cited by Hendricks et al, and Timmins et al., as needing to include a wider scope of psychological processes, such as coping mechanisms (35,36). The present thesis aims to include these concepts.

1.3 Social support and coping mechanisms of trans individuals

In Meyer’s minority stress framework, he included ‘coping and social support’ as factors that mediate the effect that minority stress has on the individual. The need for social support and connection is not unique to the trans population. The effect coping can have on individuals who have encountered stressors has long been documented in gay men (37). Nicholson found in 1990 that gay men were more likely to utilise avoidant coping mechanisms when encountering greater homophobia and had less self-esteem. Indeed, minority groups have long been identified in coping research as groups likely to experience exposure to stressors. The cause of this is partly determined by a lack of personal control over life and emotionally stressful life events, such as discrimination or exclusion (38).

In their seminal book on stress and coping from 1984, Lazarus and Folkman theorised two main categories of coping mechanisms, emotion-focused and problem-focused (39). These have since been re-termed as facilitative and avoidant coping (40). Budge et al. describes facilitative coping as when a person reacts to a stressor by positively adapting behaviour or accessing social support. Avoidant coping is when, in response to a stressor, the person reacts by minimising or avoiding the problem, utilising drugs and alcohol, detachment or distancing themselves physically from the issue. A bulk of research now shows that positive, problem-focused coping is directly connected with social support (41).
A number of quantitative studies have found that social support, both indirectly and directly, lessened the impact of distal stressors on mental health morbidity of trans persons (42–46). These studies found that a variety of social support markers, such as size of social network and peer support, were associated with less depression, anxiety and suicide ideation. Alternatively, a number of studies have found associations between a lack of social support and rejection, with increased mental health morbidity (43,44). Lack of parental support by family was found to be particularly significant to the mental wellbeing of younger trans persons (47,48). Social support mediates the impact minority stress has on an individual’s mental wellbeing.

A qualitative study from 2014, in the US, investigating coping methods of trans individuals identified three levels of coping: individual, interpersonal and systemic coping (49). Interpersonal coping was further categorised into social-relationship coping and preventative-preparative coping, updated terms of emotion and problem focused coping. This 2014 study found social-relational coping to crossover significantly with the forms of coping categorised within systemic coping strategies. Systemic coping strategies were listed as: resource-access coping, defined as sharing information with peers, connecting with peers on social media; spiritual and religious coping, connecting with a religious community in order to cope with transphobia; and lastly political-empowerment coping, becoming involved in trans activism and the political trans community. The ability for social support from the trans community to aid in trans individuals’ mental wellbeing has also been noted in several papers over recent years (50).

1.4 Lack of trans research and trans visibility in research

In the field of trans research, and specifically transgender health research, there has been a significant amount of criticism toward studies for not accounting the individual experiences of trans people (51,52). In an essay from 2014, Kunzel highlights that transgender voices are so often unheard or suppressed by the nature in which they are studied (53). For example, there is a wide variety of work that focuses on trans health from the perspective of healthcare providers, instead of the individuals themselves (18,54–56). The same can be said for the exclusion in research of those within the trans community most at risk: trans people of colour, trans migrants, trans individuals living rurally or trans persons with low-income (57). Not only that, but research on gender minorities is often conflated with sexual orientation. Adopting
policies addressing the needs of the LGBTQ+ community has led to a focus on sexual minority issues, whilst omitting many trans issues. This is caused by the assumption that the experiences of all who identify as LGBTQ+ are similar. Giving a greater voice to trans experiences is a way to challenge this notion. In addition, the size of the trans community appears to be underestimated in a portion of the literature. An oft-cited study in the Netherlands estimated that around that around 1 in 30,400 people who are assigned female at birth and 1 in 11,900 people assigned male at birth identify as transgender (58). However, this number is often contested by more recent studies that put the prevalence significantly higher (28). This underestimation is detrimental to trans health, as it impacts the resources given to trans-centred research, and reinforces the notion of trans individuals as a fringe minority of the LGBTQ+ community. One explanation for this underestimation is because participants in trans studies are often recruited through gender confirmation clinics and other trans-specific health centres; however, it is known that many people identifying as trans or non-binary never medically transition, or access these services. In addition, trans people are less likely to access primary health centres due to anticipated stigma (59). There is a distinct need for trans studies to apply a wider approach, focusing instead on the reported experiences of trans individuals. Therefore, this thesis utilises qualitative methodology, to focus on trans experience. To enable a more representative sample of the trans population, participants for this thesis were not recruited through trans-specific health centres.

1.5 The Swedish context

In order to investigate the need for trans research in Sweden, it is important to detail the context of trans healthcare and rights in Sweden. Sweden has been largely progressive in its legislation surrounding LGBTQ+ rights. Homosexual intercourse was legalised in 1944, and the classification of homosexuality as a mental health disorder was removed in 1979 (60). However, rights for trans individuals have lagged behind. The ability to legally change gender and confirm sex via surgery has been in place since 1972, though individuals were required to be surgically sterilised to undergo surgery, up until 2013 (61). As a result of this legislation, the Swedish government decided in 2018 to pay compensation to the roughly 700 trans individuals who were forcibly sterilised between 1972 and 2013. The declassification of transgender identity as mental illness in Sweden was discussed in 2017 by health policy makers, however no changes have been made as of April 2019. In May 2018, discrimination
toward people based on their gender identity and expression was added to hate crime legislation (62). Sweden’s hate crime laws have been criticised as being poorly applied, with a number of notable cases of hate speech going unpunished. Results from a focus-group study of LGBTQ+ persons in Sweden detailed the participants consider hate crimes to be a real risk, with several describing being physically assaulted due to their sexual orientation or gender identity (63). A trans participant in this study pointed to homosexuality and bisexuality as being far more accepted in society than being trans. The risk of discrimination and violence was something that participants considered when deciding how to dress, or where they might be going.

In Sweden, in order to access gender confirming care (such as hormone therapy), individuals need referral to trans-specific medical teams in order to obtain a diagnosis of gender dysphoria (64). The process involves a variety of investigations, both physical and psychological. The individual is also required to present as their gender identity for a period of around 6-12 months, meaning that they must adhere to social constructions of gender presentation. The results from these investigations are sent to the Legal Advisory Board (LAB), which determines whether the applicant has the right to confirm their gender as other than that as the gender they were assigned at birth. The length this process takes varies greatly, with different regions having different guidelines and regulations. The application is usually sent to LAB following around 2 years of investigations (51).

The use of largely US-based studies referred to in this introduction is a signifier of the lack of trans health research in Europe and Scandinavia. Although there are only a limited number of studies on trans health in Sweden, they do provide important context for the present study. There was a comprehensive study performed in 2015 with 1194 participants from across the whole of Sweden. This study indicated that trans people in Sweden do not exhibit better health than trans individuals in other Western European or Nordic countries, as has been confirmed by other studies in the country (23,24). A qualitative study from 2017, utilising the same data set as the present thesis, found that trans individuals navigating gender confirmation services described experiencing significant distress and anxiety due to long waiting times and lack of support (65). In the study, participants described purchasing hormones online from other countries, in an effort to quicken the investigation. Participants encountered healthcare providers who did not have adequate knowledge about transgender
identity or health. This resulted in the participants often taking a significant responsibility and charge for their own medical care. Other studies have revealed discrimination and cis-normativity within trans-specific care setting in Sweden, with counsellors reinforcing binary gender norms with their patients (26).

1.6 Rationale for study
Recent decades have seen an improvement in public attitudes towards transgender individuals (14,66). Despite a significant increase in research interest of trans health and trans identity, there is still a large scope of improvement that needs to be made in order to address the health disparities seen in the trans population. There are wide gaps in trans health research, with few studies focusing on sources of social support for trans individuals. The studies that do exist, rely heavily on samples that are drawn from trans health centres, or community centres (57). Such recruitment methods are likely to exclude some of the least visible members of the trans community: those who live in rural areas, those who do not utilise trans or primary health centres, and those who are inactive in trans community or activism. The trans population is underestimated in size, and suffers erasure due to the binary nature of many population-level surveys and studies (28,52). Trans health studies rarely include gender theory, the role of sex in society, cis-normativity, or minority stress in their conceptual or theoretical framework (57). Thereby, these studies miss identifying new areas where improvements can be made. The investigation of trans coping mechanisms needs to include a wider breadth of psychological concepts, including rumination and mediation. In order to develop better support services for trans individuals, social support should be further divided into distinct categories and source of support, or the lack thereof.

The present thesis aims to answer the following question: what are causes of minority stress for trans individuals in Sweden, and how do they cope?
Methods

2.1 Study Design

This thesis is a qualitative study, utilising data from semi-structured in-depth interviews. This thesis uses a deductive approach to explore the Minority Stress Model within Sweden, with the aim of identifying minority stressors and coping strategies used by trans individuals. A qualitative study design with semi-structured interviews allows better exploration of experiences and phenomena than a questionnaire or quantitative design (67).

2.2 Sampling process

The participants were recruited and interviewed during November 2014 and September 2015, with an additional 4 participants being recruited and interviewed during February-March 2017. Inclusion criteria were that the participants were adults (aged 18 and older), lived within Sweden, spoke Swedish and identified as transgender. The aim was to obtain a sample of participants with a broad range of economic status, age, gender identity and location. The status of the participants medical transition was not an inclusion criteria. Recruitment was done via a number of different trans networks in Sweden: The Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights (RFSL), Full Personality Expression Sweden (FPES), and Gender-Sex Identity-Diversity (KIM). In order to combat the exclusion of trans individuals who do not utilise gender confirmation services, participants were not recruited through trans specific health centres. The organisations distributed material advertising the study through their social media pages, websites and newsletters. Following contact by a prospective participant, they were, sent via email, a more detailed description of what the study entailed by, its aim, how the interviews would be conducted and anonymity.

2.3 Participants

The participants ages ranged from around 20, up to 65-70 years. Participants lived across the whole of Sweden, in a mixture of larger cities and smaller, rural towns. The participants were employed in a variety of work from IT consultancy to nursing to youth leader, with three on sick leave compensation relating to poor mental health. 6 participants identified as women, 7 identified as men, and 5 identified as non-binary and used a range of pronouns. The participants were at a variety of different points in their transition. Some participants did not
wish to seek gender confirmation treatments, whilst others had medically and surgically transitioned. I have avoided going into too much depth about the individual participants, in an effort to avoid compromising anonymity. However, a list of the participants’ names (altered), age ranges, pronouns, employment and family situation (living with partner, children, single) is included in the appendices for reference.

2.4 Data collection
All of the interviews were conducted by Ida Linander\textsuperscript{6}. Participants were able to pick the setting of the interview, so as to allow them to feel comfortable. This resulted in a variety of setting for the interviews, including participants’ workplaces and homes, as well as the interviewer’s office in Umeå and cafes. The interviewees were guided through a letter containing detailed information about the studies, usage of the data and written consent was acquired from the participants. The interviews were semi-structured with use of open-ended questions in order to promote open discussion about a variety of topics related to trans identity and trans health. Topics included, medical transition, safety, interpersonal relationships, discrimination and coming out. The interviews were conducted in Swedish. Each interview began with a series of short-form questions, asking the participant to explain their preferred pronouns, trans identity, education, employment and if they had children. The length of the interviews varied from 55 minutes to 135 minutes. Each interview was digitally recorded and then later transcribed by Ida Linander and two additional external transcribers. The choice of semi-structured interviews was to encourage two-way communication. This allows the participants to act as collaborators in guiding the discussions. Semi-structured interviews are also ideal for approaching sensitive topics, such as discussing harassment or traumatic events, therefore semi-structured interviews aided in making the participants feel comfortable.

2.5 Analysis
Once being granted access to the interviews, the immediate step before analysis could start was translation of the interviews into English. This involved a preliminary translation by Lloyd Ellis with an aim to identify the themes covered in the interviews. Following this initial

\textsuperscript{6}Ida Linander collected the data included in this thesis as part of doctorate research at Umeå University. This data has been used in this thesis with her permission. A contract for the usage of the data is included in the appendices, page 56. Ida also co-supervised this thesis.
translation and analysis, the participant’s experiences of minority stressors and coping was identified as an area that had not yet been analysed by Ida Linander’s previous papers. A more thorough translation was then performed of the relevant sections of the interviews, aiming to retain the original ‘voice’ of the participants, without altering their meaning. When needed, a Swedish language teacher was shown short excerpts, in order to aid in clarify the language used and original meaning in translation. This thesis aimed to keep to the methodological recommendations for cross-language qualitative research, as detailed in a review from 2009 (68). However, it is important to note that this thesis did not have access to professional translation services. As such, translation of the transcribed interviews from Swedish to English remains a limitation of this thesis, as detailed later, in the discussion.

After the interviews had been translated, initial coding of the data was performed. A descriptive analysis technique was used with the Minority Stress Model forming the framework through which the data was coded. Codes were manually (no use of coding software) generated from each new concept that was expressed by the participants, following a line-by-line analysis of the transcribed interviews. From initial coding, a code list was generated. This list allowed some of the codes to be consolidated during focused coding of the interviews, in line with the use of abductive thematic analysis (69). From the final focused code list, categories and subcategories were formed from aggregated codes due to observations of repetition, similarities or differences of codes in the data. This process was informed by the literature on social support, minority stress and coping. Codes were categorised into the two different themes and eight different categories. A framework matrix was generated in Microsoft word, with each column containing a category and each row containing the open code (quote).

2.6 Ethical considerations

The original data collection was approved by The Regional Ethics Committee in Umeå (Dnr: 2014/61-31Ö). Once approved by Ida Linander to use the data, as per the original ethical approval, I signed a contract agreeing to the handling of the data. The data was to be handled in a way that always protects the anonymity of the participants. The contract over the handling of data between myself and Ida Linander is attached in the appendices. The files containing the transcribed interviews (both in Swedish and English) were always encrypted and password protected, stored on a PC that only I had use of, which itself was password
protected. I have never had any personal information of the participants, such as name and specific location. The ages of the participants were replaced with age categories. Cities where the participants worked or lived were changed to only state the general size of the city for example “MEDIUM CITY”. Workplaces were altered to XXX, as were the names of any people referred to by the participants. The second translator\(^7\), was only shown excerpts of the interviews with myself present in order to maintain anonymity and security of the data, and were always shown separate from the fully transcribed interview. The trans community in Sweden is not large in comparison to other communities, therefore these changes were made so that none of the participants would be identifiable, and they would retain their anonymity. The fact that the data handled in this thesis was not collected by myself, creates distance between myself and the participants. The participants would not recognise me in a social setting, nor I them. Therefore, this thesis does not encounter the ethical issues that come with meeting qualitative study participants in person.

In line with literature on the topic, this thesis has been approached with a number of ethical considerations (70). This thesis followed the Belmont Report guidelines with regards to respect for participants, beneficence and justice (71). The participants of this thesis are considered collaborators in the investigatory process. It is their experiences that are analysed through the eyes of the researcher. The participants of this thesis have been considered as a dynamic part of this research. Qualitative research is governed by deontological ethics and as such the participants of this thesis are not tools for acquiring knowledge (72). Instead the aim is to work and collaborate with trans individuals in an effort to better understand trans experience, to aid with tackling the health inequity seen in the trans population (70). However, ultimately, as researchers, we are determining the final product of such research. In the transcribing and translation of the interviews, the researchers have an ethical duty to maintain the detailing of the participants’ experiences as faithfully as possible.

2.7 Reflexivity

The influence of the researcher is undeniable, but it is important to acknowledge the effect. Myself not being trans, means I am not able to fully understand what the participants have experienced but I have a duty to highlight their experiences pertaining to the aim of this

\(^7\) Jonas Thál, language teacher at Stockholm University, aided with translation.
thesis, as true to their meaning as possible. It has been important throughout this process to acknowledge my position and maintain a critical eye of the data. Whilst certainly a limitation in some ways, having not conducted the interviews personally gave me a level of distance from the struggles and emotional hardships described in the interviews. Ida has also written about the benefit of being both a medical doctor (although not practicing) and recognised by the participants as a member of the queer community. It is possible that if I had conducted the interviews, I may have not been offered the same openness as Ida, being that I would have been perceived most likely as a heterosexual male.
Results

3.1 Identified themes and categories

From the analysis, 5 themes emerged, with a total of 18 categories. The different causes of facilitative and avoidant coping were categorised into 5 main themes.

1. The medical investigation as a source of minority stress
   1.1 Uncertain outcome of medical investigation causing stress
   1.2 Forced to fit to a binary gender standard during the medical investigation
   1.3 Trans discrimination in a healthcare environment

2 Stress from changing interpersonal relationships due to trans identity
   2.1 Fear of being misgendered
   2.2 Loss of friendship
   2.3 Not pursuing intimate relationships for fear of rejection and harassment

3 Unsafe and non-inclusive spaces for trans individuals
   3.1 Harassment and discrimination in public spaces
   3.2 Lack of trans community
   3.3 Lack of trans inclusion at LGBTQ+ events

3. Trans community as a source of psychosocial support
   3.1 “You don’t feel alone” – strengthened in community
   3.2 Using the trans community as a source of trans health knowledge
   3.3 Strengthened by activism

4. Stress from relationship with family
   4.1 Not coming out due to fearing rejection
   4.2 Negative reaction to coming out resulting in avoidant coping
   4.3 Negotiating pronoun usage

5. Psychosocial support from family and close relationships
   5.1 Family acceptance allows facilitative coping
   5.2 Chosen family support
   5.3 Support in unlikely place
3.2 The medical investigation as a source of minority stress

3.2.1 Uncertain outcome of medical investigation causing stress

An important category that emerged from the data was that the medical investigation caused significant stress for the participants. The investigation prior to being confirmed for gender confirmation treatments, and the medical processes throughout transition-based healthcare were sources of minority stress for the participants. The uncertainty of being confirmed by the medical council for gender confirmation treatment generated significant amounts of stress for the participants. The ability to align physical appearance with the participant’s trans identity was so paramount to their mental wellbeing that the unpredictable outcome of the medical council diagnosis was a mental strain.

I often felt bad when I left [the medical investigation appointments]. I would cry afterwards. On the other hand, I was delighted that things were progressing and that the investigation seemed to work. But I was also very afraid because I did not know if I would get a diagnosis, because that’s what they said. – [Elias]

In this instance, even though the investigation was progressing in a positive manner, the medical team themselves expressed to the participant that this does not equate to being approved for gender confirmation treatments by the medical council. This uncertainty caused stress for Elias.

3.2.2 Forced to fit to a binary gender standard during the medical investigation

The participants described that the medical investigation very much relied on the trans individuals presenting themselves in a very binary nature. For those who were transitioning to female, they were expected to present as feminine during the investigation. The equivalent was found for those who were transitioning to male. These expectations of presenting as masculine or feminine included the clothes that the participants would wear, their behaviour and speech. Considering that some of the participants did not wish to present in a traditionally feminine or masculine way, this was a significant stressor during the investigation.

It’s a lot to deal with, you’re always worried about not being able to fit in with what they wanted. It was because you had to dress
as the investigator wants you. I considered using my clothes that I wear at my school to the treatment, but then I was worried that it would also be a negative thing for my investigation just because it would not be considered feminine enough. – [Alice]

Having to present to society as more feminine and masculine than you wish to portray, is a stress that trans individuals who do not pass have to cope with. The medical investigation was seen as a very draining for this reason. The participants were required to portray themselves to an adequate standard and expectation of masculine or feminine in order to be granted access to gender confirmation treatment. Alice went on to say how this affected her mental health: “I was already depressed, but it was, you were even more depressed, very worried, very bad, mentally, every time before I went there, I was terrified, felt in my stomach”.

Fitting in a fixed binary view of gender and the binary physical characteristics associated with gender, extended to the types of treatments that the participants were expected to have. Louise commented on how she felt there was a pressure to go through with chest surgery, “There is this focus on chest surgery. One has to go through care where I need to meet a very narrow standard of gender expression, to match their expectations”.

The participants felt the need to express wanting to receive all gender confirmation treatments, against their own wishes of how they want their physical expression to be. Alice explained how being forced to present very feminine in the way she dressed and appeared, meant that she failed to pass, causing further stress.

To have to go through an investigation where you have to introduce yourself as a woman without even using hormone treatment, is a big challenge because you get so many looks, it made me very introverted and I hid because I was afraid. – [Alice]

To cope with the stress of failing to pass as a woman, Alice chooses to avoid social situations, to avoid any threats. This is an archetypal example of an avoidant coping mechanism. This reaction to potential threats is clearly founded in personal experience, Alice went on to describe a number of instances where she had been harassed in public due to her failing to pass successfully as a trans woman. The binary understanding of physical characteristics that the health professionals involved in the medical investigations, caused significant stress for trans individuals.
3.2.3 Trans discrimination in a healthcare environment

Another cause of minority stress for the participants was the discrimination in a healthcare setting. This centred around care received in the medical investigation and also in mental healthcare. Discrimination went beyond the stress of navigating the complexities of the medical investigation to determine whether a participant could proceed with gender confirmation treatment. One participant, Annika, explained that she was denied care due to her trans identity, “I’ve met two psychotherapists who denied me therapy because I’m transsexual. I was questioned all the time because I was too confident to be a woman”. Alice also commented on the negative way she had been treated by some of the healthcare providers she had encountered, “You can call it bullying really. It was specifically from the psychologist... It made me feel really bad”. A similar encounter with a psychologist was described by Love:

I have been treated a long time for mental illness and I am very disappointed and very frustrated [with the care]. I had to change psychologist a few times because they have been transphobic. I’m pretty stubborn, so I’m still going to care and trying to get the care I’m entitled to, but it’s quite stressful and very tough of course. – [Love]

When asked what kind of transphobia they had experienced by this psychologist, Love said, “She would not respect my pronoun. In her world, there were women and men”. The stress of these healthcare encounters was a theme throughout the interviews, and caused some participants to avoid seeking care. This was not true for all participants however. Love explained feeling strengthened by the hardships of seeking care as a trans individual.

I’m not so afraid of care anymore. It has been very difficult when there have been long periods when I would not even call a doctor at the health centre. Now, I know with experience, that I’ve fought so much, that I feel stronger because I’m not really going to give in. – [Love]

So, whilst for some of the participants the reaction to this stress was to avoid seeking healthcare as much as possible, for some it empowered them to fight for the care they are entitled to. This an example of facilitatively coping with the stress discrimination has caused.
3.3 Trans identity changing interpersonal relationships

3.3.1 Fear of being misgendered

Coming out to family, friends and co-workers, changed how the participants were perceived. Individuals taking gender confirmation treatments, such as hormone therapy, may be identified visually as trans by others. Not passing in a cis-normative environment as a trans person can face unique challenges. Participants detailed how interpersonal relationships with cisgender people shifted, following coming out or gender confirmation treatments. This leaves trans individuals more open to discrimination, and this stress resulted in the participants avoiding some social situations:

> I feel quite distanced from cis people, so I have further distanced myself and I do not even look for cisgender friends. Oh God, I cannot even cope with that. I'm afraid of what's going to happen. That it will be tough to be misgendered in such an intimate situation. – [Love]

For some participants, it was difficult to separate general social anxiety and anticipation of trans discrimination as the cause for avoidance of some social environments. Love explained:

> So, I get a lot of stress. It is difficult to say what comes first. I have issues with being in a larger social context, and perhaps this is social anxiety. And, of course, I feel if I come to a room where I know people do not understand me or that they will misgender me, I'm not so keen on that. – [Love]

Mio described a contradictory view, of wanting to fit in, but also finding comfort in queer spaces that were safe.

> I would just like to fit in. Even though I enjoy the queer bubble. – [Mio]

Mio went on to comment on how queer spaces (or “oases”) felt as opposed to non-queer spaces:

> Safer, because I always feel that I'm not completely safe yet, but definitely safer space. – [Mio]

3.3.2 Loss of friendship

Friendships shift, as perception of the individual changes with gender identity. Sometimes this caused the end of friendships with older friends. The loss of friendship due to trans identity could be seen as an example of avoidant coping, the fear of discrimination or being
misednered led to less contact with those friends. On the changing nature of friendship after coming out, Johanna said:

It has become a little weird among friends and many of the people I've worked with. I've been friends with them earlier, but now I almost never hang out with them in my spare time. So, it's a bit sad. – [Johanna]

The feeling of distance growing between the participants and previous friends was noted by Mio also. This was partly as a result of avoiding bringing up aspects of trans identity to those family and friends. These friends were identified as being cis and Love thought of as not having knowledge about trans identity.

For me it feels like I always have to be a secretive or not take up space or, talk about being trans. And that makes me feel more distant to many of my close friends and to my family members... I think I'm creating a sense of insecurity. I don’t feel that we are very close, when you don’t take the [social] space that you should take. – [Love]

Even if Love was not experiencing discrimination or harassment from any of his friends or family, the need to avoid talking about being trans resulted in him interacting less socially. This was the case with other participants as well. The fear of negative social reactions was reported more often than actual negative reactions from these friends of family members. One of the participants felt that by criticising cis-normative behaviour, or raising awareness by sharing articles on social media, it was creating distance within friendships held with cisgender friends. This fear led to avoiding these friends.

I feel like there’s a distance growing so I’m afraid they will not respect me. I'm afraid that they feel that they are in some way being doubted, because I can express anger, or share articles on Facebook about the cis norm for example. – [Eli]

3.3.3 Not pursuing intimate relationships for fear of rejection and harassment

Many of the participants were not in romantic relationships, with some stating the need to focus on transitioning as a reason for not pursuing romance. Some participants noted experiencing fear at entering into sexual or romantic relationships, which could be interpreted as expressing an internalised cis-normative view of trans people misleading cis individuals into sex. This fear led to avoidance of initiating romantic relationships, and a feeling of loneliness and isolation.
Yes, I’m a little afraid to get into relationships. As I pass, it is difficult without the operation, if it were to come to something intimate. It’s like ‘oh, what’s this?’ So, then you have to tell them before and then I’m afraid that’s where it will end really fast. Because I don’t want to go around and fool people either, because it feels like that sometimes. That’s how society also perceives me, to walk around and trick people. – [Alice]

Embodiment that does not align with the cis-normative view of body in broader society, could lead to difficulties in initiating romantic and sexual relationships. On the effect that this fear has, Alice then said:

It’s hard. I feel alone often. I do not get a company at all (laugh) – [Alice]

This fear and hesitation then could lead to feelings of loneliness and isolation. Eli, identifying as non-binary, found difficulties in finding partners who accepted their gender identity, as Eli did not fit in the binary view of gender. On being asked if being trans has impacted romantic relationships, Eli said:

I’m afraid it has. Nowadays, if I meet someone completely random who has nothing to do with the queer circle, it’s difficult. I’ve had a lot of luck before and have had a relationship with a guy who actually saw me as a man and we had a gay relationship and that was great. So, he really saw this (pointing to himself) like a dude as well. – [Eli]

Eli felt limited in choice of who they could be romantically attracted to, due to the fact someone would need to understand what biological characteristics Eli had, so as to avoid deception:

There will have to be someone who has the kind of gender analysis that can read this body as just ‘yes but you’re not female enough for me but I can still accept you’ kind of – [Eli]

Eli requires someone to have a certain level of understanding of trans bodies, in order to avoid a negative intimate experience.

3.4 Unsafe and non-inclusive spaces for trans individuals

3.4.1 Harassment and discrimination in public spaces

One of the clear examples of minority stress that can be experienced by minority groups, is that of discrimination and harassment. Harassment from strangers in public spaces is one of
the most apparent examples of transphobia. The participants detailed their experiences of discrimination and harassment. Alice explained that she rarely experiences harassment that is verbal or physical “but it is mostly glances and people who look and gape and stare”. However, she also said that her and a group of other trans friends had been openly laughed at and mimicked, with comments such as “there are three boys who want to be girls”. Annika also detailed how she had experienced verbal abuse from strangers, “Mostly men screaming angry for one because they want to know which gender one has”. This was a common theme of verbal abuse, that the gender of the participants was questioned, and that the confusion experienced often resulted in verbal aggression. As Alice summarised it, “when they are looking at me, they appear to be a computer that has gotten a big error, blue screen in the brain and just stands and glares and processes nothing”.

These encounters often served as a reminder to the participants of their failure to successfully pass as their gender identity in public spaces. Body dysphoria is a major mental stressor for trans individuals, and being aggressively questioned exacerbated these feelings of dysphoria. Not all the harassment experienced was verbal. Others had experienced physical acts of violence against them, although this was not as common as verbal abuse.

There were some guys who stood and had a discussion with me and my friends. What gender identity we had. Were we girls, were we boys, were we lesbian? Like what are we? Were we gay? This actually caused a physical fight. – [Elias]

This sort of harassment was performed by strangers, and seemed to result from the same confusion that caused the verbal abuse. To deal with this stress caused by harassment and verbal abuse, Alice said that she sought the support of other LGBTQ+ friends.

3.4.2 Lack of trans community

Physical isolation from the trans community led to some of the participants finding support in online sources of information for affirmation and support.

Now that I live here, I have no other relationships with other trans people. I do not know what I would do if I could not Google some podcasts or YouTube clip with someone who talks about their everyday life, and their
trans experiences. So, it’s very nice, very affirmative as well. – [Mika]

On being asked if she had had an opportunity to live in a city with a larger trans community, Alice said:

Absolutely, that would be great fun. To meet people who are in the same position as myself. It has been very difficult here, with knowing so few people. – [Alice]

3.4.3 Lack of trans inclusion in LGBTQ+ community

Whilst the support of the trans and LGBTQ+ community were largely described as a source of positive interpersonal relationships and interaction; some participants did note trans exclusion within the LGBTQ+ community as well. Eli found that some LGBTQ+ events were not organised in a way that was trans inclusionary, with considerations not being taken to avoid having to ‘out’ oneself:

I'm at this lesbian breakfast here for example, and it's crazy. Everyone had to have a nameplate, and I was told to get up and say ‘hello my name is and I'm lesbian’ but I cannot do that because then I have to define my gender as well. Even if they had not thought about it, that’s what I would have to do. It turned out that I've heard a lot of transgender people who think that particular event is very difficult as well. – [Eli]

Mio explained that for many people, LGBTQ+ events that were not trans inclusionary, were more damaging than trans exclusion in mainstream society. This was due to expectations of receiving affirming behaviour in such an environment, not being met.

People come there with expectations, so there will always be conflicts because people have such high demands, and maybe think ‘oh, no, my identity was not confirmed enough’. Then they feel it's even worse that things happen at a LGBTQ+ festival than when it happens in the majority of society. – [Mio]

For some of the participants, there was a fear of how they would be perceived in an LGBTQ+ context after coming out. This fear came from being rejected from a social group that provided significant support, and political purpose.
I was very active the lesbian community before I came out... So, I was pretty I was a bit worried like I realized they would lose faith in me in some way, or something like that. – [Jens]

3.5 Trans community as a source of psychosocial support

3.5.1 “You don’t feel alone” – strengthened by the queer community

Whilst there are instances of the LGBTQ+ community being exclusionary towards trans individuals, the LGBTQ+ and trans community was still a major source of support for the participants. Social support from the trans community, the broader LGBTQ+ community and feminist spaces was one of the key ways participants coped with minority stressors. Participants described how they were able to find support in a community that understood what they were going through, and they could relate to. Following trauma, participants were able to reach out, and ameliorate the difficulties they were experiencing. This acted as facilitative coping for the participants. On describing how valuable being part of the queer community has been in support with the stressors of trans specific healthcare, Elias said:

I usually say that the queer bubble has saved my life. And also, I've had the luxury of working and being active in many contexts where there was really good LGBTQ knowledge. And that, yes, it's been very crucial, I think. Because I would have been completely destroyed otherwise. It can be really awful. – [Elias]

Several participants detailed how, even if friends and family are supportive, there is a limitation to how much they can understand, as they themselves are not trans. Friends who were also transgender were often described as an informal support group, where they could discuss trans-specific issues openly, with others who can relate. On answering if the participant had developed trans friends since coming out, one participant said:

It’s been really good. We have been able to support each other and such. I have three trans friends here in town and one in a different town. – [Alice]

Later, Alice went on to describe the importance of having such friends:

You don’t feel alone. Because there are such a small proportion who are trans here, you feel that; I’m not alone in this, there are people who are like me. It's like
a sense of security. Because my friends can only help me so much, but they cannot get into what I really feel. My trans friends can really do that. They can understand how difficult it is to come out to your parents, to change your name. And this frustration caused by all the bureaucracy as well. – [Alice]

Such sentiments were repeated by other participants. The opportunity to find social support in the trans community allowed participants to cope when stressors were at their worst. On having a community who you can share your experiences with, Eli said, “it’s saved me, even though I think that, when it’s at its worst, I think you save each other”. Mio summarised the effect that having a safe space in the trans community had on mental wellbeing, saying:

Well, it's very big influence, of course, to feel respected and confirmed firstly and to share a connection, that is, it's kind of like Maslow’s Hierarchy of Needs (laughter), to have that connection, it really feels like a basic need. It’s incredibly important. – [Mio]

3.5.2 Using the trans community as a source of trans health knowledge

The shared experiences of the trans community not only benefitted participants in the form of friendship and emotional support. The trans community was also described as being a source of knowledge for the participant to utilise. Many of the participants detailed significant stress and anxiety due to the structure and bureaucracy of the medical investigation prior to accessing gender confirmation services. Elias described the lack of knowledge about trans health and the transition process by medical professionals:

Neither my general physician nor the psychiatrist had dealt with this before. So, I had to tell them what they should do. – [Elias]

The trans community could therefore be used as a source of information throughout the process, when other options felt difficult to access:

Yes, it has been important to have contact. There is a Facebook group called TS Sweden where you can get a lot of help and most of the discussion is about the medical investigation. So that has been very helpful. You can get answers to questions that you have had and so on. – [Mona]
In this way, the online trans community is fulfilling the needs of trans individuals that would normally be performed by healthcare or social services.

3.5.3 Strengthened by trans activism

One aspect of having strong support from the trans community, was the benefit of having a safe space to express oneself in. Due to the default cis-normative nature of society, many situations and spaces that are seen by cis-gendered people as safe are spaces that can feel unsafe to trans individuals. Even spaces that are LGB friendly, may still reinforce the gender binary and be exclusionary to trans individuals. There is an evident area of crossover between trans activism and trans community, with members of the trans community creating safe spaces for other trans individuals to access. Trans activism can be seen as the political aspect of the trans community – which is largely a social space. Participating in these safe spaces acted as a coping mechanism for dealing with the stressors of “norm environment”, as detailed by Eli:

We have started a so-called separatist meeting place here. It is exclusively for transgender, intersex people and people who are questioning, to explore. That's once a week. It is, first of all, a breathing space ... there will not be any cis people and the [binary] norm environment does not exist there. – [Eli]

The formation of trans activist groups led to an expansion of social network size, as well as the formation of new friendships and sources of support. Trans activism was distinct from that of the trans community, as it centred on the progress of transgender rights in the political sphere. Needless to say, there is a social component to activism, but for some of the participants, trans activism was present despite little-to-no trans community where they lived. In places where the trans community is not as large, activism provided some participants with motivation to remain resilient to the obstacles they face. On being questioned what situations enabled coping with poor health and minority stress over a long period, Love answered:

It is indeed the political aspect, and feminist. It does not matter how much I'm at the bottom, it's always there, that power, saying that things are unfair. I do not know why, but I can always get angry, no matter how dismissed I am, I can always be political as well. So, I've been active in different places and then, and then I think it's good for me, because I do not have the trans
community in the same way that I’ve had before. – [Love]

Jens spoke about how being a part of democratic associations in his hometown, as well as being active in trans politics created many close friends.

So, being in associations and activism both gave me my best friends and fortified my best relationships. – [Jens]

The formation of trans activist spaces allowed the formation of trans community, as well as safe space for trans individuals to meet other trans people. These environments form spaces that are not afflicted with the same cis-normative influence that broader society has. In the same way that many spaces in everyday life and society are trans exclusionary, trans activist environments were controlled to be solely trans inclusive.

I have a band that is labelled as a transpolitical band, there’s only trans people in it. It is very exclusive. No one else is allowed to join. – [Eli]

3.6 Stress from relationship with family

3.6.1 Not coming out due to fearing rejection

Rejection by family was a common theme in the interviews. Some of the participants detailed a variety of difficulties in dealing with family who did not accept them. Some of the participants feared they would not be accepted by some of their family members and therefore remained in the closet. Remaining in the closet to close family members led to avoidance of those family members. Wishing to remain in the closet for fear of a bad reaction was also described by one participant in a work setting. Remaining in the closet for fear of negative reaction from family members created stress for the participants:

I don’t have a good relationship with my dad, we have little contact, he knows nothing about my gender identity and so on with gender identity. My mom knows about it but does not really take it seriously. That’s just how it is. It is stressful, it really affects me so if I want her to meet my friends. If I want to visit, it feels like there will be so many obstacles. – [Love]
3.6.2 Negative reaction to coming out resulting in avoidant coping

Some of the participants detailed how, even if they were not outright rejected by their family, the reaction to coming out to them was not positive. This was described by Alice as being caused by the loss of how they originally perceived their child or grandchild:

My mum and my grandmother became very sad and upset. It was tough, they wanted you to be a certain way and then I came out to them. It was difficult because they were sad for who I am. I understood afterwards that they became sad because they had lost something.

– [Alice]

3.6.3 Failure to use correct pronoun and name

Some of the participants found that family members would not accept their use of preferred pronouns or chosen names. Therefore, interacting with family members was a source of stress due to the fact that they would be called by their previous name and pronouns, disregarding their gender identity. Mio identified this as controlling behaviour:

I’ve also said, ‘yes, but my name is this now,’ they only say ‘it doesn’t fit you’, just, ‘no, you were named this name and it’s very beautiful name, it means this…’. Like what? So, that does not help. I cannot live my life fully because of my parents, how long will I be ruled by them? – [Mio]

Acceptance did not necessarily equate to full understanding or correct use of pronoun or name. Correction of incorrect name and pronoun usage was a draining experience for some of the participants. Acceptance of being misgendered is an example of avoidant coping. Being misgendered caused stress for the participants, but it was accepted because they no longer had the energy to correct their family. Robin, who is non-binary, found that not all their family who they grew up with took their identity seriously:

Mum and dad have [accepted it] now. Dad has anyway, accepted it for a few years. They are still not using the pronoun. I have chosen a name and they use it, or my nickname, but sometimes it happens that they use my old name and I don’t know. It’s been so long, I just cannot correct them anymore... I’ve given up pointing out because they never learn with the pronoun. – [Robin]
Participants who identified as genderfluid, or non-binary, faced unique difficulties, as they were perceived as cis-passing. Due to the binary nature of society dressing as effeminate, or ‘cross dressing’ if you were assigned male at birth, may be more obvious signifier of trans identity. However, for individuals who did not equate coming out to a shift in how they presented themselves in how they dressed or physical characteristics, it was harder to be taken seriously. In effort to be taken seriously, some considered gender confirmation treatment as a tool to convince their family of their identity. Mika, who identified as non-binary, was not taken seriously by their family, and did not know how accessing gender confirmation treatment would affect this:

I have tried to come out to the rest of my family, but they do not understand stuff. Since I'm cis-passing, they think of me as a cis-person, but if I start with sex-confirming treatment, I do not know what it could lead to. – [Mika]

Whilst some of the participants found not being accepted by family a significant cause of stress, others attempted to understand why it might be difficult to be accepted as trans. In the process expressing a level of internalised cis-normativity, that it is normal to be rejected due to their gender identity, because their parent is old. Elsa explained her mother not accepting her, saying age was the key factor:

The only negative (laughing) reaction I received was from my mother. Well, maybe she was not well prepared, but she's old now. She's 95 years old, she's pretty spritely though. That's the only one who has been a little negative (laughing) if I say so myself. But it's a normal motherly feeling I suspect. – [Elsa]

The stress of managing these relationships, as well as the fear of discrimination in unsafe spaces, led to avoidant and protective behaviour, with multiple participants detailing choosing carefully which social groups to engage in.

And my social life, I have no contact with the family I grew up with, but it's a self-chosen group of people that I now associate with – [Elias]
3.7 Psychosocial support from family and close relationships

3.7.1 Family acceptance allows facilitative coping

One of the most significant forms of interpersonal relationships detailed by the participants was support and acceptance by immediate family. The nature and quality of the relationship between participant and immediate family was a topic touched in nearly all interviews. Support from family had a significant determination over mood and how the participants were dealing with stress from the medical investigation, or stigma and discrimination in society. Johanna detailed how her family’s initial reaction to her coming out led her to feel significant distress. Later being accepted rectified this, and led to the reformation of family relationships and the ability to utilise social support from family as a coping mechanism:

> It went to hell at first, and it was really bad for over a year. Our relationship was so tense and I broke down several times in tears. Now in the fall or late summer, I heard from dad and, we talked. And after that he has only become better and better and we spend much more time together. And, that feels really good now. – [Johanna]

There were different levels of support described by the participants. Acceptance was not black and white. Some family members accepted the trans identity of the participant, but failed to use correct pronouns or name. Elliot explained that the closeness of family meant that acceptance of identity and correct use of pronouns and name was vital to feeling positively about one’s identity.

> My mom knew about it from the beginning, since I was a teenager, she has always accepted it, my siblings, too. Such as the change of pronoun, changing my name, they really supported me. My family, they mean so much to me, I’m constantly hanging out with them so it helps me feel better to have their support. – [Elliot]

Participant who had families that accepted them after coming out recognised the difficulties they would have faced without such positive coping mechanisms:

> Since my family, friends and acquaintances, have accepted it without any major problems, they have been an important part, of course. If they had negative opinions, then it would have been so much harder. – [Louise]
Due to the fact that social support by family was so key to dealing with stress, it was noted that mood was therefore governed by this support. Participants’ mental health was beholden to the quantity and quality of support from family members. This demonstrates that participants acceptance or rejection by family resulted in facilitative coping mechanisms (social support), or avoidant coping (avoiding contact with family). Alice described:

> I’ve had both good and a lack of support from home. When I have received good support, it has felt great, but when I get poor support, it feels like a defeat kind of. So, the family has been very influential. – [Alice]

3.7.2 Social support from chosen family

Romantic partners were also a source of significant social support for participants. The difficulties of the medical investigation resulted in substantial stress and pressure on the mental health of the participants. Johanna found that the support of trained psychologists and psychiatrists was inferior to that her partner could offer:

> He has been more of a psychiatrist for me than even the psychiatrist ever has been. – [Johanna]

Elliot, who’s partner was active in the queer community, received great support and motivation from his partner, when struggling with the difficulties of the investigation:

> Then I met someone who I lived with, who was active in an LGBTQ organisation. That really supported me and they said "come on now you can do this" and picked me up. – [Elliot]

The majority of the participants were child-free, however Elliot described the impacted of being so quickly accepted by his daughter, after coming out to his family:

> She is amazing, she may have thought it has been difficult but she has not shown it, I haven't noticed anyway. She just used my name straight away when I changed it, and the pronoun, never said anything else. She did not feel ashamed about it in front of friends, at school she tells it to people and, she takes it as normal and natural. It feels great, it could have been really hard. – [Elliot]
3.7.3 Support in unlikely places

Although support from within the trans community was noted throughout the interviews, multiple participants drew attention to the positive effect that acceptance from unlikely social groups. Acceptance and support from people outside of the LGBTQ+ community appeared to have a large positive impact due to the fact it was unexpected from the participants. This difference between LGBTQ+ community and broader society was characterised the participants anticipating that social groups outside the LGBTQ+ community would not support their identity or trans specific struggles. On coming out to colleagues as a transwoman, Johanna noted that she got a significant increase in support from female colleagues:

I get better and better treated by the women in the workplace. It's like they're supporting me and that's something like they did not do before. They don't do that, maybe, to any of these guy friends in my age at work either, anymore, still. But to me, they have started to treat me differently, talk to me differently and so on.

– [Johanna]

When discussing social environments or situations which might have caused the participant to feel worse, Mona commented on how non-LGBTQ+ social groups had been:

People have been very accepting and positive. Not least, the neighbours here in the housing association. They say they've noticed that I'm much happier since I came out. It has been really positive indeed.

– [Mona]

One participant discussed the support he had received from family members, on coming out. Traditional, attitudes towards sexual and gender minorities are perceived as being worse in older ages. Leon explained that his grandparents had in fact been the most supportive, and that he felt very moved to have such supportive grandparents:

Grandfather took it very well. He is probably the one who took it best... 'You're a good guy," he said, he patted me on the back and then he just said, 'yes, I'll remember to say him now'. Dad was afraid of how he would take it because he was an even older generation and you know, farmer, grew up in the country.

– [Leon]
4 Discussion

The aim of this thesis was to investigate the causes of minority stress in trans individuals in Sweden, and how they cope with minority stress. Several themes emerged from the data as to what was causing significant stress in the participants lives. Minority stressors can be categorised as distal and proximal, as per Meyer’s Minority Stress Model (31). For trans individuals, types of proximal stressors are internalised stigma and rejection; distal stressors are discrimination and a heteronormative environment (36,73). The results of this thesis can be categorised similarly, and therefore are in keeping with the Minority Stress Model. The data showed participants experienced internalised stigma, rejection from family and friends, discrimination and harassment in public spaces. Finally, stress from the medical investigation can be categorised as a heteronormative environment.

The medical investigation was a significant source of minority stress for the participants. This result has been demonstrated to be the case in a sample of trans individuals from the US in a 2013 paper (42). The nature by which trans individuals are approved for gender confirmation therapy varies from country to country. The design of the medical investigation included the need to fit into a binary perspective of gender, in order to progress the medical investigation. This caused significant stress for the participants as they did not feel as though they were able to present themselves how they wished, but instead how they needed to present, in order to access treatment. The same dataset has been used in a previous study and found that trans specific care in Sweden places a large emphasis on gender norm conformity (74). This pressure to conform directly conflicted with the identities of the care seekers and contributed to poor mental wellbeing.

 Whilst the approach of the medical investigation produced stress for the participants, they also faced discrimination in a healthcare environment. This was not limited to trans specific care but also psychological and primary care. Refusal of care, refusal to use the correct name or pronoun and being bullied by healthcare providers was detailed by the participants. Examples of trans discrimination are found throughout trans health literature, and these results show that Sweden is no exception to such discrimination (10,14,27,75). Healthcare providers demonstrated a poor understanding of trans identity by healthcare providers, this contributed towards poor quality of care given. A lack of LGBTQ+ education of health workers has been found in a number of studies and led to a feeling of unpreparedness in caring for
transgender patients (14,18,55). This poor quality of care that was received had a profound effect on participants, often causing strong emotional reactions following these encounters. The results from the present thesis would indicate that this is also an issue in Sweden, and should be investigated further in future research.

Participants also experienced discrimination in public spaces. Verbal abuse was the most common form of abuse. The participants explained how this often started with the perpetrators of such abuse questioning their gender identity. This confusion then turned to abusive behaviour. This confusion was due to a lack of understanding of trans identity and a binary view of gender. This was largely based on being visibly non-passing, and therefore failing to fulfil gender role in the eyes of the discriminators (76). This form of public discrimination is in itself a method of policing gender and sexual norms within society. Discrimination experienced in both a healthcare environment and public spaces were produced from a similarly cis-normative view of gender. Therefore, binary understanding of gender was often the cause of minority stress.

Both discrimination within a healthcare environment and in public spaces initiated coping mechanisms. Avoidant coping mechanisms such as avoiding seeking future care and avoiding potentially unsafe spaces were employed by some participants. Other participants utilised facilitative coping mechanisms and sought social support from the transgender community, family and friends.

4.1 Facilitative coping with the use of psychosocial support

The data revealed that psychosocial support was a way in which participants coped facilitatively with minority stressors. The main forms of psychosocial support reported by participants were that of family support, trans community support, trans activism and support from non-LGBTQ+ relationships.

The trans community was a huge source of support for many of the participants. The use of the trans community as a facilitative coping mechanism has been previously described in a qualitative paper from 2013, where researchers investigated coping mechanisms in a group of 19 MtF and FtM participants in the US (40). This thesis confirms that finding support in trans community is a key facilitative coping strategy, and reinforces the need to create and maintain trans social networks, whereby individuals can connect with the broader trans
community. One of the biggest benefits of interacting socially with other trans persons was the realisation that they were not alone, and that there were other people outside of a family or medical sphere, that they could communicate with about transition-related subjects. Participants who lived in smaller towns or more rural areas noted the lack of trans community, and found support from other trans individuals on social media, and accessed other internet resources such as podcasts. Participants used the online trans community to cope with the stresses of the medical investigation. The online trans community was used to compare experiences and gain information about the medical investigation that was not provided by healthcare providers. In this way, this community acted as a lay form of medical knowledge. Similar online patient communities have been found to be an important aspect of support in other patient groups, and their visibility should be increased (77).

In previous studies, there was found to be different utilisations of social support between trans female spectrum (TFS) and trans male spectrum (TMS) individuals, with TFS individuals accessing more social support from the trans community and TMS individuals accessing more general social support (73). There was not sufficient data in the present study to comment on differences in social support utilisation form the trans community between the different trans identities of the participants.

Within the trans community, some participants found strength in engaging with trans activism. Partaking in activism has been shown as a resilience strategy utilised by trans groups in the US, and this is confirmed to be the case in a Swedish setting also by this thesis (78). Activism is a form of facilitative coping when exposed to distal stressors, such as discrimination. Finding a common goal with others, gives a recognisable aim with which to use negative feelings with a positive focus. Lastly, it was noted that LGBTQ+ spaces were found to also exhibit trans exclusionary structures. This was noted as being more damaging than when exclusionary behaviour was found in cis-hetero dominated spaces. The lack of trans-inclusion in the LGBTQ community has been previously noted (78).

4.2 Family relationship as a source of stress and cause of avoidant coping
Participants detailed poor relationship to their family as a source of pain and distress, often leading to avoidant forms of coping. The powerful effect of family relationships on coping has been widely documented in a variety of quantitative studies, but not investigated in a
qualitative Swedish context (79–82). Parental physical and verbal abuse based on transgender identity and expression have been found to be significantly associated with suicide ideation in trans youth (83). Similarly, utilising data from the National Transgender Discrimination Survey, in the US, a study from 2016 found greater level of family rejection increased odds of suicide ideation and attempt significantly (84). One study found the absence of avoidant coping to be a more important mediator of depression and anxiety in a sample of MtF and FtM individuals than the presence of facilitative coping strategies (40).

4.3 Internalised stigma

One theme that ran throughout the results was that of internalised stigma. Internalised stigma is the process by which people internalise shame, blame, hopelessness, guilt and fear of discrimination associated with trans identity, and identify with stereotypes surrounding trans identity (85,86). Internalised transphobia has been identified as one of the key proximal stressors in the Minority Stress Model (36). Evidence of internalised stigma within the participants can be seen from the use of compromise with family members, for example allowing the use of incorrect pronouns and old name in certain scenarios. This is an example of internalised cis-normative attitudes, whereby the participants accepted being misgendered, for fear of maintaining relationships with family members. The participants also attempted to rationalise reasons for family rejection and transphobic attitudes.

Spaces and behaviour that reinforced a binary view of gender, resulted in participants avoiding such social spaces. This is an example of avoidant coping. Some cis-normative attitudes had been internalised by participants, such as trying to rationalise relatives’ reasons for rejecting them, or experiencing difficulties initiating romantic and sexual relationships. This is epitomised by some of the participants accepting transphobic and cis-normative attitudes or behaviour toward them.

This avoidant coping was also exhibited in the fear of misleading romantic partners, and therefore avoidance of forming romantic relationships. Finally, the participants also confirmed that avoidant coping strategies resulted in not attempting to form romantic or sexual relationships. The fear of being seen as misleading or sexually deviant due to society’s perceived incongruency between gender expression and biological sex characteristic, was significant. The majority of participants who did have partners found them to be a substantial
source of social support. The fear of being seen as misleading someone into a sexual encounter is not unfounded. The trans panic defence is a documented legal strategy in the case of a heterosexual man killing a transgender woman, on the grounds of shock in discovering the victim did not have female biological sex characteristics (34).

4.4 Implications and future research

The results of this thesis aid in addressing gaps in understanding trans health from the perspective of trans individuals. The amount of research in a Swedish context is limited and the present thesis is progress toward creating a more comprehensive understanding of the trans health landscape in Sweden. The choice of qualitative methodology, allowed for the thesis to focus on the experiences of the participants. There is a clear need for trans voices to be elevated in trans-specific research, and I aimed to ensure that the results and direction of this thesis were dictated by the participants stories and words. Semi-structured interviews allowed for the participants to control the direction of their interview, and create an environment of comfort.

The results of this thesis have a number of implications. Firstly, the results confirm the importance of social support as an important source of facilitative coping. The visibility of the trans community and accessibility is paramount to receiving psychosocial support as a trans individual. Policies should focus on increasing the visibility of the trans community, particularly in rural areas where there is very limited LGBTQ+ focused health centres. The organisation of trans-inclusive LGBTQ+ events is a good strategy for creating a safe environment where social support can be found, and trans individuals can grow their social network. Special care should be taken to ensure LGBTQ+ spaces and inclusive and safe for trans individuals.

To combat the issue of everyday cis-normative attitudes, education is key. Giving space to trans people in mainstream media, and allowing an open discussion of gender identity will aid in combating these damaging attitudes. As of the recent inclusion of trans discrimination in Swedish hate crime law, acts of discrimination should be investigated fully in accordance with this law, to combat verbal and physical abuse based on gender identity. In order to promote acceptance of trans identities in families, the families should be provided with support and information to aid them to understand trans identity and what gender confirmation
treatment can entail. In the US, The Family Acceptance Project (FAP) aims at providing services to families of LGBTQ+ youth, including educational materials, documentaries and assessment tools. The FAP’s resources helped to create acceptance in these families, and therefore enable facilitative coping mechanisms (87). This thesis had confirmed that family acceptance and rejection is still a major determinant of wellbeing in trans persons. There is a similar project to FAP currently operating in Sweden, ‘Transammans’, which aims to support trans individuals and their relatives (88). However, such organisations need greater support in order to reach as many trans individuals across Sweden as possible.

Finally, different difficulties and stressors are faced by trans individuals based on the point at which they are in transition. The trans experience is a fluid and changeable process, and specific support needs to be developed so that trans persons have access to help regardless of their point of transition. A 2013 paper by Budge et al. details the different emotional and coping processes based on transition phase (40). Future research should examine the how social support from interpersonal relationships varies during transition. From this knowledge, better support services and interventions can be offered specific to the point of transition.

4.5 Strengths and limitations

There are several limitations to this thesis that should be noted. One limitation was the use of translation from the original Swedish transcriptions to English transcriptions. To ensure trustworthiness, a second translator was used when required. The translation process was a good method of gaining thorough insight into the data, prior to analysis. A key review on the topic of cross-language qualitative research contained a list of methodological considerations which was utilised to provide a template from which to develop proper translation practices (68). Cross-language qualitative research has the possibility to lose the original meanings and nuances expressed by the participants in their original language. This could have resulted in negatively impacting the trustworthiness of the data.

Another limitation of the study is that different individuals collected and analysed the data. Ida conducted the interviews and, not being present (the data was collected in 2014, 2015 and 2017), I was not able to guide the direction of the interviews. Therefore, there are some aspects of interpersonal relationships that were touched on during interviews that were not covered in-depth, and could not be analysed further in this thesis. However, Ida was able to
identify with the participants as both a medical doctor and a member of the queer community. This is likely to have offered a greater deal of comfort for the participants than I would have otherwise had, likely being perceived as a heterosexual, cis male. Furthermore, if I had personally conducted the interviews in English, the participants might have not been able to as clearly communicate their experiences as they did when interviewed in Swedish.

There was limited demographic data on the participants, partially to avoid compromising their anonymity. This meant it was difficult to explicitly separate the experiences of rural trans individuals from that of urban living trans individuals, participants merely referred to living in a smaller town as opposed to a larger town or city. There was no information on the ethnic backgrounds or the economic status of the participants. It is difficult to therefore extrapolate the findings of this thesis to specific groups, as the experiences detailed in this thesis may not be representative. Therefore, a fully intersectional analysis was not possible with this data. Future research should aim to analyse how coping varied across different ethnic groups and incomes.
5 Conclusion

The present thesis successfully aids in addressing gaps in the causes of minority stress in trans individuals in Sweden and how they cope. By investigating the different cause of minority stress and how these impact trans individuals, a clearer indication is presented for what support and services are needed. The results showed that the participants utilised supportive relationships for facilitative coping. Cis-normative spaces, as well as discrimination, resulted in participants using avoidant coping. This manifested in either not engaging in new relationships, or creating distance in current relationships. The thesis supports the indication there is a great need for improved trans-specific resources in Sweden. The families of trans individuals need to receive support and information in order to be better equipped to offer support for family members coming out as trans. More visible trans social groups should be created and supported, particularly in smaller rural communities, in order for members of the trans community to easier access social support from other trans persons.
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Appendices

Biographies of the participants

The following participants were interviewed in 2014-2015:

**Alex** is 20-25 years old. He has no partner, lives in a big city and studies at university. He has tried to get access to gender-confirming medical procedures.

**Alice** is 25-30 years old. She has no partner, lives in a medium-sized city and studies at university. She has had gender-confirming medical procedures.

**Anna** is 25-30 years old. She lives with her partner in a medium-sized city and works in the public sector. She has had gender-confirming medical procedures.

**Annika** is 25-30 years old. She has no partner, lives in a small city, is on sick leave and is unemployed. She has had gender-confirming medical procedures.

**Elias** is 30-35 years old. He is married, lives in a big city and works in the public sector. He has had gender-confirming medical procedures.

**Elsa** is 65-70 years old. She has no partner, lives in a medium-sized city and is retired. She has had gender-confirming medical procedures.

**Johanna** is 25-30 years old. She has no partner, lives in a small city and works in the private sector. She has had gender-confirming medical procedures.

**Leon** is 30-35 years old. He is engaged, lives in a big city and works in the private sector. He has had gender-confirming medical procedures.

**Eli** is 25-30 years old. Identifies as non-binary. They have no partner, lives in big city and is on long-term sick leave. They have considered, but not yet had, any gender-confirming medical procedures.

**Louise** is 35-40 years old. She has no partner, lives in a medium-sized city and works in the public sector. She has had gender-confirming medical procedures.

**Love** is 25-30 years old. Identifies as non-binary. They have no partner, lives in a big city and is on sick-leave. They have considered, but not yet had, any gender-confirming medical procedures.

**Mark** is 20-25 years old. He has no partner, lives in a medium-sized city and studies at university. He has had gender-confirming medical procedures.

**Mio** is 35-40 years old. Identifies as non-binary. They have a partner, lives in a big city and works in the public sector. They have considered, but not yet had, any gender-confirming medical procedures.

**Mona** is 55-60 years old. She is married, lives in big city and works in the private sector. She has had gender-confirming medical procedures.

The following participants were interviewed in 2017:

**Elliot** is 30-35 years old. He has a partner, lives in medium-sized city and works in the public sector. He has had gender-confirming medical procedures.
**Jens** is 25-30 years old. He has a partner, lives in a medium-sized city and works in the private sector but was at the time for the interview on sick-leave. He has had gender-confirming medical procedures.

**Mika** is 25-30 years old. Identifies as non-binary. They have no permanent partner, lives in a small town, and is temporarily employed in the public sector. They have had no gender-confirming medical procedures.

**Robin** is below 20 years old. Identifies as non-binary. They have no partner, lives in a medium-sized city and is currently unemployed. They have had contact with the trans-specific healthcare but has not had any gender-confirming medical procedures.
## Master Degree Project Description/Contract for individual supervision

**Programme:** Master’s Programme in International Health  
**Course Code/Credits:** 30 credits

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**Project title:**  
How trans individuals’ interpersonal relationships affect coping with minority stress

**Starting date:** 1/3/18  
**Expected finishing date:** 26/9/18

I have read and understood the information for students undertaking a degree project  
1/2/18

Date/ Signature of student

I accept the student for a degree project and will fulfil the tasks as described in the given supervisors instructions  
1/2/18

Date/ Signature of Supervisor
Contract for using interview material about Trans, Health and Healthcare (18 interviews)

The following agreement has been agreed upon in order for the student/researcher to use the interview material for the research question defined below.

Data should be handled with all ethical and secrecy considerations. The transcribed interviews should always be encrypted or password protected. The files must not be shared with anyone.

If publications are derived from studies wholly or partly including the present data the PI (Ida Linander) should always be informed about the whole publication process. This is to assure accurate presentation of the study and handling of the data.

When the research collaboration on this paper/s is finished, the total data material should be deleted. A signed letter confirming the deleting of the data files should be sent to Ida Linander.

The student/researcher is always personally responsible for the handling of the data.

State the research question:

How do interpersonal relationships impact health in children individuals?

Date: Umeå 28/2-2018

Signature of PI

Ida Linander
Name

Uppsala 27/2-2018

Signature of researcher

Lloyd Ellis
Name