EXPLORING THE MENTAL HEALTH CARE CHALLENGES OF OLDER TRANSGENDER PEOPLE IN THE CAPE METROPOLE: A PARTICIPATORY PHOTO VOICE RESEARCH PROJECT

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Date: 12 December 2019

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DEDICATION

I dedicate my thesis to my brother, Christian and my sister, Jolene. Your continuous believe in my abilities is what keeps me going in life.

I also dedicate this thesis to my late parents and sister. You have moulded me into who I am today, and I am proud to be a product of guidance and love.

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ABSTRACT

This project was born after the researcher, a practicing social worker at a psychiatric facility, observed the presence of high rates of anxiety and depressive disorders among transgender patients. These patients were often also abandoned by their family or primary caregivers. This research was part of a larger National Research Foundation (NRF) project in the Western Cape and Gauteng, which explored LGBT older persons' care needs. It differed from the main project in that it focused on the mental health care challenges experienced by older transgender people. The project was funded by the NRF and the researcher was allocated funding from that project to explore LGBT aging and care in the marginalised areas. LGBT discrimination has been indicated as a key factor in the onset of mental health issues later in adulthood. Older adults are generally at a higher risk of developing mental disorders. The older transgender community with mental health care needs thus often suffers multiple forms of oppression within a heteronormative society. The aim of the research was to determine the mental health care challenges experienced by older transgender people in the Cape Metropole, Western Cape. Objectives to reach this aim included exploring and describing the unique challenges faced by older transgender people, their experiences when accessing mental health care, and describing strategies of addressing their mental health care needs.

The research methodology entailed a qualitative approach. Snowball sampling was applied for selecting five older transgender participants and five key informants. Photo voice, a Participatory Action Research (PAR) design, was used. Data collection consisted of in-depth interviewing, focus groups, and photo journaling. Themes were developed from the data utilising Thematic Analysis, aided by Atlas.ti software. Ethics and trustworthiness were certified through guidance by the research supervisor. This research was classified as high risk, since it involved marginalised individuals from the aged LGBT community. Anxiety in the group was anticipated and dealt with by providing further counselling where needed.

The findings indicate that older transgender people experience minority stress across all racial and age cohorts. They suffer heightened anxiety when accessing healthcare services, as they anticipate transphobia and oppression. In addition, the intersectional socio-economic status of age and gender identity seems to contribute to building resilience within the participants. Lastly, substance use and social and professional support were identified as coping strategies in the face of on-going discrimination.

Keywords: Mental health, transgender, older, intersectionality, photo voice

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ACRONYMS

Abbreviation	Full Word/Term
APA	American Psychiatric Association
BMREC	Biomedical Research Ethics Committee
COP	Community of Practice
DSM	Diagnostic and Statistical Manual of Mental Disorders
GAP	General Adult Psychiatry
GNC	Gender Non-Conforming
ILGA	International Lesbian, Gay, Bisexual, Transgender and Intersex Association
LGB	Lesbian, Gay & Bisexual
LGBT	Lesbian, Gay, Bisexual & Transgender
LGBTI	Lesbian, Gay, Bisexual, Transgender & Intersex
MTF	Male to Female
FTM	Female to Male
NIA	National Institute on Aging
NPO	Non-Profit Organisation
NRF	National Research Foundation
PAR	Participatory Action Research
UN	United Nations
UWC	University of the Western Cape
WHO	World Health Organisation
SOGI	Sexual Orientation and Gender Identity
TGNC	Transgender and Gender Non-Conforming

CHAPTER 1: INTRODUCTION

1.1 Introduction

There is a growing body of research available on the aging of Lesbian, Gay, Bisexual & Transgender (LGBT) people (Henderson & Almack, 2016), specifically since recognising that this community is now growing older (Almack, 2007). Older adults are generally at higher risk of developing mental disorders (WHO, 2016). Bailey (2012) describes transgender people as a range of individuals within the LGBT community, presenting unique and diverse needs. A new wave of older people is now visible within the transgender community, thanks to advances in medicine, which enables people to live longer and healthier lives (Bailey, 2012). Within a heteronormative society, a plethora of care guidelines and research exists on the mental health and social care needs of older heterosexual people (Strydom, Hassiotis & Livingston, 2005; WHO, 2016), however, the same is not true for older LGBT people. Being a marginalised gender minority puts LGBT elders at an even higher risk of developing mental health issues. The minority stress theory suggests that sexual and gender minorities experience unique types of stressors, specifically related to stigmatisation and prejudice, which may cause mental health adversities (Meyer, 2003; Hendricks & Testa, 2012). The provision of mental health services requires the diagnosing and treatment of people with mental disorders, as well as the application of measures to prevent mental disorders. Healthcare workers should be skilled and competent in terms of the psychosocial sciences. These include, among others, skills in the interviewing process, ethical counselling, and interpersonal skills, which will aid in enhancing the health outcomes in mental healthcare (WHO & Wonca Working Party on Mental Health, 2008), with the minority stress theory in mind.

This project was funded by the National Research Foundation (NRF) to conduct research into LGBT aging and care. The study formed part of a larger NRF project in the Western Cape and Gauteng, which explored the care needs of LGBT older persons. Gender Dynamix is a Cape Town based Non-Profit Organisation (NPO) that aims to address human rights violations experienced by both gender non-conforming (GNC) and transgender persons in South Africa. For this research, Gender Dynamix provided the participants; they also provided training and support services to the researcher and the participants of the study. The researcher focused on older transgender people, as a lack of research exists in South Africa on the mental health care needs of specifically the older transgender community. Fredriksen-Goldsen et al. (2014) proposed 10 evidence-based practice guidelines for social workers to account for the

environment, strengths, and challenges facing older LGBT adults. These guidelines do not consider the unique caretaking needs, stressors, and experiences by post-Apartheid South African LGBT people. The research endeavoured to contribute to the body of existing knowledge by exploring the lived experiences of older transgender people (aged 50+) when accessing mental health care in the Cape Metropole, Western Cape. In doing so, the outcomes highlighted specific mental health care needs of the older transgender community and recommendations were made for practice and legislation.

1.2 Motivation for the study

Bailey (2012) describes transgender people as range of individuals within the LGBT community, presenting unique and diverse needs. Many mental health professionals have not been afforded the opportunity to deal with the deeper prejudices experienced by the LGBT community and as such, continue to have a limited knowledge base about the real lives of LGBT people (Mallon, 2018). Classical feminists generally focus on cisgender females to help understand the functioning of patriarchy. Recently, literature on the importance of intersectionality has expressively increased. However, LGBT and intersectional studies mostly overlook the experiences of transgender people (Gerwe, 2019). The Psychological Society of South Africa (PsySSA) released 12 guidelines for working with sexually and gender diverse people. However, many professionals still work within a cisgender, heteronormative space (Mchlaglan, 2019).

Important to note is the absence of social workers within the transgender sphere. Addressing the invisibility of social work within the transgender communities would require inclusive social work education, assessment tools that are appropriate to the unique needs of transgender people, as well as on-going support (Fish & Donaldson, 2018).

This study explored the lived experiences of older transgender people (aged 50+) and the way these experiences shape their notions when accessing mental health care in the Cape Metropole, Western Cape. It does so by adding previously unexplored knowledge on how older transgender people navigate their lives and how their gender identity intersects with their age, racial background, and socioeconomic status.

1.3 Aim and objectives

The aim in research refers to a statement that describes the purpose of the investigation. It is a declaration of the anticipated intents that clarifies and directs the focus of the research, and

states that achievement is anticipated (Largan & Morris, 2019).

The research objectives are an interpretation of the aim into statements, which advises the reader on the steps that will be taken to answer the research question (Abdulai & Owusu-Ansah, 2014; Largan & Morris, 2019).

1.3.1 Research aim

The research aim of the study was:

To determine the mental health care challenges experienced by older transgender people in the Cape Metropole, Western Cape.

1.3.2 Research objectives

The objectives of this study were:

- To explore and describe the unique challenges faced by older transgender people in the Cape Metropole, Western Cape
- To explore and describe the experiences of older transgender people when accessing mental health care in the Cape Metropole, Western Cape
- To explore and describe strategies of addressing mental health care needs of older transgender people in the Cape Metropole, Western Cape

1.4 Research questions

A research question refers to the question that the research is designed to answer, and provides guidance and aids in shaping the research process (Largan & Morris, 2019). The research question for this study was:

What are the mental health care challenges experienced by older transgender people in the Cape Metropole, Western Cape?

1.5 Significance and limitations of the study

Limitations of research can be defined as anything that influences the analysis of findings and has an impact on the capacity to generalise (Largan & Morris, 2019).

The research only focused on older transgender people and thus excluded lesbian, gay, and bisexual participants. The study was further limited by a small sample and could therefore not be used in generalisation of the broader population. This is partly because many transgender

individuals choose to remain invisible, especially after any gender reassignment process.

The use of photo voice for data collection also proved challenging for some participants, as they were not completely comfortable with using a camera to capture the essence of the story. Contrary to this, some participants had a photography background and used the opportunity to tell their stories in a unique and creative manner.

The significance of the study is that it will add to a very limited body of knowledge available on the lived experiences of older transgender people in South Africa.

1.6 Definition of concepts

Transgender: Transgender is an umbrella term used to describe a gender identity or gender expression different to that of the person's biologically assigned sex (Altilio & Otis-Green, 2011; Forsyth and Copes, 2014; Berg-Weger, 2016).

Cisgender: Cisgender refers to people whose gender identity is the same as their biological sex assigned at birth. For example, a person who identifies as a man and was assigned male at birth is a cisgender man (Schilt & Westbrook, 2009).

Heteronormativity: Heteronormativity refers to the notion that heterosexuality, based on the gender binary, is the norm or fundamental sexual orientation. It is based on the assumption that sexual and marital relations are most appropriate for people of the opposite sex. A 'heteronormative' understanding involves configuration of biological sex, sexuality, gender identity and gender roles (Goodman & Gorski, 2014; Harris &White, 2018).

Heteropatriarchy: Heteropatriarchy is a socio-political classification where cisgender males and heterosexuals have authoritative power over cisgender women and various sexual orientations and gender identities. The term highlights that discrimination exercised both upon women and the LGBTQ community has the same sexist social value (Francisco, 1996).

Older: The term 'older' used in this study refers to any age above 50

years. This definition is traditionally used across Africa to describe a person between the ages of 50 and 65 years (WHO, 2016).

Coming out: To declare openly something about oneself that was previously kept hidden, e.g. one's sexual orientation or gender identity (Merriam-webster.com, 2019).

1.7 Preliminary literature review

1.7.1 Transgender

Transgender is an umbrella term used to describe a person's gender expression and/or gender identity that is different to the person's biologically assigned sex (Altilio & Otis-Green, 2011; Forsyth & Copes, 2014; Berg-Weger, 2016). It refers to a range of individuals with unique and diverse needs (Bailey, 2012). The LGBT community inherently and historically suffers oppression from all social classes (Harper & Schneider, 2003). A world-wide survey conducted by the International Lesbian, Gay, Bisexual, Transgender and Intersex Association (ILGA) in 2016 indicated that same sex sexual acts are criminalised in 11 counties in the Americas, 23 countries in Asia and 33 countries in Africa (Carroll, 2016). In South Africa, LGBT Rights are upheld by Section 9 of the Constitution, stating that the state shall not directly or indirectly discriminate against a person based on (among others) gender, sex, and sexual orientation (The Constitution of the Republic of South Africa, 1996). Despite the many advances in the rights of the LGBT community, this population still suffers significant discrimination and stigmatisation. A study conducted in 2008 by the UCLA School of Law concluded that as much as 84% of the South African public is of the opinion that homosexual sexual behaviour is wrong (Smith, 2013) despite the constitutional protections. In general, there is an absence of research on differences between transgender adults and non-transgender lesbian, gay, and bisexual (LGB) adults or younger transgender adults (Fredriksen-Goldsen et al., 2013). The National Centre for Transgender Equality and the National Gay and Lesbian Task Force released a report in 2011 that confirmed the pervasive and serious discrimination transgender people in the US face. The report outlines the elevated levels of discrimination transgender people experience in employment, accommodation, wellbeing, education, and in their family setting (National Centre for Transgender Equality, 2012). Such discrimination is further fuelled by the decision taken by United States (US) President Donald Trump to ban transgender people from the military (Diamond, 2017). In South Africa, The Alteration of Sex Description and Sex Status Act of 2003 (Act No. 49 of 2003) permits individuals have their

sex status amended in the population registry, and accordingly to receive their identity documents and passports indicating their new sex. The law does however require a person to have undertaken gender reaffirming treatment. However, hormone replacement therapy (HRT) is adequate and gender reaffirming surgery is not required (Deyi et al., 2013). The literature suggests that transgender people with all its complexities are recognised by policymakers and certain laws; however, the intricate lived experience of transgender people are lacking from research.

1.7.2 Prevalence of mental health distress among LGBT people

Despite many advances in laws and policies, LGBT discrimination has been indicated as a key factor in the onset of mental health issues later in adulthood (Mays & Cochran, 2001; Russell & Fish, 2016). A 2010 study conducted in the United States on the prevalence of mental health illness, psychological despair, and suicidal ideation in a varied sample of LGBT people concluded that 33.3% of participants met criteria for any mental disorder, of which 15% were for major depression, and 9% for post-traumatic stress disorder (PSTD) (Mustanski, Garofalo & Emerson, 2010). A diagnostic interview was administered to a sample of 246 LGBT young people between the ages of 16 and 20. The authors further assert that many studies excluded adequate numbers of transgender participants to account for statistics in this understudied population (Mustanski, Garofalo & Emerson, 2010). The Diagnostic and Statistical Manual of Mental Disorders Version 5 (DSM-5) published by The American Psychiatric Association (APA) lists Gender Dysphoria (GD) as a mental disorder. GD is characterised by the "marked incongruence between one's experience/expressed gender and assigned gender" (American Psychiatric Association, 2013:452). According to the DSM-5, worldwide prevalence of the diagnosis of GD ranges from 0.005% to 0.014% for adult males and from 0.002% to 0.003% for adult females (American Psychiatric Association, 2013). The APA further asserts that clinically referred adults with Gender Dysphoria often show elevated levels of anxiety and depressive disorders (American Psychiatric Association, 2013). The fact that a person's expression of gender may be considered a mental disorder in itself may lead to the mental distress experienced by transgender people to be overlooked.

1.7.3 Aging

Classic concepts regarding ageing gained momentum in the 1980s. Phillipson (1982) cites the 'crisis of the old age', whereby the author refers to the negative connotation in the general society that older people are becoming increasingly problematic for society. The term

‘ageism’ became more widely used after formation of a social justice movement to challenge the mandatory retirement at age 65 from the United Presbyterian Church (Nelson, 2004). The author asserts that “issues pertaining to old age and aging constitute an enormous challenge to the whole society and raise basic moral and ethical questions about social justice and the survival of our society” (Kuhn, 1987:376). This notion is consistent with current critical gerontology (Kolb, 2014). With aging, the body naturally experiences changes that may render a person less capable of performing daily tasks (Snedeker, 2017). Older people also often isolate themselves from the world, either voluntarily or involuntarily, due to stigmatisation and stereotyping (Snedeker, 2017). The United Nations (UN) lists five principles for older persons, including independence, participation, care, self-fulfilment, and dignity. The latter specifically states that older persons should be able to live free from mental abuse and have the right to be treated fairly “regardless of age, gender, racial or ethnic background, disability or other status” (United Nations Human Rights Office of the High Commissioner for Human Rights, 2011:14). The provision does not explicitly refer to sexual orientation or gender diversity, although ‘other status’ provides the opportunity for committees to consider “age-related discrimination” (United Nations Human Rights Office of the High Commissioner for Human Rights, 2011:6). The US Department of Health and Human Services asserts that its Healthy People 2020 programme vows to ensure high priority is given to people that have historically suffered discrimination and “less influence or acceptance in society”, including gender and sexual orientation status (Healthypeople.gov, 2019). The programme aims to establish goals and objectives for policies, programs, and activities to address the main health issues in the US (Healthypeople.gov, 2019). Older people are however not explicitly mentioned in this plan. In South Africa, the Older Persons Act of 2006 (Act No. 13 of 2006) aims to uphold and protect the status, wellbeing, safety, and rights of older persons. The Act however does not address the unique needs of the LGBT community. The term ‘older’ as used in this study refers to any age above 50 years. This definition is traditionally used across Africa to describe a person between the ages of 50 and 65 years of age (WHO, 2016).

1.7.4 Methodological approach

A qualitative research approach was used in the form of a Participatory Action Research (PAR) design. Participants were engaged with PAR by using photo voice as a data collection method to identify the challenges they face when accessing mental health care as an older transgender person. Participants were asked to photograph and describe a situation/object/ subject within their community to best depict the challenge. Focus groups and journaling were

used to determine common themes. Similarly, key informants were interviewed using semi-structured interviews to elicit data for triangulation.

The target population of the research were people who identify as transgender and are above the age of 50 years, residing in the Cape Metropole. The population of key informants were mental health care professionals who work predominantly with transgender clients. Snowball sampling was applied as it aided in finding participants due to the stigma surrounding mental health and gender diversity.

Thematic analysis was used as data analysis method. The photos, journals, transcriptions of focus groups and interviews were analysed and stored in the Atlas.ti qualitative data analysis software.

To warrant the quality of the study, the researcher guaranteed that the research is dependable, credible, conformable, and transferable. Consistency and reliability of the research were upheld by the researcher through the documentation of the research design and the provision of detailed information of data collection including field notes, memos, photos, and journals.

An in-depth discussion of the methodology follows in Chapter 3.

1.8 Structure of the thesis

The following is a brief description of the five chapters:

Chapter One: Introduces mental health pertaining to older transgender people and provides context and a background for the study. The chapter provides broad information on the aging transgender community and the mental health challenges experienced by them. The chapter presents a summary on the significance of this study and briefly discuss the methodology employed to conduct the study. The research question, aims, and objectives are discussed, including key concept definitions and a preliminary literature review.

Chapter Two: Explores the theoretical framework employed in the study. A discussion on Feminism and Intersectionality follows as a theoretical lens through which the study was conducted. These theories are theoretically rigorous exemplars, presented to provide a baseline and background to consider when discussing aging and mental health of the transgender community. The chapter provides an in-depth perspective on the literature

pertaining to the study. This includes discussing key concepts and terms, such as transgender aging, Transsexualism, Gender Identity Disorder and Gender Dysphoria as a basis for understanding the research problem. Furthermore, causality factors for mental health problems pertaining to older transgender people, such as minority stress, oppression and transphobia is discussed. Finally, anxiety and depression among older transgender people from available global literature is elaborated on.

Chapter Three: This chapter discusses and unpacks the qualitative research design and methodology. The chapter also unpacks the sampling procedure, data collection process, data analysis, and discussion of trustworthiness, reflexivity, and ethical considerations. The chapter ends with a brief conclusion.

Chapter Four: This chapter presents the findings and the discussion. It explores the main themes and sub-themes related to mental health care challenges experienced by older transgender participants and juxtaposed with data collected from key informants. This section of the study serves to emphasise the direct narratives and experiences of the participants and key informants. Sample photos and narratives from the transgender participants are included to provide context and a reference point for further discussion. The researcher discusses the key information of the lived experiences of the transgender participants pertaining to their mental health and the aging process. Light is shed on the emotions, feelings, and attitudes towards their experience as an older transgender person in the Cape Metropole.

Chapter Five: The conclusions, with recommendations, and/or suggestions informing future research on this topic are presented.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Theories seek to describe, predict, and comprehend phenomena. It may also critically test and extend on existing knowledge. The theoretical framework can be defined as the structure that support or carry a theory of a research project. Furthermore, it introduces and defines the theory that describes why the research problem transpires (Abend, 2008). The theoretical framework explains the route of a research process by grounding it in theoretical constructs. The aim of the theoretical framework is to make research findings more eloquent and conventional to the theoretical constructs in the field of research, by ensuring generalisability (Dickson, Hussein & Adu-Agyem, 2018). A theoretical framework is consequential to an existing theory (or theories) that has been verified and authenticated by others (Osanloo & Grant, 2016).

The theoretical framework of intersectionality was employed in this study. Intersectionality is rooted in feminism theory; therefore, feminism and intersectionality will be discussed.

2.2 Theoretical framework

2.2.1 Feminism

The goal of feminism is to describe, establish, and realise political, economic, personal, and social equality between males and females (Beasley, 1999; Hawkesworth, 2006). It does not necessarily imply that this school of thought favours the female gender. Feminism has been criticised by cohorts of gender-neutral language in that the use of gender-specific language may suggest male dominance or reflect unequal social order (Reilly, 2013). The Handbook of English Linguistics argues that the English language has historically treated men as prototypical of the human species by, for example, making use of generic masculine pronouns and gender-specific job titles (Aarts &McMahon, 2006). Hence, Merriam-Webster selected 'feminism' as its 2017 Word of the Year. The Word of the Year is a measurable indication of a high interest in a specific word (Merriam-Webster, 2017). Merriam Webster annually determines the word of the year through an online poll and recommendations from visitors to their website (Merriam-Webster, 2017). This suggests that society is taking more interest into the subject of feminism and a desire to explore the subject matter.

The importance of gender issues in history, politics, and culture is emphasised in feminism. Essentially, the interdisciplinary modus operandi of feminism allows for the examination of

relationships between men and women and the differences in power differentials for the economy, social and cultural rights (of women and men) over a diversity of times and environments (Bahri, 2013). Feminist interpretations on transgender people are contrasting. For example, many feminists do not view transgender women as women (Reilly, 2013) quoting that due to their sex assignment at birth, they enjoy male privilege (Goldberg, 2014). Furthermore, some feminists do not accept the notion of transgender, as they support views that behavioural differences between genders is a product of socialisation (Lierre, 2013). Social learning theory upholds that various stimuli socialise us as women and men. For example, children are dressed in gender stereotypical clothing and colours and given gender stereotypical toys. Parents often also tend to reinforce certain suitable behaviour. Albeit gender socialisation changing since the inception of second-wave feminism, girls are still discouraged from playing rough sports such as football and would be given dolls and kitchenware to play with. Likewise, boys are discouraged from crying and are most likely to be given toys like vehicles and guns. Social learning theorists furthermore argue that children are influenced by what they observe in the world around them. Socialising encouragements such as these are thought to send imbedded messages with regard to the way females and males are anticipated to act, which mould us into feminine and masculine beings (Mikkola, 2019).

On the other hand, trans-feminists believe that the emancipation of transgender women is an integral part of feminist goals (Dicker & Piepmeier, 2003). De Beauvoir (1972:18) claims that a person is not born, but becomes a woman, and argues that social discrimination has such a major moral effect on women that, “they appear to be caused by nature”. The aim of modern-day feminism should be to create a genderless society, where sexual anatomy does not play a role (Mikkola, 2019).

In terms of mental health, the feminist perspective suggests that classification of mental health disorders is anti-feminist. Swartz (2013) argues that this place the origin of mental health disorders within the individual, while backgrounding the social and political impact on mental health. However, a diagnosis of a mental health disorder might at times be useful, as the absence of a diagnosis may be detrimental to a person with mental distress (Swartz, 2013).

Using a feminist framework emanates from a social constructionist view, as feminism focuses strongly on the way an individual is represented in society.

2.2.2 Intersectionality

Intersectionality is a theoretical framework suggesting that various social classifications, such as racial background, gender identity, sexual orientation, and socioeconomic status, intersect with how an individual experiences multiple interconnecting systems of privilege and coercion at the a social-structural level (including inter alia racism, sexism, heterosexism). Intersectionality is engrained in black feminist scholarship. The term 'Intersectionality' was coined by feminist legal scholar, Kimberlé Crenshaw to describe the exclusion of black women from white feminist discourse (Bowleg, 2012).

Intersectionality conceptualises a person, group of people, or social problem in terms of how it is affected by several discriminations and disadvantages, by considering the overlapping identities and experiences of people. This serves to have a better understanding of the complexity of prejudices they have to face. Intersectional theory thus emphasises that people are often experiencing deprivation through various sources of oppression, such as their racial background, social class, gender identity, sexual orientation, religion, and other identity indicators. Intersectionality recognises that these identity indicators do not exist autonomously, but rather inform each other. This often creates a multifaceted assimilation of oppression (Boston, 2019).

Intersectionality's origins in black feminism are deep and respected, with valid and significant insights. The justification of intersectionality originally meant the contemplation of either racial background or gender, autonomous of one another, could cause tenacious consequences for those who are affected by racism and sexism concurrently. Lately, intersectionality is used as an all-purpose buzzword for paying prompt respect to every kind of dispossession in the modern age (Brahm, 2019).

Numerous contemporary and current events highlight the influence of intersecting systems of oppressions and discriminations, such as the murders of transgender women of colour. An intersectionality lens can help us better attend to intersecting systems of oppression that are linked to these distressing patterns (Santos & Toomey, 2018). Other theories, such as Bronfenbrenner's (1979) ecological systems theory, points out the ways in which individuals are entrenched within multiple systems, however, these perceptions often lack the importance of the intersecting organisational oppressions that shape daily interactions (Santos & Toomey, 2018).

Smooth (2010) identified five principles of intersectionality:

i) Instead of "treating categories of identity as additive, the markers of identity are regarded as interconnecting or intertwining;
ii) taking into account variation within categories of social difference and identity, there is not one understanding of, for example, blackness or whiteness, or one type of femininity or masculinity, or working or middle class; rather viewing social identities as interconnected allows for a variety of ways to experience or make meaning of blackness, femininity, or working class status;
iii) recognising that social identity and status categories and the systems of power within which these are embedded change over time and across geographical locations, what it means to be marginalised shifts over time as some social markers lose their stigma and others emerge as new forms of marginal status;
iv) accepting the synchronicity of privilege and oppression instead of treating them as mutually exclusive categories; thus, the same person can experience oppression along one axis (e.g. age) while being privileged along another (e.g. gender); and
v) seeking to change society by considering how categories of privilege and oppression function and providing tools for reducing inequalities and creating a more just world" (Smooth, 2010:33-38).

Intersectionality as a theoretical framework is particularly useful for understanding how various racial and ethnical backgrounds of older transgender people play a role in their experience of mental health challenges and seeking professional mental health care services within a heteronormative society. Participants in the study were selected to include intersections of race, class, age, and gender. In South Africa, the raced and classed inequalities which resulted from the Apartheid/Colonial era sees LGBTI elders facing marginalisation which goes beyond only their gender identity and age group (Reygan & Khan, 2019). Consequently, non-white LGBTI elders have experienced both the established racism of Apartheid as well as its on-going heritage both within their LGBTI spaces and in the broader society. A body of literature exists on the experiences of people of colour in South Africa who unceasingly have to manage racial borders despite attempts to live beyond racial thought patterns (Reygan, Henderson & Khan, in press). As conformations of oppression and privilege is experienced differently in various conditions, an intersectional lens is important for engaging the intricacies which will inevitably characterise the lived experienced of older transgender people (Reygan & Khan, 2019). Furthermore, intersectionality can aid in understanding how the aging of this marginalised community affects their mental wellbeing.

Thus, an intersectional lens will provide a guide to understand how age, gender, race, and class intersect to influence how older transgender people experience and interpret mental health challenges.

Anthias (2013) asserts that intersectionality does not denote a singular framework but rather a variety of social positions. Using an intersectional framework for this study could bring to the forefront other social positions, including any of the following 14 binary positions of difference, as proposed by Lutz (2002): sexuality, race, gender, ethnicity, ability, social class, religion, age, nation, origin, wealth, culture, west/the rest, and stage of social development. The intersectional lens of this study however only considered positionality in terms of race, age, and gender. Gender was specifically considered as experienced by a transgender person, particularly as previous intersectional research on transgender individuals was grouped with the general LGBT community (Gerwe, 2019).

2.3 Review of literature

2.3.1 Introduction

Older adults generally have an increased risk of developing mental disorders (WHO, 2016) since risk exposures in the formative stages of life can influence mental well-being many years later (Fisher et al., 2011; Kieling et al., 2011). The 'multiple jeopardy' (King, 1988) faced by older LGBT people with mental health care needs are less represented in research and academia.

This literature review examines current research conducted mainly in the US, UK, Australia and South Africa, with particular focus on mental health issues faced by older transgender people. Transsexualism, Gender Identity Disorder, and Gender Dysphoria are discussed to add context and a background in the pathologisation of these circumstances; however, the focus of the study was on generic mental health issues experienced by older transgender people. This review does not explore physical needs and challenges of older transgender people.

2.3.2 Definition and background

To understand the intricacies of identifying as transgender, it is imperative to define and expand on certain terms. The acronym LGBT is often used to describe Lesbian, Gay, Bisexual, and Transgender people within a community. Lesbian, gay, and bisexual however refer to sexual orientation, whereas a transgender person can be heterosexual, lesbian, gay, or

bisexual. It is predicted that by 2020, the acronym LGBT would have disappeared (Cook, 2017) where the transgender community will be referred to as a separate, marginalised community.

2.3.2.1 Transgender

The term 'Transgender' was first coined by psychiatrist John F. Oliven of Columbia University in 1965 in his work, 'Sexual Hygiene and Pathology', arguing that when a "compulsive urge reaches beyond female vestments, and becomes an urge for gender ('sex') change, Transvestism becomes Transsexualism" (Oliven, 1965:514). It can be argued however that the term is misleading. Actually, 'Transgenderism' is what is meant, as sexuality is not a major factor in primary Transvestism. Oliven (1965) further deduced that "psychologically, the transsexual often differs from the simple cross-dresser; he is conscious at all times of a powerful desire to be a woman, and the urge can be truly consuming" (Oliven, 1965:514).

Transgender is an umbrella term used to describe a gender identity or gender expression different to that of the person's biologically assigned sex (Altilio & Otis-Green, 2011; Forsyth & Copes, 2014; Berg-Weger, 2016). It refers to a range of individuals with unique and diverse needs (Bailey, 2012), and may also include people who are not entirely masculine or feminine (Forsyth & Copes, 2014). A person identifying as transgender could have a biological male body but feel that they are female, or vice versa.

> "They experience a deep incongruence between their physiological gender and their basic internal sense of gender self (gender identity). They may choose hormone treatment and/or surgery to address this or simply live their lives according to their internal sense of their gender" (Bateman, 2011:91).

The term transgender is also used to describe individuals belonging to a third gender or classifying transgender people as a "third gender" (Stryker & Whittle, 2006:666). In certain cultures, transgender individuals are classified as a third gender, thus "treating this phenomenon as normative" (Chrisler & McCreary, 2010:486). Such is the case in some non-Western cultures, where gender is not binary and one can cross liberally between male and female (Sell, 2004).

From the mid-1990s to early 2000s, the terms 'female to male' – FTM (females who transitioned to male) and 'male to female' – MTF (males who transitioned to female) were often used in the transgender community and social sciences. The terms have since been

replaced by 'trans man' and 'trans woman' (Myers, 2018). Based on the literature, transgender refers to individuals with unique and diverse needs in terms of their gender identity. The question is however how this label psychologically affects the person. Particularly, how do other social labels intersect with this label?

2.3.2.2 Gender identity and gender expression

Gender identity refers to how the person feels on the inside about their gender despite societal expectations. This internal sense of gender manifests itself by way of how people express it socially (Human Rights Campaign, n.d.). An individual's self-concept of their gender (irrespective of their biological sex) is referred to as their gender identity. A person can therefore not identify as either female or male (Moleiro & Pinto, 2015). Thus, gender identity refers to a person's perception of the self and the way they refer to themselves. A person's gender identity can be the same or dissimilar from the biological sex assigned at birth (Human Rights Campaign, n.d.).

As gender identity is defined as an individual's intimate concept of self, the expression of said identity, or gender expression, refers to the exterior appearance of one's gender identity. This is usually expressed through conduct, choice of clothing, hairstyle, or the sound and pitch of the voice, and may or may not conform to socially determined behaviours and characteristics generally associated with being either masculine or feminine (Human Rights Campaign, n.d.).

It is important to grasp the connection between a person's felt concept of the self and the expression thereof. This leads on to further questions as to how societal expectations put pressure on an individual to express their gender identity in accordance with an inherently heteropatriarchal society.

2.3.2.3 Sexual orientation

Sexual orientation refers to the sex (biological male or female) of the person whom one is attracted to both sexually and romantically (American Psychological Association, 2008). Sexual orientation is categorised as heterosexual (experiencing emotional, romantic, or sexual attractions to persons of the opposite sex), gay/lesbian (experiencing emotional, romantic, or sexual attractions to persons of the same sex), and bisexual (having emotional, romantic, or sexual attractions to both sexes, i.e. men and women (Human Rights Campaign, n.d.).

In more recent times, the terms 'lesbian' and 'gay' refer to people who experience attraction to persons of the same biological sex, and the term 'bisexual' describe people who experience attraction to persons of both biological sexes (Moleiro & Pinto, 2015). Important to note is that sexual orientation can be defined in terms of relationships with others. It is expressed through behaviours with others, for example, simple gestures such as holding hands or kissing. It can therefore be deduced that sexual orientation involves "deeply felt needs for love, attachment, and intimacy, as well as nonsexual physical affection between partners, shared goals and values, mutual support, and on-going commitment" (Choplin & Beaumont, 2016:51).

This raises the question as to why transgender is included in the acronym LGBT (Lesbian, Gay, Bisexual, Transgender) as sexual orientation is different to gender identity. It is possible that not enough is known about a transgender person and that their lived experiences are misconstrued.

2.3.3 Oppression of gender minorities

The LGBT community inherently and historically suffers oppression from all walks of life (Harper & Schneider, 2003). A world-wide survey conducted by the International Lesbian, Gay, Bisexual, Transgender and Intersex Association (ILGA) in 2016 indicated that same sex sexual acts are criminalised in 11 counties in the Americas, 23 countries in Asia, and 33 countries in Africa (Carroll, 2016). In South Africa, LGBT Rights are upheld by Section 9 of the Constitution, stating that the state shall not directly or indirectly discriminate against a person based on (among others) gender, sex, and sexual orientation (The Constitution of the Republic of South Africa, 1996).

Despite the many advances in the rights of the LGBT community, this population still suffers significant discrimination and stigmatisation. A study conducted in 2008 by the UCLA School of Law found that 84% of South Africans feel homosexual sexual behaviour is always wrong (Smith, 2013) despite the constitutional protections. More recently, a 2016 South African survey on the public's attitudes towards homosexuality and gender non-conformity in South Africa was conducted by The Other Foundation in conjunction with The Human Sciences Research Council (HSRC). The survey concluded that 7 out of 10 (70%) South Africans feel strongly that "homosexual sex and breaking gender dressing norms is simply wrong and disgusting" (The Other Foundation, 2016:34).

In general, there is an absence of research on differences between transgender adults and non-transgender lesbian, gay, and bisexual (LGB) adults or younger transgender adults (Fredriksen-Goldsen et al., 2013). The National Centre for Transgender Equality and the National Gay and Lesbian Task Force released a report in 2011, which confirmed the pervasive and serious discrimination transgender people in the US face. The report outlines the elevated levels of discrimination transgender people experience in employment, housing, health care, education, legal systems, and in their families (National Centre for Transgender Equality, 2012). Such discrimination is further fuelled by the decision taken by US President, Donald Trump, to ban transgender people in the military (Diamond, 2017). The Trump Administration also ruled to remove Sexual Orientation and Gender Identity (SOGI) questions from a national aging survey. The SOGI category will instead be added to a national disability survey. These measures have raised concerns that the previous expansion of SOGI data collection may be at risk of being annihilated. Data collection pertaining to SOGI is important to understand lesbian, gay, bisexual, and transgender (LGBT) health and the way clinical services are accessed by this gender minority (Cahill & Makadon, 2017).

Although LGBT health and needs are often ignored in the United States, Müller (2017) cites 'queer symbolic annihilation' as the motivation behind the exclusion of queer identities in the training of health professionals. Sexual and gender minorities in South Africa also face social exclusion, discrimination, and violence due to conservative, heterosexist societal norms, as in the rest of the world. Transgender-specific health needs are specifically different from the needs of sexual minorities (Müller, 2017).

A study conducted in Cape Town and Johannesburg whereby 15 healthcare users (one woman who identified as queer, four women who identified as lesbian, ten men who identified as gay) of the LGBT community were interviewed about their experiences of using public health facilities. The study concluded that most of the LGBT participants received inadequate and unsuitable medical advice. Healthcare providers also more than often reverted to heteronormative understandings of gender roles and identities (Müller, 2017).

In South Africa, the Alteration of Sex Description and Sex Status Act of 2003 (Act No. 49 of 2003) allows people to apply to have their sex status altered in the population registry, and consequently to receive identity documents and passports indicating their new sex. The law does however require a person to have undergone medical or surgical treatment. Hormone replacement therapy is sufficient and sex reassignment surgery is not required (Deyi et al., 2013). The literature suggests that transgender people with all its complexities are recognised

by policymakers and certain laws, however, the intricate lived experience of transgender people are lacking from research.

In 2010, a conference was held in Hout Bay, South Africa where transgender people, health care providers, and the Department of Health met to establish a research and policy agenda to address pertinent transgender issues. The conference revealed that attempts by South African transgender people to access care in the public often result in humiliation, long waiting periods for surgery and referral to the private sector at major cost implications and no assurance of the outcome (Bateman, 2011).

According to the literature evidence base, gender minorities are inherently oppressed in various social settings, albeit certain policies claiming to protect and uphold the rights of gender minorities. Studies to explore and describe the lived experiences of gender minorities using either qualitative or quantitative methods are comparatively scarce.

2.3.4 Minority stress and transphobia

The Minority Stress Model refers to how external and internal minority stress processes (stigma) operate relative to other minority statuses, for example, race/ethnicity and gender (Hendricks & Testa, 2012). It is important to note that while external minority stressors (i.e. discrimination and victimisation) may be experienced by anyone who is alleged to be of a minority status, only those who self-identify with a minority status are subject to internal minority stress processes. Internal minority stressors are mostly long-term suppression of minority identity (Meyer, 2003), including gender identity (Cole et al., 2000), and internalised stigma attached to a certain minority status, which includes identifying as transgender (Hendricks & Testa, 2012).

A study conducted in 2015 in the USA, with a national sample of 552 transgender adults, assessed a hypothesis taken from minority stress theory. The study explored the relations of minority stressors (i.e. anti-transgender discrimination, stigma awareness, and internalised transphobia) as well as individual- and group-level buffers (such as resilience) of minority stress. The study found that minority stressors positively correlated with psychological distress. In terms of buffers, resilience correlated negatively with psychological distress. Furthermore, awareness of stigma facilitated the relation of anti-transgender discrimination with higher psychological distress. Internalised transphobia showed to be a significant mediator of the relation between discrimination and distress (Breslow et al., 2015).

Transgender individuals often encounter stigma in relation to a non-conforming gender identity, which can contribute to higher levels of depression, anxiety, and suicidality. Transphobia may create barriers to employment and other areas of functioning. Furthermore, transgender individuals with a history of mental health issues may experience stigma on a double level (Mizock & Mueser, 2014). In 2014 a two-part study was conducted in the USA to explore experiences of double stigma, internalised stigma, and coping strategies for dealing with transphobia. The quantitative results in Study 1 indicated that all 55 transgender participants experienced higher levels of stigma (both internalised and external). In comparison, higher levels of abilities to cope with stigma were associated with lower levels of stigma (both internalised and external). Participants who indicated the use of psychiatric medication reported higher levels of coping. Those receiving outpatient mental health services presented lower levels of coping with mental health stigma.

A grounded theory analysis was applied in Study 2 with 45 of the 55 transgender participants, to identify strategies for coping used to deal with transphobia. Findings of Study 2 revealed the presence of disclosure strategies, including decisions to reveal or conceal one's transgender identity, and anticipatory stigma, i.e. expecting and preparing for prejudice and discrimination. The results of the studies suggest the need for interventions for transgender people to increase coping mechanisms towards stigma and reduce or eliminate internalised stigma (Mizock & Mueser, 2014).

Similarly, a study with 30 diverse Transgender and Gender Non-Conforming (TGNC) individuals was conducted in 2017 to have a better understanding of the much-underexplored minority stressor of internalised stigma (Rood et al., 2017). In-depth interviews were conducted using consensual qualitative research (CQR) methodology. The study concluded that TGNC people are subjected to a variety of minority stressors, which have not been fully articulated or explored within research literature. Six distinct themes emerged: (1) TGNC identities are negatively observed by society; (2) Social cues are perceived as being initiated by the media and religious dogma; (3) TGNC individuals experience increased emotional distress; (4) Negative perception of the self in response to social cues; (5) TGNC individuals report resilience in response to negative social cues; and (6) Social cues are perceived to impact differently on TGNC people of colour. The findings highlight the mutual experience of facing social marginalisation for TGNC individuals and recommend fundamental interventions that target prevalent negative sociocultural messages regarding TGNC identities (Rood et al., 2017).

At the far end of the spectrum are thinkers who deduce that minority stress could build resilience in people who suffer at the hand of oppression. Shih (2004) asserts that stigmatised people often develop skills to compensate for the stigma. These skills include being more persistent or assertive, and paying closer attention to how they present themselves. Fredriksen-Goldsen (2014) concurs, citing that LGBT older adults display significant resilience in their daily lives. The author asserts that this resilience may be a result of adversity that strengthens their determination. The question however is what the impact of such resilience building (whether conscious or sub-consciously) is on the mental wellbeing of the stigmatised person.

2.3.5 Aging

Classic concepts regarding ageing gained momentum in the 1980s. Phillipson (1982) cites the 'crisis of the old age', whereby the author refers to the negative connotation in the general society that older people are becoming increasingly problematic for society. The term ageism became more widely used after formation of a social justice movement to challenge the mandatory retirement at age 65 from the United Presbyterian Church (Nelson, 2004). The author asserts that "issues pertaining to old age and aging constitute an enormous challenge to the whole society and raise basic moral and ethical questions about social justice and the survival of our society" (Kuhn, 1987:376). This notion is consistent with current critical gerontology (Kolb, 2014). With aging, the body naturally experiences changes that may render a person less capable of performing daily tasks (Snedeker, 2017). Older people also often isolate themselves from the world, either voluntarily or involuntarily, due to stigmatisation and stereotyping (Snedeker, 2017).

Since no census count is available for LGBT older adults based in the United States, agents have employed diverse methods to estimate the size of the population. One such study approximates that there are over 2.4 million LGBT adults over age 50 in the United States, expecting to rise over 5 million by 2030 (Choi & Meyer, 2016).

The United Nations (UN) lists five principles for older people, namely independence, participation, care, self-fulfilment, and dignity. The latter specifically states that older persons should be able to live free from mental abuse and have the right to be treated fairly "regardless of age, gender, racial or ethnic background, disability or other status" (United Nations Human Rights Office of the High Commissioner for Human Rights, 2011:14). The provision does not explicitly refer to sexual orientation or gender diversity, although "other

status" provides the opportunity for committees to consider "age-related discrimination" (United Nations Human Rights Office of the High Commissioner for Human Rights, 2011:6). The US Department of Health and Human Services asserts that its Healthy People 2020 programme vows to ensure high priority is given to people that have historically suffered discrimination and "less influence or acceptance in society", including gender and sexual orientation status (Healthypeople.gov, 2019). The programme aims to establish goals and objectives for policies, programs, and activities to address the main health issues in the US. Older people are however not explicitly mentioned in this plan.

In the UK, considerable evidence exists of the reluctance of older LGBT people to "come out" to care and staff professionals in old-age facilities (Almack, 2019). Almack and the National Council of Palliative Care (2016) propose a good practice guideline for the care for older LGBT people. These guidelines include:

- Inclusive communication – avoid assumptions that everyone is heterosexual
- Encourage communication with clients through open-ended questions, e.g. Do you have a partner?
- Caretakers should be prepared to meet disclosures about sexual orientation/gender identity in a positive, open manner
- Caretakers should speak openly about LGBT issues where appropriate, e.g. to make language use more general and open
- Clear and visible statements should be developed about policies and procedures related to discrimination
- Links with local LGBT community organisations and LGBT community papers to advertise services should be made to encourage visibility
- Members of staff should function as LGBT champions to spread awareness

Similar guidelines are non-existent in South Africa. The development of such guidelines should however take into consideration the historic corrupt government of South Africa; continuous monitoring and evaluation of these guidelines by independent audit professionals would be necessary. Furthermore, all members of the staff force of care facilities could function as LGBT champions to spread awareness to avoid othering of certain staff members.

In South Africa, the Older Persons Act of 2006 (Act No. 13 of 2006) aims to uphold and protect the status, wellbeing, safety, and rights of older persons. The Act however does not address the unique needs of the LGBT community. Several South African organisations offer support services for managing the life of older persons in terms of "health, finance,

technology and leisure" (Reygan & Khan, 2019:172); however, the inequalities between black and white South Africans would see these services mostly aimed at older white people. In terms of care of the elderly, the issue of affordability becomes apparent in an unequal society such as South Africa. Furthermore, many black South Africans prefer home-based care for elderly families, as is the case in many developing countries. Medical aids however often only emphasise covering for registered institutional care, without the consideration of the unique needs of LGBTI elders (Reygan & Khan, 2019).

While the needs of older people are recognised and upheld in various policies and acts, studies into the needs of elderly care in South Africa, including the needs of older transgender people, seem to lack from the knowledge base. Conducting research on a population of older transgender people in the Cape Metropole could add to the sparse body of knowledge on the subject matter and hopefully encourage further research and policy developments.

2.3.6 Mental health issues specific to older transgender people

2.3.6.1 Transgender, Transsexualism, Gender Dysphoria and Gender Identity Disorder as mental diagnoses

The Diagnostic and Statistical Manual of Mental Disorders Version 5 (DSM-5) published by The American Psychiatric Association (APA) lists Gender Dysphoria (GD) as a mental disorder. GD is characterised by the "marked incongruence between one's experience and/or expressed gender and biologically assigned sex as evidenced by two of the below, present after the onset of puberty" for at a minimum period of six months:

i) A marked incongruence between one's experienced gender and primary sex characteristics
ii) A desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender
iii) A strong desire for the primary and/or secondary sex characteristics of a different gender
iv) A strong desire to be of a gender different from one's biologically assigned gender
v) A strong desire to be treated as a gender different from one's biologically assigned gender
vi) A strong belief that one has the typical response of a gender different from one's biologically assigned gender

The condition is related to distress or continuous impairment in social, occupational, or other important areas of functioning that are clinically substantial (American Psychiatric Association, 2013).

According to the DSM-5, worldwide prevalence of the diagnosis of Gender Dysphoria ranges from 0.005% to 0.014% for adult males and from 0.002% to 0.003% for adult females (American Psychiatric Association, 2013). The APA further asserts that clinically referred adults with Gender Dysphoria often show elevated levels of anxiety and depressive disorders (American Psychiatric Association, 2013).

In the first two publications of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I in 1952 and DSM-II in 1968), no gender diagnosis was included. 'Transsexualism' as a diagnosis (sic), appeared in 1975 in the ninth revision of the International Classification of Diseases (ICD) and subsequently, in the DSM-III in 1980 under the category, Sexual Deviations. A diagnosis was made if the patient exhibited the following characteristics:

i) Discomfort about one's biologically assigned sex
ii) 'Cross-dressing' in certainty or fantasy, as the other sex, but not for sexual excitement
iii) The desire to discard one's primary and secondary sex characteristics and to obtain those of the other sex

The DSM-III also included Gender Identity Disorder of Childhood (GIDC).

The revised version of the DSM-III, namely the DSM-III-R included Transsexualism and GIDC, however, it was no longer categorised as sexual deviations. It was placed under the parent category, 'Disorders Usually First Evident in Infancy, Childhood, or Adolescence' (American Psychiatric Association, 1980), along with Disruptive Behaviour Disorder, eating disorders, and 'tic' disorders. The DSM-IIIR added a new diagnosis, Gender Identity Disorder of Adolescence and Adulthood Non-Transsexual Type (GIDAANT). This addition argues that Gender Identity Disorder (GID) has its onset from childhood, and may or may not persist into adolescence and adulthood. It states that if it does persist, it might not necessarily entail a desire for the primary or secondary sexual characteristics of the opposite sex (American Psychiatric Association, 1987).

With the release of the DSM-IV in 1994, the diagnoses of Transsexualism and GIDAANT were discontinued, but GIDC and GIDAA endured and was categorised under Sexual and Gender Identity Disorders, along with unrelated sexual dysfunctions and paraphilia.

Individuals with intersex disorders experiencing dysphoria due to dissatisfaction with their gender assigned at birth could be diagnosed under the category Gender Identity Disorder – Not Otherwise Specified (American Psychiatric Association, 1994).

The fact that the DSM retained the diagnosis and inclusion of the word 'disorder' was perceived by many as stigmatising and contributing to societal discrimination against transgender people (Karasic & Drescher, 2005). With the release of the DSM-5 in 2013, the diagnosis was retained, albeit with a name change to Gender Dysphoria (GD). This move was hailed by many for removing the stigmatising 'disorder' label and shifting the focus to dysphoria as the target symptom for intervention and treatment (American Psychiatric Association, 2013; Zucker et al., 2013).

It is important to note that the DSM is a manual on mental disorders and thus, despite the name change, GD remains categorised as a mental disorder. The ICD however is not limited to only mental disorders. With the release of the eleventh edition of the ICD on 18 June 2018 (ICD-11), the diagnosis of Gender Incongruence (GI) was removed from the mental disorder section. It is now in a separate section named Sexual Health Conditions (Reed et al., 2016). The World Health Organisation cites that clear evidence now exists that GI is not a mental disorder, and that the classification of it as such can cause enormous stigma for people who are transgender (WHO, 2018). Adding GI under this section will declassify it as a mental disorder; however, it will maintain a diagnosis that will enable access to care through third party reimbursement. It is hoped that it will also eventually lead to the American Psychiatric Association (APA) removing GD from the DSM entirely (Byne et al., 2018).

A diagnosis of GD does not apply automatically to transgender people, however is made to those who,

> "…either exhibit clinically significant distress or impairment associated with a perceived incongruence between their experienced/expressed gender and their assigned gender or who, after transition, no longer meet full criteria, but require on-going care (e.g. hormonal replacement therapy)" (Byne et al., 2018:60).

The fact that a person's expression of gender may be considered a mental disorder may lead to the mental distress experienced by transgender people to be overlooked.

Despite many advances in laws and policies, LGBT discrimination has been indicated as a key factor in the onset of mental health issues later in adulthood (Mays & Cochran, 2001; Russell & Fish, 2016). The Health Service Executive (HSE) in the United States produced a

report in 2009, which looked at meeting the Health Care Needs of Lesbian, Gay, Bisexual, and Transgender People. This report identified key health issues for trans people, including rejection, which contributes to depression, anxiety, substance abuse, and suicidality. The evidence suggests that transgender people around the world are at a higher risk of psychological distress and substance abuse, including experiences of transphobic harassment, discrimination, violence, and stigmatisation (McNeil et al., 2013). International studies have emphasised the relationship between minority stress in transgender people and increased risk of mental health challenges. The high rates of depression recorded among transgender people may be causally related to stresses arising from gender issues. For example, a history of suppression of transgender feelings may result in isolation, loneliness, and feelings of hopelessness (Bockting, Knudson & Goldberg, 2006). In a study of 515 transgender people, 62% of MTF respondents and 55% of FTM respondents met the clinical criteria for depression, while 22% of MTFs and 20% of FTMs reported recurring mental health hospitalisation (Clements-Nolle, Marx & Katz, 2006).

Research suggests that 77–84% of transgender people seriously consider taking their own lives at some point in their life (Mayock et al., 2009; McNeil et al., 2013). This alarming figure is reiterated by the high rate of attempted suicide, with research indicating that between 18% and 54% of trans people attempt suicide (Kenagy, 2005; McNeil et al., 2013). In a study conducted in Ireland on the support of LGBT lives, 80% of transgender respondents reported having seriously thought about ending their lives; 26% reported that they had attempted suicide at least once (Mayock et al., 2009). Some evidence and critique suggest that substance use is a major causal factor of suicide ideation in the transgender community, as substantiated by studies conducted in North America, which illustrates that drug and alcohol use is common among transgender individuals (Nuttbrock et al., 2014). However, as with the general population, transgender individuals' history of substance use varies widely (McNeil et al., 2013).

A 2010 study conducted in the United States on the prevalence of mental health disorders, psychological distress, and suicidality in a diverse sample of LGBT people concluded that 33.3% of participants met criteria for any mental disorder, of which 15% were for major depression, and 9% for PTSD (Mustanski, Garofalo & Emerson, 2010). A structured diagnostic interview was administered to a community sample of 246 LGBT young people between the ages of 16 and 20. The authors assert that many studies excluded sufficient numbers of transgender participants to report on statistics in this understudied population (Mustanski, Garofalo & Emerson, 2010).

A systematic review and meta-analysis of articles published between January 1966 and April 2005 on the prevalence of mental disorder, substance misuse, suicide, suicidal ideation and deliberate self-harm in LGB people was conducted by a team of medical and mental health professionals at prominent UK universities in 2008. In total, 13706 papers were identified, 476 were initially selected, and 28 (across 25 studies) met inclusion criteria. Data were extracted from 214,344 heterosexual and 11,971 non-heterosexual people. The meta-analyses revealed double attempted suicide cases in LGB people. Risk for depression and anxiety disorders and substance abuse proved 1.5 times higher in the LGB community. The transgender community was completely excluded from this study (King et al., 2008).

The focus was shifted to the transgender population in the UK and the Republic of Ireland, when, in 2012, the Scottish Transgender Alliance (STA), together with the Trans Resource and Empowerment Centre, TransBareAll, Traverse Research, and Sheffield Hallam University undertook a study focusing on trans people's mental health and wellbeing. Using this survey aided in understanding the diverse needs of specifically transgender people in the UK and Ireland, and comparing and contrasting it to that of other countries. In the Irish study, participants rated their overall mental health as more positive than negative. On a scale of 1 to 7, with 1 being extremely poor and 7 being excellent, the average score was 4.8 (N=114). No significant differences in scores were present when participants were separated by gender identity, or by stage of transition. Twenty-seven percent (27%) of respondents felt that there was no relationship between mental health and being transgender. Twenty-seven percent (27%) of participants felt that being transgender had a negative impact on mental health, as opposed to 12% who felt it had a positive impact. In terms of specific mental health issues identified most often by participants, 83% (N=100) indicated stress, with depression 82% (N=107), and anxiety 73% (N=100). These results were almost an exact replication of the UK survey, where stress (80%), depression (88%), and anxiety (75%) were the most common issues. These figures may be directly influenced by the available policies and laws catering for the unique needs of transgender people in the UK and Ireland (McNeil et al., 2012).

Although research into the specific mental health issues among transgender people in South Africa is sparse, the country and City of Cape Town is host to the only Transgender Clinic in South Africa. Apart from providing gender reassignment surgery, the Transgender Unit at Grootte Schuur hospital also offers psychosocial support and psychotherapy, as these are valuable interventions in supporting the individual's right to autonomy and self-identification. Transgender individuals are no longer required to live as the self-identified sex or undergo mandatory psychotherapy to progress to sexual reassignment surgery.

The fundamental role of mental health practitioners is evaluative and supportive (Wilson et al., 2014). The literature suggests a higher prevalence of mental health conditions within the LGBT community. South Africa is on the forefront of providing health care services to transgender people, however, research into the efficacy of these services, particularly the experiences of transgender people accessing these services are lacking.

2.3.6.2 Depression

The most prevalent chronic mental health condition affecting older Americans is depression (Pratt & Brody, 2014). With a rapidly expanding older adult population, the World Health Organisation (WHO) predicts depression to be second major cause of disease worldwide within a few years (WHO, 2012).

A 2011 study conducted by Fredriksen-Goldsen and colleagues reveals that 48% of older transgender adults reported depressive symptoms at a clinical level. Similar results were detailed in another study by the same author, which compared prevalence of depression between transgender older adults with cisgender LGB older adults (Hoy-Ellis & Fredriksen-Goldsen, 2017). This was reiterated in a large community-based research project in 2013, which suggests that transgender older adults may be at greater risk of depression than lesbian, gay, and bisexual (LGB) older adults (Fredriksen-Goldsen et al., 2013).

Estimates of the prevalence of depression among older adults in the general population range from 1–5% to 6–8% (Hoy Ellis & Fredriksen-Goldsen, 2017). Moreover, subsyndromal depression among older Americans may range as high as 15% (Fiske, Wetherell & Gatz, 2009). Large community and national Internet surveys screening for clinically depressive symptomatology indicated that rates of depression among transgender adults range from 44% (Bockting et al., 2013) to 48% (Fredriksen-Goldsen et al., 2013), and potentially as high as 55–62% (Clements-Nolle et al., 2001; Clements-Nolle, Marx & Katz, 2006).

Factors such as internalised stigma are a major contributor to the heightened risk of depression among older transgender adults (Fredriksen-Goldsen, et al., 2013). A lack of research into depression among older transgender people exists in South Africa and the African content at large. Research methodologies however were based on less active participation from the sample population. Future research should replicate the above findings, with paying attention to the individual’s experiences of depression as an older transgender person.

2.3.6.3 Anxiety

Anxiety is defined as an emotion characterised by an unpleasant state of inner chaos and subjectively unpleasant feelings of fear over expected events. It is often accompanied by tense conduct such as pacing up and down, somatic complaints, and contemplation (Seligman, Walker & Rosenhan, 2000; Davison, 2008).

Research suggests the presence of higher rates of anxiety among transgender people as with the general population. A comparative study conducted in Europe (Spain, UK and Belgium) to determine anxiety symptomatology in a non-treated transgender population and comparison to that of a general population sample (matched by age and gender) revealed that transgender people had an almost threefold increased risk of probable anxiety disorder. In total, the sample consisted of 913 individuals who self-identified as transgender attending a transgender health service during a three-year period, with 3,816 people from the general population. Sociodemographic variables and measures of depression and anxiety (HADS), self-esteem (RSE), victimisation (ETS), social support (MSPSS), and interpersonal functioning (IIP-32) were used as tools to measure various stressors that may cause anxiety symptoms. The study concluded that transgender people (particularly trans males) have higher levels of anxiety symptoms indicative of possible anxiety disorders compared to the general population. The study also found that self-esteem, interpersonal functioning, and hormone treatment are related to lower levels of anxiety symptoms, which indicates the need for clinical interventions targeting self-esteem and interpersonal problems and highlights the significance of rapid access to transgender health services (Bouman et al., 2017). The study focused only on a wide population of participants across the age spectrum and did not consider mental health care challenges that older transgender people struggle with.

A systematic review of the literature published from 1966 to April 2016, indicates elevated levels of anxiety symptoms and disorders among transgender people attending gender services. In total, 25 cross-sectional (N=17) and longitudinal (N=8) studies were reviewed. Cross-sectional studies describe a higher occurrence of anxiety symptoms in the transgender group than in the general population. The literature suggests the prevalence of common anxiety disorders, e.g. specific phobias, social phobias, panic disorders, and obsessive-compulsive disorders. The prevalence of anxiety disorders ranges from 17% to 68%, predominantly before commencement of Hormone Replacement Therapy (HRT). Furthermore, social anxiety and panic attacks appear to be common. The authors however believe more rigorous studies should be conducted to confirm that the latter are needed

(Millet, Longworth & Arcelus, 2017). The study population consisted of all races, ethnicities, cultural groups, and ages, and thus did not consider anxiety experienced by the older transgender community.

A 2013 study conducted in the United States aimed to examine facilitative and avoidant coping as intermediaries between distress and transition status, social support, and loss among transgender individuals. The sample consisted of 351 transgender individuals (N=226 transgender women and N=125 transgender men). The participants completed questionnaires based on the Multidimensional Scale of Social Support (MSSR), Ways of Coping (WC-R) scale, Transgender Perception of Loss Scale, Centre for Epidemiologic Studies Depression Scale (CES-D) and Burns Anxiety Inventory (BAI) instruments. These instruments measure transgender identity, family history of mental health concerns, perceptions of loss, coping, depression, and anxiety. Of the 351 participants, 40.4% of transgender women and 47.5% for transgender men experienced high rates of anxiety, which is significantly less that the general population. The findings suggest that a considerable number of the participants used avoidant coping as a measure to address distress caused by transitioning, social support, and loss. Avoidant coping occurs when a person attempts to avert an emotional response to a stressor, for example, trying to disengage oneself from the outcomes of a problem, or overeating or drinking. The study concluded that a need exists for practitioners to focus on interventions that reduce avoidant coping strategies, while simultaneously increasing social support to improve mental health for transgender individuals. Those who are in the beginning phase of their transition will use different coping strategies than those who are in later stages. Professional interventions should thus be adjusted based on transition status of transgender clients (Budge, Adelson & Howard, 2013). This study, although significant in considering the adjustment of coping strategies based on the stage of transition, did not consider the experiences of older transgender individuals.

2.3.7 Transgender intersectionality

As established by the intersectional model, it can be deduced that that there are factors other than their gender that classify a person. Individuals who identify as transgender are concurrently associates of other diverse social groups that add to their individualism (Gerwe, 2019). According to Zabus and Coad (2013), people in the trans community do not experience or express gender separately from other social positions they occupy. Furthermore, Gerwe (2019) points out that the society often assume that beauty transpires in certain privileges such as cultural-racial identity and social class. This holds especially true in a post-Apartheid South

African context, where the notion that white-privilege and upper-class societies are associated with physical beauty. The popularity of famous transgender people such as Caitlyn Jenner in all spheres of media adds to the impression that to be transgender requires medically transitioning from one's biologically assigned sex to one's gender identity (Nicolazzo, 2016). The pressure then falls heavily on transgender people to obtain expensive surgery, despite socioeconomic status often preventing such interventions. Similarly, age may also prevent a person from gender reaffirming surgery. As older people might be married, in a relationship or have children, they might fear apprehension from family or their partner should they opt for gender reaffirming intervention (Gerwe, 2019).

When accessing mental health care services, professionals need to bear in mind the various interactions of a transgender in terms of their race, age, socioeconomic, and cultural background. Mental health professionals need to highlight these diversities in their therapeutic approach and adjust current approaches to see to the needs of their transgender clients holistically by using an intersectional model (Gerwe, 2019). A study by McCullough et al. (2017) on the experience of 13 transgender individuals who accessed mental health care intervention reveals that the transgender participants value a warm and empathic setting. Furthermore, participants indicated they prefer that therapists do not overemphasise their gender identity and that they do not assume issues with their gender identity is the focus of intervention (McCullough et al., 2017). Health care professionals should also recognise the value of support and association with significant others, health and mental health professionals, and the community at large (Gerwe, 2019).

The literature evidence base suggests that a range of factors, such as (among others) race, culture, socioeconomic status, and age intersect with a person's gender identity to establish their experience as transgender person. Research explored is limited on the experiences of transgender people at the intersection of gender identity, race, and socioeconomic status, especially with respect to these minority statuses' connotations with increased anxiety, high risk of depression and minority stress. It can be concluded that the consideration of these factors when studying the mental health care challenges of older transgender people, will aid in better understanding their unique lived experiences.

2.4 Conclusion

This chapter discussed the theoretical framework applied in the study and the existing empirical literature relating to the mental health needs pertaining specifically to older

transgender people. An intersectional theoretical framework, which has its roots in feminism, was discussed and applied to this study. This literature review unpacked key concepts in terms of the study, including gender identity, gender expression, and sexual orientation to place the study into context.

The general findings within this literature review suggest that older transgender people are at higher risk of developing mental health conditions. This is attributed to causal factors such as minority stress, internalised transphobia and a general misunderstanding of the complexities experienced by transgender people. Furthermore, the history and current interpretation of gender-related mental health care diagnoses such as Transgenderism, Transsexualism, Gender Identity Disorder, and Gender Dysphoria were discussed. The literature suggests a higher prevalence of depression and anxiety among older transgender than with the general population. The intersection of race, age, and socioeconomic status plays a key role in a transgender person as viewed by themselves and the broader community. Internalised transphobia and societal expectations were cited as adding to mental distress experienced by transgender people. Mental health care professionals need to be aware of the impact of these intersections and adapt their theoretical approach accordingly. This holds particularly true since a significant lack of research on mental health care needs of transgender people exists in South Africa and the rest of the world, with only a few key researchers and authors exclusively involved in the subject matter.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

Research methodology refers to the procedure followed by researchers to conduct their study, in terms of by describing, explaining, and predicting phenomena (Rajasekar, Philominathan & Chinnathambi, 2013). In Chapter Two, current literature was reviewed on mental health care needs of transgender and older people to gain a better understanding of the study topic.

Chapter three aims to describe the appropriate research methodology applied to this study. A detailed discussion covers the research question, the study's aims and objectives, the research approach, the study's design, the target population, and sample as well as data collection procedures and instruments used to achieve the research aims. A qualitative research approach was used as it employs an "array of attitudes and strategies for conducting an inquiry that are aimed at discovering how human beings understand, experience, interpret, and produce the social world" (Sandelowski, 2004:893). Qualitative research emphasises words instead of using quantification in the collection and analysis of data (Hammersley & Campbell, 2012).

3.2 Research question

The research question acts as a guide to the investigation and narrows the topic of the research project. This includes the search for literature, research design, data collection process, data analysis, explanation of findings, and the course of the argument (White, 2009). The research question for this study was:

> **What are the mental health care challenges experienced by older transgender people in the Cape Metropole, Western Cape?**

3.3 Aim of the study

Bryman (2004) defines a research aim as a broad statement of anticipated outcomes, or as the general purpose of what the research wishes to achieve. With specific reference to this current study, the aim of the research was to determine the mental health care challenges experienced by older transgender people in the Cape Metropole, Western Cape.

3.4 Research objectives

The objectives of research describe what we anticipate achieving by a study. Research

objectives, as a statement, can aid to guide the activities of research (Soas.ac.uk, 2019). The objectives of this study were:

- To explore and describe the unique challenges faced by older transgender people in the Cape Metropole, Western Cape
- To explore and describe the experiences of older transgender people when accessing mental health care in the Cape Metropole, Western Cape
- To explore and describe strategies of addressing mental health care needs of older transgender people in the Cape Metropole, Western Cape

3.5 Research approach

A qualitative research approach, employed by this study, can be defined as a systematic method where case studies, semi-structured interviews, and coding are used with marginalised groups to recognise and test the knowledge, experience, and power of researchers in the research process (Hoeber & Shaw, 2017). Qualitative research on the other hand prompts quantities and percentages that have the status of 'facts' (Barnham, 2015).

The methodology used for this research was a qualitative approach designed to answer questions and best reflect the participants' experiences in the context of their daily lives. Qualitative research can employ various theoretical notions, while quantitative methodology explores a particular theory (Eriksson & Kovalainenn, 2015). Qualitative research also enables researchers to form part of the research process and be included in social actions. Since the output of the research was narrative and reported in the spoken words of participants (Taylor et al., 2015), a qualitative approach was deemed appropriate for the study. This method facilitated an in-depth understanding of the subject matter, which afforded the researcher an understanding of social actions rather than generalising from a population as with quantitative methods (Lewis, 2015). The researcher had to be vigilant in remaining objective and unbiased, while upholding key social work skills and values such as confidentiality, active listening, empathy, and professional boundary setting.

3.5.1 Research design

A Participatory Action Research (PAR) design was utilised which enabled the participants to become actively involved in identifying, investigating and formulating solutions to the problem (Bertram & Christiansen, 2014). PAR aims to enable people within a community to solve the presenting problems within their community by themselves. PAR is thus referred to as a "change-generating" research design (Bertram & Christiansen, 2014:47). Participants

engaged in PAR to identify the challenges they face when accessing mental health care as an older transgender person. The participants were asked to photograph and describe a situation/object/subject within their community to best describe the challenge. Focus groups were used to determine common themes, where participants provided input on suggested solutions to the identified challenges.

Paulo Freire, who is often associated with PAR, states that solutions should not originate from the oppressors aiding the oppressed, but rather from the oppressed themselves (Bertram & Christiansen, 2014). PAR complemented the intersectional theoretical framework that guided this study, as the research was conducted in a population that is marginalised based on their age, gender expression, and gender identity.

3.6 Population and sample of study

Population refers to the total number of people that could be included in a study (Bertram & Christiansen, 2014). The target population for this research comprised individuals who identify as transgender, aged 50 years or higher, and who had not been clinically diagnosed with a mental illness. The accessible population was the aforementioned target population residing in the Cape Metropole area of the Western Cape. The social workers and key informants were recommended by Gender Dynamix and approached by the researcher to request voluntary participation in the study.

3.6.1 Sample and sample size

The sample size of a study refers to the number of participants selected from which data were gathered. Moreover, the final sample size refers to the number of completed interviews or participants from which data were collected (Lavrakas, 2008). Samples in qualitative research are generally small to maintain the depth of the data analysis (Sandelowski, 1996).

The sample size was deemed sufficient, as data were representative of the participants' experiences of mental health care challenges in their daily lives. The final sample population consisted of five (5) participants and five (5) key informants. An initial meeting with Gender Dynamix where participants were accessed addressed the participant recruitment process. Inclusion criteria were as follows: i) identifying as transgender; ii) aged over 50 years; iii) a resident of the Cape Metropole area; and iv) with current or previous mental health challenged. Individuals who have been clinically diagnosed with a mental illness were not included in the study, as this could render the participant biased towards the service they were

currently receiving. Key informants including social workers at various institutions were also interviewed to triangulate the collected data.

3.6.2 Sampling procedure

Sampling refers to the process or technique of choosing a sub-group from a population to participate in the study. It entails the selection of several individuals for a study to such a degree that the selected participants represent the large group from which they were selected (Ogula, 2005).

Snowball sampling was used to select and find participants and key informants for the study. This method of sampling calls for well-informed individuals with extensive knowledge about a phenomenon to identify critical issues. This method is also useful in the identification of instrumental cases that are identified by expert informants as important (Cohen & Crabtree, 2006). Snowball (or network sampling) was appropriate for this study, as it could prove difficult to get participants due to the stigma surrounding mental health and gender diversity. It also serves as a suitable methodological tool when focusing on sensitive or private matters (Waters, 2015). Furthermore, many transgender individuals go back to a closet-lifestyle due to discrimination and stigma.

Sampling commenced with the researcher contacting a few potential respondents provided by health care professionals who work primarily with transgender clients. Given the narrow sample requirements, respondents were then asked if they know of any potential respondents who fit the inclusion criteria and might be interested in participating in the research, by providing the researcher with an introduction to the potential participant (Griffith, Morris & Thakar, 2016).

Snowball sampling tends to be more effective when potential respondents are unlikely to identify any negative consequences from participation in the study (Waters, 2015). The researcher thus interviewed each potential respondent personally or telephonically to address any concerns. The sampling procedure took much longer than anticipated, however, contact with potential participants gave the researcher further insight into the intricate challenges experienced by the transgender community. It became evident that the social classifications within the trans community (such as their racial background, gender, sexual orientation, and socioeconomic status) intersect and influence their experience as a transgender individual very differently.

For example, one potential participant (55 years old, white, MTF, agnostic) advised the researcher that she had her gender reassignment surgery performed in Thailand and remained touring the Far East for months after the procedure. She exclaimed that her family and friends supported her from an early age and that she rarely experiences major prejudice. According to her, she did not understand why so many transgender people in South Africa are impatient to have their gender reassignment performed. This experience was one of many encounters the researcher had with potential participants, which echoed how the social classification of people can intersect to shape their view of the world through a lens of privilege or oppression.

Throughout the sampling procedure, the research aim, objectives, and data collection methods were explained to the potential participants.

3.7 Qualitative data collection process

Qualitative data collection is a process whereby the researcher obtains information through structured or semi-structured interviews, observation, and visual material (Creswell, 2013). Various data collection methods were used for this research, including:

- Photo voice by the transgender participants
- Focus groups with the transgender participants
- Semi-structured interviews of the key informants

The data collection for each of the above will be explained below.

3.7.1 Participants

Photo voice was used as a data collection method, which aided the participants in helping others see the world through their eyes (Palibroda et al., 2009). Photo voice is a method designed to empower marginalised groups to represent and enhance their communities by telling their stories as it relates to the photographs they take (Wang & Burris, 1997; Palibroda et al., 2009). Photo voice at its core draws upon theories of Paulo Freire's participatory education and the feminist approach of focusing on giving a voice to the marginalised (Wang & Burris, 1997). Data collection in photo voice is a continuous process and is thus constantly evolving (Palibroda et al., 2009). Photo voice data collection includes taking photographs, participation in recorded discussions and guided dialogues, writing journals, and may end with an exhibition of the findings, feedback, and debriefing (Palibroda et al., 2009). Focus groups were conducted in English with the older transgender sample over a period of 10 sessions (Annexure A).

A focus group can be defined as small, varied group of people whose responses are studied through guided or open discussions (Merriam-Webster, 2017). The group met continuously to maintain motivation among the participants and to support each other to discuss any difficulties in presenting visual data (Wang, 2003). Participants each received a disposable camera, which they were required to use to take photographs over a course of four weeks. The photography process was discussed through interviews during sessions 3 to 7. Sessions 8 to 10 focused on data analysis and discussion of collective themes that emerged among the group. Powers, Freedman and Pitner (2012) suggest providing digital cameras to the photo voice participant to photograph their community. These cameras should then be donated to participants upon completion of the project as an incentive. The participants instead received a disposable camera. Providing cheaper disposable cameras eliminated the financial repercussions, which could result from loss or theft of the more expensive digital cameras. It also ensured that photographs could only be produced in print form, thereby eliminating the risk of ethical and privacy violations, which may have resulted from sharing photos online through social media.

3.7.1.1 The preparation of participants

The researcher attended a gender sensitisation workshop, whereby training was provided by Gender Dynamix on how to address and provide an inclusive service to transgender individuals. The approaches and terms discussed during the workshop formed the basis for any contact the researcher had with the participants. The researcher took on the role of educator, whereby key terms (e.g. gender reaffirming instead of gender reassignment) were shared with the participants.

Preparation of the participants was done during Session 1, where the research aim and objectives were discussed. The researcher had to ensure that rapport was built and the objectives of the coming sessions were explained to participants. Each participant was provided with pens, and two blank books, one for writing a reflection about the photo and the second for writing down any ideas, reflections and questions they might have had for discussion in upcoming sessions. The participants were advised of confidentiality within focus groups, and informed of what confidentiality means and how to remain confidential throughout the project. Session 1 ended with participants signing informed consent letters and a confidentiality clause. They were also advised that they could end their participation at any time during the project, without any repercussions to them.

The take home exercise for Session 1 was an instruction to write a journal about themselves, including where they were at that stage in the gender reaffirming process. During Session 2, the photo voice method, photography skills, and journaling skills were introduced and discussed with the participants. Each participant was issued with a disposable camera. Various scenarios were discussed, including ethical practice when taking photos, the safety of participants, and the way to operate the disposable camera.

3.7.1.2 Course of the focus groups

Focus groups are organised conversations with a small group of purposefully selected participants who focus on a particular research topic. These groups are generally guided by a semi-structured, open-ended questionnaire or certain focus group scenarios (Gaižauskaitė, 2012).

Sessions 3 and 4 consisted of focus groups whereby participants were provided the opportunity to reflect on their experience and discuss any challenges and ideas about their photos. Participants were advised to take at least 10 photos per week and write down how the photograph relate to their feelings, experience, and view of the world as they go about their daily lives. During these sessions, the researcher made notes that were later used for self-reflection, which were also useful in guiding the course of the focus groups. Throughout these sessions, the researcher had to be vigilant against any possible bias by making sure questions were objective and neutral. Each focus group lasted approximately 90-120 minutes.

In Session 5, the cameras were collected from the participants. The session consisted mainly of participants reflecting on the data collection process and their feelings around using a camera and journaling as a method of telling their stories.

During Sessions 6 and 7, the researcher displayed the developed photographs to the participants, and they were allowed the opportunity to tell the group why they took the photo and their feelings around the subject in the photo. The sessions were recorded by the researcher and together with the journals, transcribed to enable data analysis.

Session 8 was a termination session, whereby the researcher presented the themes that emerged from the data analysis to the participants. The researcher had to remain aware that termination is a critical phase of group work practice and that the researcher and members would now form their lasting impressions of the group (Toseland & Rivas, 2012). The researcher had to be observant of possible feelings of loss from participants. This was

achieved by revisiting the aim and objectives of the research. Each focus group session followed the following four steps as proposed by Gaižauskaitė (2012):

Step 1 – Each session was introduced by greeting the participants and revisiting the research purposes. The researcher also reviewed research ethics and reminded participants that the sessions were audio recorded. Care was taken by the researcher to ensure that each member of group discussion is respected.

Step 2 – Each session was preceded by a general discussion of how each participant personally relates to the discussion topic. This was done to avoid vague input by going straight to the main discussion points.

Step 3 – During the discussion of topics, the researcher took care to avoid close-ended questions. The researcher had to remain patient, as some participants were not able to answer a question immediately. Only after prolonged silences, the researcher paraphrased a question to avoid participants feeling interrupted and evade their answer. This method is especially important for focus group discussions with vulnerable groups in a social work context. The researcher had to take note of the generally silent participants and encouraged them to express their opinions or experiences. Referential questions were used to address this issue, for example:

> *Interviewer: P just shared the guidance she received from mental health care professionals when she started her hormone therapy...Sandy (a silent participant), what is you experience with that?* (Focus Group Session 5–25 May 2019).

The researcher also elicited involvement by referring to past experiences during discussions. For example, to elicit discussion of experiences with minority stress, the researcher posed the following question to the group:

> *Remember the last time that you experienced a transphobic comment in a public space…how did that make you feel?* (Focus Group Session 4–11 May 2019).

Follow-up or clarifying questions were also used, for example:

> *Do you mean the man behind you deliberately spoke loud so others around him could also take note of you?* (Focus Group Session 4–11 May 2019).

Lastly, the researcher continuously used hypothetical questions, for example:

> *If you were responsible for the process of changing your name or gender marker with Home Affairs, what would you change or improve?* (Focus Group Session 6–29 June 2019).

Step 4 – Each discussion was summarised, and participants were asked to add their final input into the discussion or express any ideas that have been omitted but are important to them.

3.7.1.3 Instrumentations used during data collection

During the focus groups, the researcher facilitated debate by making use of open-ended questions. The effectiveness of the use of open-ended questions in focus groups is reiterated by Singer and Couper (2017:117), who identified seven primarily methodological uses of open-ended questions, namely:

- "Understanding reasons for reluctance or refusal;
- determining the range of options to be used in closed-ended questions;
- evaluating how well questions work;
- testing methodological theories and hypotheses;
- checking for errors;
- encouraging more truthful answers;
- and providing an opportunity for feedback."

Throughout the focus groups, the researcher employed the SHOWeD instrument (Annexure B) whereby participants were required to answer five questions about their photographs:

S: What do you **S**ee here?

H: What is really **H**appening here?

O: How does this relate to **O**ur lives?

W: **W**hy does this situation, concern, or strength exist?

D: What can we **D**o about it?

The researcher also used the SHOWeD instrument to transcribe participant narratives and journals during the focus groups.

3.7.2 Key informants

To triangulate data, individual interviews were conducted with key informants, including Gender Dynamix and social workers dealing with mental health challenges of older transgender people. Five key informants were recruited through snowball sampling. The key

informants all rendered health care services primarily to transgender people in the Cape Metropole.

3.7.2.1 The preparation of key informants

Individual in-depth interviews were conducted with the key informant sample. Individual in-depth interviews refer to the elicitation of data for research through the questioning of participants. Qualitative (or in-depth) interviews have an informal, conversational quality, shaped in part by the interviewer's pre-existing topic guide. In contrast, quantitative interviews are conducted in surveys (Bloor & Wood, 2006). Key informants were advised of the background and rationale of the study and were required to sign a confidentiality form.

3.7.2.2 Course of the interviews

Social work interviews have a distinct beginning, middle, and end. The interview process is the purposely-active movement through consecutive stages to accomplish the purposes of the interview (Kadushin & Kadushin, 2013). Semi-structured interviews were used to collect data from the key informants. When referring to semi-structured interviews, we mean that the questions have some categorical structure to them in terms of theory or technique, but are not fully structured (Blandford, 2013). The structured component of the interview consisted of a set of predetermined questions drawn from the literature and theoretical framework (Annexure C), but took on open-ended questions as the interview progressed. The latter was done to elicit clearer information from the key informant.

3.8 Qualitative data analysis method

Data analysis entails the process of exploring, investigating, and contrasting the data collected (Palibroda et al., 2009). In photo voice, data analysis cultivates a better understanding of the issue being addressed. Through analysis of the data, the researcher and the participants are able to identify general themes and patterns (Palibroda et al., 2009). The photos and memos from the participants' journaling and interviews were analysed and stored using Atlas.ti qualitative data analysis software. Utilising this software enabled easy linking of themes and concepts to the photographs, and integration of the theoretical framework and review of the literature.

Researchers often report a 'gap' between the collected data (i.e. the outputs of the interviewing process) and the analysis of the data. Qualitative methodology requires

respondents to disclose the distinctions they make. Analysis should therefore be interpreted as a continuation of the process of defining and redefining how transgender people make these distinctions. This investigation always starts during the interview process and continues in the analysis stage in the absence of the respondent (Barnham, 2015).

Thematic analysis was used as a method of data analysis for this study. Thematic analysis is a technique for recognising, examining, organising, describing, and reporting themes found within a data set (Braun & Clarke, 2006). This method of data analysis offers a more accessible form of analysis and does not require in-depth theoretical and technological knowledge of other qualitative approaches (Braun & Clarke, 2006). Thematic analysis was thus useful for this study, as it provided an effective method for exploring the perspectives of dissimilar research participants, allowing for the highlighting of similarities and differences, and producing unanticipated perceptions (Braun & Clarke, 2006).

The 6 phases of thematic analysis as proposed by Braun and Clarke (2006) were followed to analyse the data. These phases were implemented as follows:

Phase 1: Familiarisation of data

Before this phase could commence, the researcher had to transcribe the verbal data from the interviews and focus groups into written data. Transcribing is the process of constructing audible and visual data into a written form and represents the first step in analysing data Bailey (2008). The researcher had to ensure that this process remains rigorous and thorough by transcribing verbatim, i.e. account of all verbal and nonverbal (e.g. coughs) statements.

The researcher had to ensure the transcript maintains the information from the verbal account to remain true to the nature of the interview (e.g., punctuation added can alter the meaning of data, for example, “I hate it, you know. I do” versus “I hate it. You know I do”). During this phase, the researcher actively read and re-read the transcribed interviews and focus groups. The aim of this step was for the researcher to search for meanings and patterns (Braun & Clarke, 2006). As the researcher read the transcriptions, possible patterns were starting to take shape. The researcher made notes and marked certain ideas for coding.

The close attention needed to transcribe the interviews facilitated interpretation, which later aided in analysing the data.

Phase 2: Generating initial codes

After the researcher familiarised himself with the data, he generated an initial list of ideas that

he found interesting about the transcriptions (Annexure D). Phase 2 involves generating initial codes from the data. When referring to codes, it requires the identification of certain features of the data that appear interesting to the researcher. Codes are "the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon" (Boyatzis, 1998:63). With the Atlas.ti software, the code is the object used to label sections in data. A code can thus be a category, a theme, an attribute, a property or a sub code (Friese, 2014). The researcher generated these codes in the Atlas.ti software by looking for code frequencies. During this phase, the researcher had to make an informed decision about which ideas will be coded, and this helped avoiding the software to guide the analysis (Friese, 2014). The researcher worked systematically through the entire data set (the literature review, interview and focus group transcriptions, journals, and descriptions of photographs) and identified interesting characteristics in the data that formed the basis of repeated patterns (themes) across the data set. See Annexure E for an extract of codes applied to a short section of data.

Phase 3: Searching for themes

Phase 3 commenced after the data were initially coded and organised, with the researcher sorting the different codes into potential themes. The researcher started to analyse codes by considering how different codes combine to form a predominant theme.

This phase was concluded with a collection of main themes and sub-themes, and all extracts of data that have been coded in relation to the themes. At this stage, the researcher got a sense of the connotation of distinct themes. The researcher however did not abandon anything yet, as the next phase required a more detailed look at all the themes where some could potentially be combined, refined, separated, or discarded (Braun & Clarke, 2006).

Phase 4: Reviewing themes

Phase 4 started when the researcher already had a set of possible themes, and involved the refinement of these themes. During this phase, some of the possible themes were identified as not being themes in a true sense, for example, not enough data to support the themes, or too diverse data, such as a possible theme of loneliness, but no data suggest that loneliness is attributed to being transgender or lacking mental healthcare. At this point, some of the themes collapsed into each other, where two seemingly separate themes formed one theme, for example, two separate themes – Stressors and Transphobia – formed one theme named Minority Stress. The researcher had to ensure that the data within themes bind together in a meaningful manner with clear and identifiable distinctions between the themes (Braun &

Clarke, 2006).

The themes were reviewed and refined on two levels. Level 1 involved the revision of the coded data extracts, where the researcher re-read all the collected extracts for each theme and reflected whether they appear to form a rational pattern. Where the possible themes appeared to form a rational pattern, the researcher applied Level 2, which involved revising the entire data set. At this level, the researcher had to consider the validity of individual themes in relation to the data set. The theoretical framework had to be considered at this level to account for accurate representation. For example, in terms of intersectionality, religion would not be an accurate representation of oppression of the participants. Christian participants indicated that they were not discriminated against by their church or family, whereas a Muslim participant indicated she was also welcomed in her religious circles as a transgender woman, however, she is aware of transphobia in the mainstream Muslim religion. During this phase, the researcher re-read the entire data set for two purposes. Firstly, to establish whether the themes were relevant in relation to the data set, and secondly to code any additional data within themes that were overlooked in earlier coding stages. Braun and Clarke (2006) assert that coding is an on-going gradual process, hence the process can be repeated during this first four phases of data analysis.

The researcher had to repeat reviewing and refining the coding until a thematic map was devised. At the end of this phase, the researcher had identified the various themes. The themes could link together in terms of the theoretical framework, i.e. how the participants' social classification intersected in terms of age, gender identity, and social class to form their notions of privilege and oppression with regard to mental health care. The researcher also had to note the overall story of the themes in relation to the data.

Phase 5: defining and naming themes

After the researcher developed a satisfactory thematic map of the data, Phase 5 commenced to do final refinements. During this phase, the researcher had to define and further refine the themes to be presented, and analysed the data within these themes. Defining and refining entail the identification of the core meaning of each theme, and all themes as a whole. The researcher took care not to merely paraphrase the content of the data extracts, but to identify what is interesting about them and why. For example, the main theme of anxiety was of interest, as key informants advised that transgender people sometimes hide their anxieties to present the best version of themselves when accessing subsidised health care services. All participants indicated a long history of anxieties throughout their lives, whether it was before,

during or after hormone replacement therapy and/or gender reaffirming surgery.

As part of the refinement, the researcher identified sub-themes contained within the main themes. Sub-themes are defined as themes-within-a-theme and can be beneficial for providing structure to a large and complex theme, and for demonstrating the hierarchy of meaning within the data (Braun & Clarke, 2006). For instance, the researcher identified three predominant themes in the data, Constant Anxiety, Gender Identity, and Coming out. Within each theme, sub-themes were identified. Braun and Clarke (2006) recommend testing to see if the scope and content of each theme can be described in a few sentences. This is essential to defining what the themes are, and what they are not. Each theme had to be named to ensure it is brief, effective, and offers the reader an immediate sense of what the theme entails.

Phase 6: Producing the report

Phase 6 involves the concluding analysis and presentation of the findings. The researcher was required to tell the complex story of the data in a way that guarantees the reader of the quality and validity of the data analysis. The researcher had to ensure that the analysis provides a comprehensive, rational, logical, non-repetitive, and interesting account of the story the data tell – within and across themes. Extracts were included to demonstrate the prevalence of the theme and to provide sufficient evidence of the themes within the data. For example, direct quotations (including Afrikaans language and non-verbal cues) were included to capture the essence of the point being demonstrated. The researcher remained self-reflexive throughout this phase, which aided in making an argument in relation to the research question.

3.9 Qualitative data verification

3.9.1 Trustworthiness

3.9.1.1 Credibility

Triangulation was used to aid in establishing credibility, thereby contributing to trustworthiness. Triangulation refers to the presentation and grouping of several research methods while studying the same phenomenon (Bogdan & Biklen, 2006). Furthermore, continued engagement with research subjects ensured further credibility of the study (Dye et al., 2000).

The researcher performed triangulation by asking the same research questions to the various participants and by collecting data from various sources through different methods to answer the same questions (Dye et al., 2000). This was achieved by collecting data from the participants in the form of photographs, journals, and focus group interviews. Data were

collected from the key informants through semi-structured interviews. By applying data triangulation, the researcher was able to avoid inherent biases that could occur from using a single data collection method.

Member verification were also conducted, where the researcher asked participants to review the data collected and the researcher's interpretations of that data (Dye et al., 2000). This enabled the participants to verify their statements and fill in any gaps from previous interviews (Dye et al., 2000) while aiding in building trust between the researcher and the participants.

3.9.1.2 Transferability

Transferability refers to the generalisation of study findings to apply it to different situations and contexts (Dye et al., 2000). Although researchers are not always able to prove that the outcomes of the data interpretation are transferable, they may establish its likelihood (Dye et al., 2000). Transferability in this research aimed to identify the phenomena and invoke a clear definition of the problem. Since qualitative research is not typically generalisable according to quantitative criteria (due to a smaller number of participants), the researcher was aware that it could prove difficult to relate the research findings to other populations (Moon et al., 2016).

To establish the probability of transferability, the researcher utilised purposive sampling, which is a form of non-probability sampling generally used to maximise explicit data in relation to the context it was collected (Dye et al., 2000). This method is in contrast to the summative data outcomes in quantitative research. Purposive sampling takes into consideration the characteristics of the sample, in direct relation to the research question (Dye et al., 2000). The researcher only used a sample of older (50+) individuals who identified as transgender and resided in the Cape Metropole.

3.9.1.3 Dependability

Dependability of the research was upheld by the researcher through documenting the research design and providing detailed information of the data collection, including field notes, memos, photos, and journals. Furthermore, sufficient details and contextual information were provided by means of detailed background of each participant and key informant.

3.9.1.4 Confirmability

Conformability refers to the ability of a study to be replicated by the researcher to

demonstrate that the findings are the outcome of independent research methods and not of conscious or unconscious bias (Dye et al., 2000). Through PAR, the researcher was able to achieve conformability by demonstrating that the research findings are clearly linked to the conclusions and can thus be replicated.

3.10 Ethics considerations

The Senate Higher Degrees Committee of the University of the Western Cape approved the research and granted ethical clearance for the study. Participation was voluntary, and participants gave permission for the use of a voice recorder during the interviews. The researcher assured participants of their right to withdraw from the research study at any stage. The researcher also prepared participants for possible emotional reactions due to the research and offered to refer them to another person for counselling if necessary. However, this did not occur in the study.

The researcher ensured anonymity and confidentiality during the study through assigning pseudonyms to the participants. Prior to commencing with the interviews and focus groups, participants and key informants were informed of the purpose of the study by means of an information sheet (Annexure F), and an informed consent form (Annexures G1 and G2) was signed by participants and key informants. The data (including signed forms, photos, audio recordings, transcriptions, and journals) were stored within the Atlas.ti software package, and only the researcher had the password for the data. The software resided on a biometric protected (fingerprint access) personal computer and backed up on a password protected, encrypted cloud service.

A memorandum of understanding (MoU) was signed between UWC and Gender Dynamix, which stated that Gender Dynamix would recommend and provide the participants; it would also offer guidance to the researcher to conduct research in an ethical manner within a gender diverse population (Annexure H). Gender Dynamix conducted a workshop with the researcher and stakeholders on sensitisation pertaining to the transgender community. The research was based on the participants' volunteered informed consent. This means the researcher was responsible to explain, fully and meaningfully, what the research entail and how it would be publicised (Corti, Day & Backhouse, 2000). All participants were required to sign a consent form that the participant, researcher, and stakeholders vowed to uphold in terms of confidentiality, privacy, and integrity during the study.

The researcher explained to the participants why the study was conducted and how the

information would be used. They were provided with the contact details of the researcher for any further information on confidentiality and anonymity issues. Confidentiality in research refers to the safeguarding of information obtained in confidence during the research (Wallace, 2009). The collected data (including photographs, audio, journals, and transcribed interviews) were stored in a locked filing cabinet in a locked office, accessible only by the research supervisor through Atlas.ti. Upon conclusion of the research project, the collected would be to be destroyed. The personal identity of participants was ensured, as pseudonyms were used. Participants were advised that should any issue arise in terms intervention that is needed, the individual would be referred to a suitable professional for debriefing. The participants were also informed that their participation was voluntary, and that they could withdraw at any time.

Given the fragile nature of the participants being a historically marginalised group, the researcher discussed ethical conduct with the participants throughout the focus groups. Using focus groups as a method of data collection opened the possibility of distressing information being shared by the participants, and the group thus had to be fully aware of the true meaning of ethical behaviour. Participants were required to sign a focus group confidentiality binding form (Annexure I). Ethics were incorporated throughout the study, with the focus on three key concepts as proposed by Sim and Waterfield (2019):

Consent – The purpose of consent is to add merit to the actions of the researcher. Walker (2018:131) describes consent as "an act that would have been impermissible for some reason is no longer impermissible for that reason". Consent is centred on the concept of autonomy and can thus be seen as a way to protect and support autonomous decision making by the participant (Sim & Waterfield, 2019). Participants received training and guidance on ethics and safety (Annexure J) to ensure that their data would be collected in an ethical manner.

Disclosure and consent – A potential issue in terms of consent in focus groups is the possibility of the disclosure of sensitive information, particularly with qualitative research, design, and methods that are continuously developing instead of being pre-specified as with quantitative research. This makes it difficult to envisage what might occur in a study, more so in focus group research, as participants may impulsively raise issues not necessarily proposed, or foreseen, by the researcher (Sim & Waterfield, 2019). The researcher had to consider these possibilities and continuously remind participants that the group is not therapeutic in nature, but rather participatory to aid in gathering information to improve the quality of life of their marginalised community.

Confidentiality and anonymity – Confidentiality refers to how information is treated and disclosed to others once it is gathered by the researcher. In contrast, anonymity describes the extent to which participants can relate to the data provided by them (Sim & Waterfield, 2019). Participants and key informants were advised to select a pseudonym by which they were referred to throughout the study. Given the nature of the photo voice project, participants were advised only to collect photographic data of inanimate objects, with no identifiable information such as frontal view of human faces, car registration numbers, identification documents, telephone numbers, and business names and logos. Participants were provided with training on the ethical use of photos and the legal issues surrounding photographic evidence collection (Annexure K).

3.11 Self-reflexivity

Conducting qualitative fieldwork research may change a researcher in many ways. Through reflexivity, researchers recognise these changes manifesting in themselves because of the research process, while taking into account how these changes affected the research process. Researchers should acknowledge reflexivity as an important part of the research findings (Palaganas et al., 2017). As social workers often base their knowledge of clients on assimilated and manufactured events dictated by their own life experiences (Mallon, 2018), the researcher had to remain aware of this concept throughout the project by employing constant self-reflection.

The researcher is a cisgender, coloured male who conducted research with older, transgender individuals. The researcher also has a mental health diagnosis and a social worker. The researcher acknowledged that this could affect the research project and his understanding and interpretations of the experiences by the older transgender participants. To ensure reflexivity in the project, the researcher took several steps before and during the research process.

As a mental health care user from the LGBT community, the researcher understands what the daily perils are of those who suffer from a mental illness and how his sexual orientation attributed to his diagnosis. Since the researcher's diagnosis of Major Depression was made at an early age, he is aware of the difficult journey to access mental health care services, as well as the stigma around a mental health diagnosis. The researcher wanted to understand what older adults must endure in order to access mental health care. As a young, gay cisgender male, the researcher has witnessed linear oppression within the LGBT community towards

transgender individuals. The researcher thus lacks understanding of how transgender people relate to oppression from within a marginalised group, including being of an older age. The researcher wanted to understand what the mental health care challenges of older transgender are, as their age, gender, and mental health need to intersect.

The researcher was aware of possible unconscious bias towards transgender people due to generations of social conditioning, because of growing up in a conservative town where transgender people were often ridiculed in public. As transgender people are considered one of the most marginalised communities within an already marginalised (LGBT) group, the researcher had to ensure that he understood all the intricacies of identifying transgender. The researcher therefore attended a Gender Sensitisation workshop, which focused on appropriate ways to address transgender people and correct terms to use when working with transgender people. This enabled the researcher to be sensitive during the sampling process. It became evident during interviewing potential participants that many older transgender people chose not to participate, as they often felt that they did not want to relive years of stigma and trauma experienced before their (social or medical) gender reaffirming. This made the researcher more aware and prepared for possible trauma and how he needed to position himself as an objective, unbiased researcher and social worker during the project.

The researcher made a conscious effort to remain self-reflexive during the sampling process; however, he did become despondent when after weeks of interviewing possible participants, only two agreed to participate. One interview with a possible candidate lasted more than two hours. During the interview, the researcher learned that the possible candidate had moved to Johannesburg after her gender reaffirming surgery. She reflected on the trauma she had to endure during months of waiting for her gender marker to be amended by the Department of Home Affairs. She also pointed out that she thinks of her new life as a rebirth and try not to think of herself as being a man before. She mentioned that no one in her new job in Johannesburg knows that she was a man before. The researcher reflected on the fact that coming out is an on-going process, as he was aware of how this creates anxiety. Although the participant indicated that she did not wish to participate, the contact with her gave the researcher a fresh understanding of the how the views of transgender people could differ before and/or after their gender reaffirmation. Many other interviews with potential participants aided the researcher in using this new insight to guide interviews throughout the project.

Being a cisgender male, the researcher valued how the transgender male in the group

exhibited masculine traits, however, the researcher had to reflect on the notion of gender as understood from a feminist perspective. The researcher had to ensure that his own understanding of binary ideas towards gender was clear and not influencing bias towards the participants. According to Mallon (2018), self-disclosure becomes substantial when social workers share commonalities with a client, e.g. LGBT identity, although the researcher believed it would not be necessary to disclose his sexual orientation to participants, as this could inhibit the participants from sharing genuine feelings. During the first session however, one participant asked the researcher about his sexual orientation. According to the participant, she wanted to have clarity on the researcher's interest in the LGBT community. The researcher disclosed his sexual orientation to the group and reminded them that the focus of the group is to gather information about **their** experiences as older transgender people and his role as advocate for marginalised people.

As a mental health care user and a provider of mental health care services, the researcher had to be aware of certain assumptions when interviewing key informants. For example, the expectation of the researcher was that key informants would be opposed to the diagnosis of Gender Dysphoria in the DSM. The feeling of the researcher was that such a diagnosis is still othering transgender people and pathologising gender expression. However, after interviewing a key informant who rendered clinical services to transgender people, the researcher learned that a diagnosis ultimately allows transgender people to access certain health care services (e.g. hormones and gender reaffirming surgery), which would otherwise not be covered by medical aids. The researcher was thus able to reflect on this notion when interviewing other key informants. Constant research on new developments within the transgender and mental health spheres guided the researcher during key informant interviews, which contributed to him remaining objective.

Throughout the focus group sessions, the researcher was aware of the social work principles of objectivity and controlled emotional involvement. Being a facilitator was a key role the researcher had to fulfil during focus group sessions, while being aware of refraining from shifting to a therapeutic platform. The researcher maintained these principles by writing a short reflective journal after each focus group session. Following is an extract from the researcher's journal:

> *(most notable experience thus far)…getting to know the personalities and background of participants…their past and current struggles. Also learning of morals and ethics of key informants as practitioners who work with such a marginalised community. Meeting like-minded advocates, researchers and practitioners at the transgender*

> *conference made me realise the importance of addressing these issues, as we are progressing towards a more inclusive society* (Extract from researcher's reflective journal).

The researcher showed respect towards participants, as this is customary in the researcher's culture to show respect to the elderly.

The researcher took notice of the possible anxiety of the termination phase. Participants became fond of these groups and often deliberated after the sessions. They decided among themselves to provide confectionaries for each focus group session, which added to the warmth and empathetic safety for a marginalised group to meet on a weekly basis. The researcher had to keep the participants focused, but he anticipated anxiety towards termination. The researcher reminded the group of the purpose of the research to keep them focused and constantly advised the participants of the termination phase.

3.12 Conclusion

In this chapter, the researcher deliberated the research methodology used in this study. Chapter Three provided a comprehensive explanation of the research methodology and its implementation. In discussing the methodology, the researcher focused on the different processes followed, from planning right through to the final phases of the research. The researcher emphasised the relevancy and advantages of a qualitative approach. The challenges experienced during the sampling, data collection, and analysis process were unpacked to provide a detailed account of the progression of the research.

CHAPTER 4: FINDINGS OF THE STUDY

4.1 Introduction

In this chapter, the findings of the data obtained from five focus group sessions conducted with five individuals who identify as transgender (participants), are presented. The individual experiences of the participants are cross-referenced with the main aim of research, which was to determine the mental health care challenges experienced by older transgender people in the Cape Metropole, Western Cape. The findings reflect the individual challenges older transgender people in the Cape Metropole experience when addressing their mental health care needs. The findings further aid in providing a visual voice to the marginalised group of participants, which is consistent with the post-colonial feminist theory. In this Chapter, the research delves deeper into the generalised experiences of older transgender people, focusing on a diverse range of participants' individual experiences. By analysing their experience of mental health care challenges within their community, the researcher endeavours to describe how the participants experienced these challenges, based on their view of their world, as captured in their photos. This information is then triangulated with data obtained through individual interviews from social and mental health professionals (key informants) who work with the transgender community.

4.2 Demographic information

4.2.1 Transgender participants

A summary of the demographic information of the participants is provided in Table 4.1 for a complete overview of the participants' biological sex, age, gender marker, and ethnicity.

Table 4.1: Summary of participant demographics

Pseudonym	Biological Sex	Age	Gender Marker	Ethnicity
P	Male	51	She / Her	White
Dolphin	Female	55	Him / His	Coloured
Didi	Male	60	She / Her	Coloured
Adriana	Male	54	She / Her	White
Sam	Male	58	She / Her	Coloured

The next section in this chapter provides a brief overview of the background of each participant, using their selected pseudonyms. Information in relation to their journey to transition from either male to female or female to male is discussed.

4.2.1.1 Participant 1 – P

P is a 51-year old white trans woman residing in Muizenberg in the southern suburbs of Cape Town. P's gender marker of choice is her/she. She started her male to female (MTF) transitioning in September 2016 by taking hormonal treatment. P lived in Zurich, Switzerland a few years ago, where she started exploring her gender fluidity through online contact with a transgender psychologist based in the United States. According to P, she has not started her social transitioning yet, meaning that she prefers to continue wearing male clothes. She has not undergone any gender reaffirming surgery; however, she has undergone extensive laser facial hair removal.

P is an IT Specialist by trade and enjoys playing various musical instruments, including the guitar, piano, drums, and trumpet. She describes herself as a soft-spoken, quiet person who is sharp witted.

4.2.1.2 Participant 2 – Dolphin

Dolphin is a 55-year old coloured trans man who lives and works in Athlone, outside Cape Town. Dolphin's gender marker of choice is him/he. He began his female to male (FTM) transitioning in December 2012, when he started taking hormonal treatment. Dolphin underwent gender reaffirming surgery in 2014 and 2016, and describes the process as fully complete. He continues taking hormonal treatment daily. Dolphin is a bus driver and a lover of music, the fine arts, gardening, working with animals, running, tennis, table tennis, swimming, and photography. He actively produces sketches and paintings and is part of his church musical orchestra. Dolphin has a calm demeanour and describes himself as a person who is firm and does not tolerate any impolite behaviour from others.

4.2.1.3 Participant 3 – Didi

Didi is a 60-year old coloured trans woman, residing on the Cape Flats, with a gender marker of her/she. Didi started her male to female (MTF) transitioning in 1984 by taking hormonal treatment, however ceased the treatment in 1992 due to availability. Didi had the option to undergo state-funded gender reassignment surgery in 1984, however declined the offer due to the unfavourable outcome of her friend who had undergone the same surgery. According to Didi, the procedures were offered as trials in an era where medical technology did not deliver acceptable results. She is however considering gender reassignment surgery as her confidence in the procedure has increased over the years.

Didi is an active and respected community worker, a well-known dressmaker for matriculants, a hair and make-up coach, and runs a senior club in her community. Her hobbies include working with the elderly and beauty pageant participation and coaching. Didi describes herself as an extrovert and avid activist for the coloured transgender community.

4.2.1.4 Participant 4 – Adriana

Adriana is a 54-year old white trans woman, from Somerset West on the outskirts of Cape Town. Adriana's gender marker is her/she. She is currently unemployed. She started her female (MTF) transitioning in 2011 when she began taking HRT. She describes herself as lucky enough to have had full gender reaffirming surgery at Grootte Schuur hospital in Cape Town, after being told that she was placed on a 25-year waiting list. According to Adriana, she lived a gay man before; however, she always just knew that something does not feel right with her body. She feels that she always tried to fit into a society by living as a man, which led to an identity crisis for most of her life. Adriana is a kind-hearted, strong woman and activist for the transgender community. She describes herself as liberated after her gender reaffirming surgery. Her hobbies include reading, acting and she is also a caretaker for her elderly mother-in-law.

4.2.1.5 Participant 5 – Sam

Sam is a 58-year old coloured trans woman, born and raised in District Six and now resides on the Cape Flats. Her gender marker is her/she. Sam took HRT about 20 years ago for approximately one year to develop her 'bust'. She is a hair stylist by trade and describes herself as a religious Muslim person, who is well respected in her community. Sam never considered having gender reaffirming surgery, as she witnessed the pain that others who had surgery went through. She decided not to proceed with surgery at all, and advised that she "still love[s] it anally". Sam's hobbies include modelling, cooking, dancing, and reading. She defines herself as generally happy and comfortable with who she is.

4.2.2 Key informants

Following is a summary of the demographic information of the key informants provided in Table 4.2. The table includes the following information: Pseudonym, Profession, Community of practice (COP) and years of experience working with transgender clients.

Table 4.2: Summary of key informant demographics

Pseudonym	Profession	COP	Experience
Charmaine	Counselling Psychologist	Trauma within transgender community Private Practice and NGO	5
Scorpio	Clinical Social Worker, Sexologist	Private and military experience, Transgender healthcare, Transgender activist	20
Vanya	Psychiatrist	Private psychiatry services to transgender patients and state patients at Grootte Schuur Transgender Clinic	2
E	Psychologist	Transgender counselling in state and private sector	8
X	Clinical psychologist	Gender affirming healthcare, Trans rights activist, Academic	10

The following section of this chapter provides a brief overview of the background of each key informant, using their selected pseudonyms. Information on their passion for working with older transgender individuals within their field of practice is discussed.

4.2.2.1 Key Informant 1 – Charmaine

Charmaine completed her Master's degree in Counselling Psychology and specialises in transgender trauma. She does most of her work within the LGBTQ community. She provides private services as well as state service at Groote Schuur Transgender Clinic. Charmaine also serves on the gender division of the Psychological Society of South Africa (PsySSA). In private practice, she runs a support group for the parents of transgender clients, for which she often does not charge. The group serves as a platform for sharing information on surgeries and hormones and discussing the side effects. She also touches on the mourning process, acceptance, and loss, as parents often feel a sense of loss when their child is transgender. Of her parent support group attendees, approximately 30% are the parents of older (50+) transgender children.

4.2.2.2 Key Informant 2 – Scorpio

Scorpio is Clinical Social Worker and Sexologist, providing his services mostly to transgender clients. He has been involved in transgender health care for 20 years. Previously, he did work at his own private practice. He practiced in the military health service where he saw transgender clients in the psychiatry department. He also volunteered at two Cape Town based LGBT advocacy NGOs. Scorpio currently provides individual therapeutic counselling to transgender clients across the age spectrum. He also run group work with families (SOFAS

– Significant Others, Friends, and Allies) of transgender clients, where he offers family counselling and individual therapy to SOFAS. He runs a monthly transgender support group at a local NGO where he focuses on trans woman exploring sessions and a trans man exploring sessions, where members can attend the relevant group pertaining to them. Scorpio also offers a service to transgender people where he acts as mediator to them in the workplace. This entails negotiating the transition with Management and offering support in terms of psychoeducation for staff who work with the transgender person. Scorpio indicated that more young people are coming out as transgender, thus he also offers psychoeducation in schools in support of the transgender client.

4.2.2.3 Key Informant 3 – Vanya

Vanya is a Psychiatrist who trained at The University of Cape Town (UCT). He has been a member of the Grootte Schuur transgender team for the past two years, where he offers volunteering services once or twice a month. Vanya has a private practice in Pinelands, Cape Town where he sees his own outpatients, with a specific interest in LGBTQ clients.

4.2.2.4 Key Informant 4 – E

E is a Counselling Psychologist in practice for 10 years. He renders his services mostly in the West Coast region, where he generally consults transgender clients. He advised that his first two clients in his private practice were transgender, which set the tone for his practice from thereon. He has since closed his practice and looking forward to re-open in Cape Town in 2020. Of his client base, 80-90% of clients were transgender.

4.2.2.5 Key Informant 5 – X

X is a Clinical Psychologist who specifically renders services to transgender clients. She has been a psychologist for 10 years, but got involved in the transgender community before her career as a psychologist when she attended a gender and sexuality inclusive church where she served as a minister. According to X, she became friends with a transgender woman at the church and at that point realised that she also needed to check her own gender identity. Her focus shifted to transgender mental health when she was contacted by the South African Department of Home Affairs (DOHA), requesting her to marry a seemingly cisgender heterosexual couple; however, the man was in fact transgender. She had to marry the couple as lesbian, which she describes as an extremely uncomfortable and unnecessary situation. Due to this incident, she went on to do research on the development of transgender identity.

4.3 Discussion of themes

The researcher interviewed five individuals who identify as transgender, aged 50 years and above. A transgender person is defined as an individual with a gender identity or gender expression that is different to that of the person's biologically assigned sex (Altilio & Otis-Green, 2011; Forsyth & Copes, 2014; Berg-Weger, 2016). The collected data obtained from the transgender participants during individual semi-structured interviews, journals, and focus groups, were transcribed and then analysed using the Atlas.ti software. Semi-structured interviews were conducted with five key informants who are health professionals with a working interest in transgender clients. These interviews were also transcribed and fed into the Atlas.ti software. Thematic analysis was used to extract recurring themes from the narratives. Thematic analysis emphasises indicative, investigative, and recording patterns of meaning (or 'themes') within the data (Braun & Clarke, 2006). The researcher will now discuss the findings of the study according to themes and sub-themes. The themes and sub-themes are supported by photos and direct quotations from the participants, compared and contrasted with relevant literature, and triangulated with the data obtained from the key informants. Table 4.3 summarises the themes and sub-themes that emerged in the study.

Table 4.3: Summary of themes and sub-themes

Main Theme	Sub-Themes
Experiences of being trans in the Cape Metropole – "*Meneer daai is 'n man in vrou klere*[1]"	• Minority stress: Living up to society's expectations • Anxiety: Should I see a doctor?
Financial challenges – The role of socioeconomic status	• The golden years: "*Age does count against you*"
Coping strategies – Resilience of transgender people	• Substance use: "*Ek suip myself smoordronk*[2]" • Social and professional support

Each theme was identified from an extract of the data, which aided in categorising the concepts conveyed by the participants. The interview process covered two main themes: their experiences of being transgender, and resilience towards being transgender in the Cape Metropole. The findings show that older transgender people experience above usual minority stress, leading to anxiety when accessing mental health care. Furthermore, due to financial constraints and racial background, resilience is much higher than in the general population.

[1] Sir, that is a man in women's clothes

[2] Drink until I am very drunk

4.3.1 Theme 1: Experiences of being trans in the Cape Metropole – "Meneer daai is 'n man in vrou klere[3]"

This theme encapsulates the experiences described by participants as a gender minority in the Cape Metropole. The following sub-themes unpack how participants experience being transgender from an early age until now.

4.3.1.1 Minority stress: Living up to society's expectations

Minority stress refers to how external and internal minority stress processes (stigma) operate relative to other minority statuses, e.g., race/ethnicity and gender (Hendricks & Testa, 2012). In this instance, it refers to the stressors experienced particularly to the older transgender minority group. Participants indicated that they have experienced stigma for most of their lives due to their transgender status. The results concur with a study conducted by Mizock and Mueser in 2014, who state that all 55 of the participants indicated they have experienced stigma. The findings suggest that minority stress is experienced within the family and wider society, and is consistent in a pre- and post-Apartheid era.

The heteropatriarchal South Africa seems to have had an impact on the participants since an early age. Sam, a Muslim MTF coloured who grew up in District Six during the Apartheid era, recalled her first memory of questioning her gender identity:

> *I must have been 5 years old then I knew I was different. I was so nervous I used to wet myself and I went home from school cos (sic) I wet myself. Then I would silently steal my sister's dresses and disappear.*

Dolphin spoke about his observation of binary roles of gender. The intersection of heteronormativity and gender was a sentiment that many participants often referred to when talking about growing up.

> *As I grew up and realised that boys and girls were treated differently, I wondered about that and came to (the) conclusion that it was unfair. Boys could do and behave as they liked and get away with anything. They were given more information and knowledge than girls were given. Girls were forbidden to do anything unladylike. I didn't tow the line and became a martyr for my 'unsocial behaviour'. I went out of my way to prove that I wasn't going be indoctrinated by structured accepted behavioural 'norms'. I became public and social enemy numero uno.*

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[3] Sir, that is a man in women's clothes

Reflections from participants suggest they often choose to remain or become invisible to avoid stigmatisation. To be invisible often seems quite difficult, especially as bodily changes become evident during the gender reaffirming process. P indicated that she would often become anxious when using public bathrooms and attributed this anxiety to the stigma of being transgender. She included a photo (Figure 4.1) of a public bathroom in her journal and reflected on many incidents where she would rather not use a bathroom in public, however, when the need was there, it was often an incredibly stressful situation. Adriana described using the bathroom as an on-going stressful event, even after she had her gender reaffirming surgery conducted. In her interview, she mentioned that she constantly 'tried' to look like a woman, but it did not look like it for others. She reflected on her experience with using public bathrooms: "You could not just go to the bathroom, as you did not know if you could use a specific bathroom".

Although more gender-neutral public bathrooms are making their appearance the world over, 80% of the participants in this study indicated they experience extreme anxiety when having to use a public bathroom with only a male or female binary option. In 2018, a transgender woman, who is a student at a local college, was advised by the principal that she would only be allowed to use the female bathroom on campus once she starts HRT and provides a letter from a medical practitioner confirming that she is transgender (Collison, 2019).

Figure 4.1: Urinals

Going to the bathroom is simple for most people. I am at a stage in transition where I don't pass well enough for the female bathroom, but I also have difficulties in the male bathroom. I often have to sneak in to a stall and try to sneak out again when nobody is around. I have bumped into men in the bathroom who were very shocked and uncomfortable with my appearance. So when I need to go to a public bathroom, I feel anxious immediately. I always hope that nobody would say or do anything harmful – P.

According to X, minority stress experienced by transgender people is a major transgressor in terms of stress and anxiety:

> *In terms of mental health care challenges, something that we see quite often in the trans community is the difficulties they had with the community…being transphobic…er…bashing them…the unacceptance, problems with who you are and being able to live your true self…so, quite often, that stigmatisation leads to people struggling with stress, which could lead to anxiety.*

Minority stress is further exacerbated by social constructed ideas of masculinity and femininity. As society has a certain expectation of what a man or a woman should look like, transgender people find themselves in a stressful state to live up to these expectations. Psychologist X reflected as follows on her transgender clients and their struggle with appearances:

> *I often see clients who are struggling with eating disorders…since they want their bodies to be more masculine, more feminine...and try to hide the features of their body that does not fit their gender identity.*

Given the age of the participants, they all grew up in the height of the Apartheid regime. The intersection of race and gender identity seems to have affected the coloured participants more so than the white participants during the Apartheid era. In the absence of a constitution, which seeks to protect all the citizens of South Africa, despite (among others) their sexual orientation or gender, Apartheid South Africa was a dangerous place to be transgender. Didi reflected on her days when she stayed in Johannesburg:

> *In Joburg during the 90s, you had to play white, or either a man or a woman. This was still during Apartheid years. Some friends were thrown from buildings and the police would say you committed suicide.*

As the oldest participant, Didi was in her prime in the height of Apartheid. She reflected on her daily struggle to remain invisible, and the horrors that unfolded when she or her friends were confronted by the police:

> *In the 80s, all my drag queen friends were thrown out of buildings. The police either take you to the highest building…and they say you committed suicide or otherwise they take you to a dam…you go into the water and they shoot you from behind…they say a (sic) unknown body was washed up. Yes, the cops was evil. I have a friend of*

mine, it is a pity she's not here, and she's now 51. They took her to the Jewish cemetery, and they hit her with a baton….and her head fell…er, a head hit against the slab, unconscious. Two hours later the rain woke her up…she crawled back to the hotel where she was staying. She phoned family to come and get her; when she came to Grootte Schuur, they had to put her in a wheelchair…that's why she survived to tell the tale. I warned her…the girls was jealous…and they said (to the police) 'Meneer daai is 'n man in vrou klere[4]' now you know, that was 1991…how the cops was.

Didi developed a grudge against the police and reflected on her experiences with a very LGBT–unfriendly Apartheid Police. With a very stern expression on her face and a hypercritical tone in her voice, Didi mentioned that on one occasion she was nearly killed by the police:

I was nearly killed. I was taken to Weatherpan…I was told to undress because they wanted to see what's there…and when they saw 'Johnny' was there they said…get dressed and fuck off. Then they got into their van and they went. As I was getting dressed…they must have spoken over the radio or whatever…they came back. I saw this lights coming…there was no escape, only into the water. I was already so far into the water…I come out for air then I go down again. Then it was 1 van, 2 big cop trucks and 2 cars…they were looking for me. That was 12 'o clock neh…the Friday night. They were staying there until the Saturday morning. The trucks was gone, only 2 cars was there. The one cop was reading a paper and the other one was lighting a cigarette standing like this…they were looking for me 'cause they wanted to kill me…they had to kill me. Till this day, I don't know who it was or what it was…Jy weet ons is Kapenaars, ons kom van die see af…maar ek kan nie swem nie[5]. Somebody pulled me by the hand…I'm telling you and I believe in the Holy Spirit. There was a man on the other side, he was bringing his grandchild to catch fish. I asked the guy is anyone following me because they want to rape me.

Sam reflected on what she described as a "very, very sad" incident when she was raped in District Six at the age of 17. At the age of 23, she was again targeted in an act of violence. The case was never taken on by the police and blatantly ignored: "…and then at the age of 23, neh…er…ooh I was on my most beautiful! At a gay club in Long Street, they cut my hair off with two knives…utility knives". Didi explained that although to a lesser extent, she still experiences stigma, even in her own community. She referred to her photo of some boys in her community (Figure 4.2), and mentioned that she often avoids this area, as people are always around and mocking her.

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[4] Sir, that is a man in women's clothes

[5] You know us Capetonians are from the sea, but I cannot swim

Figure 4.2: Boys in my neighbourhood

This field is close to my house and I regularly have to cross it when I travel. Young children, especially young boys would often pass remarks like yelling 'Moffie'. I sometimes retaliate, but this area always causes me to feel anxious when I come close to this field. I sometimes just feel totally depressed when I think of my community. Children should be taught in school that this is prejudice, especially among coloured community. Some are respectable towards me. They call me Aunty – Didi.

Both Didi and Sam live on the Cape Flats in a predominantly coloured community. Similar to Didi, Sam also experienced mocking in her community, albeit not recently. She referred to her photo of her nearby railway station (Figure 4.3) and reflected on how she often was mocked and later raped at age 17.

Figure 4.3: Train station

I was raped at the age of 17. Terrible at the age of 17 – Sam.

Although Didi indicated that most incidents of transphobic stigma occurred during the Apartheid years, other participants reflected on many similar events in more recent years. It is evident that the role of the anti-discriminatory clause of the Bill of Rights in the Constitution of the Republic of South Africa (1996) does play a role in transgender people experiencing less prejudice that during the Apartheid era. However, the race of the participant would see a vastly different picture of experiencing minority stress for the white participants during the Apartheid era. Two of the white participants, Adriana and P indicated that they experienced less stigma from governmental institutions based on their gender identity. The story however is much different for them now in a post-apartheid South Africa.

Adriana, who grew up in a very conservative family often fell victim to stigma based on her gender identity. Adriana had a distant look in her eyes when she told the group about her experience of being mocked in public:

> *Uhm...wat met my gebeur het…uhm, voordat ek transition het, het ek by 'n winkel sentrum gegaan en ek het, uhm…goedjies gekoop en toe het ek my mond begin oopmaak net toe ek begin praat…toe begin die mense agter my lag, en toe word daar gesê …Oe, kyk daai moffie, hoor hoe praat hy, mens sou sweer hy's 'n vrou*[6].

The incident above caused Adriana so much stress that she could even recall the exact date as 20 June 2011. Although Adriana was mocked by adults during this incident, she advised that it was even more painful when she was once verbally attacked by young children in the community. She described a similar incident in a mall involving children:

> *Ek het eenkeer…uhm, net toe ek begin het, ook mall toe gegaan en die kinders het begin lag en gesê: Oh my word, look how freaky is she. So dit was baie embarrassing gewees, en dit was nie lekker gewees nie*[7].

P reflected on an incident in a so-called upper-class shop in the famous tourist suburb of Muizenberg:

> *I was recently in a shop and, it's in…uhm…a Fish and Chips shop in Muizenberg…and what happened was…uhm…I was busy paying for an order…uhm…and uhm…what I didn't realise it, but there was a guy…er…he was standing behind me. And while I was busy paying at the speed point, he sort of came around the left side of me and…er…sort of went right around me…uhm…he...he*

[6] Uhm…what happened to me…before I transitioned, I went to a shopping center and…uhm…I bought some things and when I opened my mouth…the people behind me started to laugh and said "Oh, look at that moffie (faggot), listen how he speaks…one would swear he is a woman."

[7] I once went…just when I started (to transition)…also went to the mall and some children started laughing at me and said: "Oh my word, look how freaky is she!" It was very embarrassing and not pleasant.

wanted to try and look…uhm…to look at my face, you know…to see what I look like. He wasn't gonna wait until I finish paying to see what I look like…uhm… he decided that he should see, who I was (laugh). So he goes back behind me again…and he said to his girlfriend…his words were: 'I think it's a dude'. I think they had a little laugh by themselves. I didn't react, I didn't say anything to them…

The experiences of public mocking by participants suggest that transgender people experience minority stress in various social settings. What might seem a normal day for everyone else could be stressful. Dolphin is a more introverted individual and spoke little during focus groups. He did however write a detailed journal. On describing his photo of a fence (Figure 4.4), Dolphin reflected in his journal on his normal, everyday life:

Figure 4.4: Fence

Sometimes I go through normal life situations like it's an uphill battle. The perception, bias, and judgemental attitudes from colleagues, family members, and authoritative figures are all hurdles in my life. The fence turned upside down resembles a ladder…but also a hurdle – Dolphin.

The narratives above suggest that minority stress experienced by transgender people in the Cape Metropole seems to be across all cultural and racial borders. The findings are congruent with that of Mizock and Mueser (2014), who conclude that minority stress (transphobia) is often anticipated and that transgender people tend to expect and prepare for prejudice and discrimination, to as internalised transphobia. Scorpio attributes internalised transphobia to a societal expectation:

Once they come to terms that they are somewhere on the transgender spectrum, the…the tension that they feel almost measure up to society's expectation of the masculine and the feminine...so to really be a trans woman I have to be super fem and to be a trans man, I essentially have to be a muscle Mary. ...so because of the anxiety of wanting to pass and be accepted, they put extreme pressure on themselves and often at the core of that is their own internalised transphobia.

The notion of living up to societal expectations is echoed by Charmaine, who reflected on her clients' response to visible physical changes in their bodies following HRT or gender reaffirming surgery:

For some it's a relief, cause now I'm actually developing into what it is I need to be. So generally it's euphoric…its excitement…its satisfaction…its happiness and all of these aspects.

After seeking advice from a psychologist friend, P was advised to see a psychologist who gave her a list of six medical doctors specialising in transgender issues. P saw one of the doctors who referred her to a psychiatrist:

That psychiatrist, actually, really freaked me out, ja…I am not gonna mention her name, but she, uhm…well, uhm…she told me that…uhm, I should…the first time I saw her uhm, she told me that I had to….speak with my family…with my parents, to tell them what was going on with me. I told her that, I will speak to my parents when I was ready. I said to her no…sorry. The pressure was ridiculous. I went back…I think, uhm, two more times and then I just cancelled her.

Participants reflected on their experiences of living their true gender in a heteropatriarchal society. Many spoke about how their gender identity often causes them to avoid certain situations. Adriana reflected on her experience when meeting a man online whom she found to be a love interest:

…I met a guy on a dating site from PE. Started asking me why I never married and no kids. I replied by saying I don't want to go into that detail, as it is in the past. When I eventually told him, he did not want to do anything with me and asked how he should refer to me. It is difficult to be in a relationship…like meet a straight person and they don't know about you.

Societal expectations of gender roles came out as a recurring theme. The findings suggest that due to society and the participants' own binary ideas of masculinity and femininity they experienced minority stress due to being a gender minority. Dolphin referred to the stress he often experiences when speaking on a telephone (Figure 4.5) and how people expect him to sound as a man.

Figure 4.5: Telephone

Almost every single time I use it (a telephone) and people don't know me or my name, I get addressed as Ma'am. If you have ever been accused of theft, murder or whatever you know nothing about it…that's how I feel. Many times I look past it or correct the person I'm talking to…diplomatically, sometimes not. I vent, most times. The rest of the time I put my energy into calming myself. Sometimes it works, sometimes not. I hate that I have to feel this way, cause it's a constant confirmation of how people think of me and see me…not pleasant – Dolphin.

Likewise, P reflected on her daily struggle to remove unwanted facial hair (Figure 4.6) while Adriana spoke about the importance of her make-up (Figure 4.7) and how it makes her feel beautiful. These narratives suggest that participants concur with the societal expectations of what a man or a woman should look like, which often causes them distress.

Figure 4.6: Shaving

Any shaving blade I see is a reminder of the terrible experience due to hair coming back out, even after expensive laser therapy – especially the grey hair, since laser cannot remove grey hair… – P.

Figure 4.7: My make-up

I often become depressed as I have to use make-up to cover facial features. I look at myself in the mirror and think, I am beautiful – Adriana.

In the sample, it was found that the participants experienced minority stress across all racial and age cohorts. These findings were consistent with the themes identified by Rood et al. (2017). As opposed to Rood et al. (2017), findings in this study suggest that negative social messages are perceived in the same manner by transgender people across all racial demographics. This discrepancy may be caused by the general adversity to gender minorities present in South Africa (Smith, 2013; The Other Foundation, 2016:34).

The narratives suggest that transgender people navigate their daily lives as a person living their true gender identity. This finding is consistent with Zabus and Coad (2013) stating that transgender people do not experience or express gender separately from other social positions they occupy. Many participants indicated that they often anxiously expect discrimination, which may negatively influence a person's mental and physical health. This in turn may cause the person to avoid interpersonal situations (Reisner et al., 2015). The findings suggest that in coping with minority stress, older transgender people seem to be less anxious when they have accepted and embraced their gender identity. The researcher reflected on instances where derogatory terms such as 'moffie' (faggot) are often used in his own community.

The findings furthermore suggest that the stigma experienced by transgender people is more inherent in nature (i.e. subconscious biases with little or no control). Stigma and transphobia also transgress across racial and socioeconomic borders. Incidents of transphobia were reported by both coloured and white participants, in both poorer and more affluent communities. This theme concludes that minority stress is a key contributor to transgender people experiencing perceived dysphoria due to dissatisfaction with their gender assigned at birth. It is well documented that minority stress seems to be a key contributor to the onset of depression in the older transgender population (Bockting et al., 2013; Fredriksen-Goldsen et al., 2013; Clements-Nolle, et al., 2001; Clements-Nolle, Marx & Katz, 2006). The negative experience of minority stress in establishing gender identity is further exacerbated by the feministic relationship between men and women in a binary set society (Bahri, 2013). The participants were often judged on the way they speak, dress, look, and act, and are generally regarded negatively by society, in correspondence with the findings of Rood et al. (2017) who suggest a negative representation of transgender people in society.

Participants experience masculinity or femininity as it intersects with gender identity as either FTM or MFT. Bodily changes, in terms of voice (Dolphin, Figure 4.5) and appearance (P and Adriana, Figures 4.6 and 4.7) suggest further mental distress as participants must adapt to a new way of how a binary society perceives them – either male or female. Since these participants are not their biological sex, but rather concur to a socially constructed idea of gender, their mental distress might stem from social discrimination against women that it appears to be caused by nature (De Beauvoir, 1972). Although transgender people experiencing minority stress negatively due to marginalisation, thereby creating major mental health care challenges in the process, one should also consider the typical gendered socialisation of the wider society. This notion concurs with the feminist view of Mikkola (2019) who argues that such socialising imbeds messages on the way females and males should act and are expected to act. It is evident that less mental distress would fall upon transgender people if society moves towards the feminist idea of a genderless society, where sexual anatomy is unrelated to a person's identity (Mikkola, 2019).

4.3.1.2 Anxiety: Should I see the doctor?

Anxiety refers to "an emotion characterised by feelings of tension, worried thoughts and physical changes, e.g. increased blood pressure" (American Psychological Association, 2019a). Although anxiety is often present in many situations, all the participants (5 out of 5) indicated that they are overwhelmed with anxiety on a daily basis, in what could be

considered by others as a non-threatening situation or routine act. This finding is consistent with the view of the key informants, where 4 out of 5 indicated their transgender clients exhibit constant anxiety.

All participants indicated an increase in anxiety in their daily lives, and in various situations, it can be deduced that a constant state of anxiety is a challenge to the transgender community. None of the participants indicated that they have pursued professional mental health care assistance for their symptoms of anxiety.

It is well documented that constant anxiety may lead to clinical depression; however, for this study, the participants were asked not to disclose whether they have been diagnosed with a psychiatric condition to aid in remaining unbiased. The anxiety experienced by transgender people, albeit often not clinically diagnosed, seems to stem from a social construct of the positionality of transgender people as a minority in a gender-binary society. Access to healthcare was a recurring theme, which came forth as a major catalyst to anxiety for most of the participants. P had the opportunity to access mental health care services in both South Africa and abroad. She conducted thorough research and reached out to many transgender people and health professionals for guidance in accessing services. P reflected on her first appointment with a psychologist:

> *I was actually communicating with a trans woman in Joburg, who have (sic) her email address out to people who were looking for assistance and whatever…on a YouTube channel. I said to her look, I have an appointment in a week or whatever. She told me she went to see her psychologist the first time, you know, and…uhm, 120 kg and a full beard, you know, and, uhm her psychologist told her, look, I don't buy it…I don't believe it. I told her, look, I'll just go there and present my best, because, I was actually very scared of being rejected...people telling me no, you (are) not one of those people…you know, go home. But these days, people are more forward thinking than backward thinking. Now, I have seen 3 different people…two of them are cool, and the one…I will never speak to again.*

After P was diagnosed by her psychologist with Gender Dysphoria, she decided to seek further insight and went to see a psychiatrist. The experience P had with the psychiatrist had led her to take the decision to consult a psychiatrist never again, which she was very vocal about in the interviews:

> *You see psychiatrists are…they are what you to deal with what you call non-functioning people. So I had this ex-girlfriend once, was very seriously bipolar…so she got to the point where she could not even work anymore…OK, but like…so that's a non-functioning person. So what happens there, when like a psychiatrist gets hold of*

that kind of person, they have to take over and they have to take control? Like when it's a drug addict they have to say, hey, stop this, take this medicine…they give orders, because they (are) dealing with people who are non-functioning. But if you've got me who wakes up every morning 4'o clock and work every day…I'm still a functioning person, so why treat me like a…you know…why tell me where to send my parents. So that's where I got more frustrated. And I just feel sorry for…for some people, because, uhm…they might get sent to her…initially…and, she was quite judgemental as well. The one day I was sitting there and she told me…you know…uhm, a young trans girl who comes to see me…her mother brings her and she's wearing like pretty clothes and fancy shoes and everything, and then she said to me, You look like…totally normal. And I said to her well sorry, I just come from work. I can't go to work dressed up all crazy…you know…I did at times felt like a bit…invalidated. Uhm, what I wasn't going to…I wasn't gonna change anything to make her feel happy.

It is evident that P experienced major anxiety when having to consult with a mental health care professional. In her case, she seemed to have exhibited anxiety towards being labelled, due to her gender identity. Pathologisation based on gender identity might explicate the increased rates of anxiety (Bouman et al., 2017; Millet, Longworth & Arcelus, 2017) among transgender people. Furthermore, the fear of being judged recurrently became known among all participants.

Didi described her first contact with a psychologist in the 80s. She described how she reluctantly went for a session, but did not have confidence in the services the psychologist rendered:

I went to see a psychologist once…the way I felt, nuh, I felt that she wants to know too much of my business…because, I was wasting my time with her, so I went back for another appointment…and when we were sitting waiting for my appointment, there was a lady before me…and the things she was…I could hear everything she was saying, but the door was closed. I think she was talking…this lady was telling her about her neighbour…and the thing that was…dit was amper soos hulle twee gesit en skinder het man…en toe voel ek, sy wil te veel weet van ander se besigheid[8]…and I thought to myself…Fuck you man…en toe staan ek op en loop ek[9]…and I never went back.

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[8] It was almost like the two of them were gossiping… and I felt she wanted to know too much about the business of others.

[9] …and I got up and left.

Didi later had a pleasant experience when she consulted a psychiatrist at Grootte Schuur's Transgender Clinic when contemplating gender reaffirming surgery. She did however decide not to continue with her gender reassignment surgery, as she witnessed her friend's surgery going wrong. Didi reflected on her encounter with the doctor at Grootte Schuur:

> *I went to see a doctor here…I'm talking about the 80s, here at Grootte Schuur here…uh…psychiatrist…and I think he was wonderful, because I went to see him thrice. The day I walked in there…he treated me like a lady. The last time I went to see him was the day he told me…come here I want to show you something…there was a man sitting there, he says this man is coming from the Strand. This man is walking for 3 years…to become a sex change and he feels the man is not ready. I came to see him thrice, he feels I'm ready. Go fetch your mother to sign to go for your op. I never turned up for my op, cause something just told me…don't go.*

Sam was of the opinion that mental health care professionals do not understand the intricacies of being an older transgender person and are quick to label. She vocalised that she has not sought mental health care for as long as she can remember: "Nee God…ek gaan nie nog sulke mense sien nie…[10]"

Although Didi and Sam experienced such high rates of anxiety when consulting with mental health professionals that they decided not to have gender reaffirming surgery, other participants described a decrease in anxiety when visiting transgender-friendly health care settings. Dolphin reflected on his visit to Grootte Schuur and believed the type of service received depends on your own character and personality: "For the most part, I'm happy with their approach to transgenders. Obviously, everybody doesn't have the same experience as I have". Adriana also consulted with a psychologist prior to her gender reassignment surgery and shared the same positive experience as Dolphin. According to Adriana, she saw a psychologist three months prior to her surgery. She described her experience at the transgender clinic as stress free: "After some time, he told me that I do not have to come see him anymore, as he could…uhm, he could tell that I was ready for my journey. I felt welcome and at home there…"

The narratives above suggest that transgender people exhibit increased anxiety especially when accessing health care, which is not gender-neutral or transgender-friendly. The presence of anxiety among the older transgender population might however stem from a life-long repression of negative feelings towards their gender identity.

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[10] No… God… I don't consult with such people.

Psychiatrist Dr mentioned that 100% of his transgender clients exhibit anxiety traits:

> *Many of the older transgender persons have grown up in a very defended way, they've repressed a lot of their emotional life, so it's quite difficult sometimes to tease out if that's like a brain thing…or if it's a coping strategy. So it takes like years for people to even label what they (sic) feeling, because they're so used to repressing their internal worlds…it's very difficult, but a lot of people are anxious, a lot of people depressed, suicidal, have thoughts of self-harming and lots of my trans women have these castration fantasies. I worry about that a lot.*

Hormone Replacement Therapy (HRT) is a key element of the gender reaffirming process. Scorpio believed the cost and availability of HRT is less of a concern to his clients:

> *It's generally readily available in South Africa…the hormones that are used for gender reaffirming therapy and the hormones being used for the general population, like your woman going through menopause…uhm…it's the same medication. So you don't have separate hormones for trans people. Hormones have to be prescribed by a healthcare professional…so a trans person can't just walk into a pharmacy and over the counter request. They are still reliant on accessing a health care professional who is willing to assist and support them and put them on the hormone treatment. It takes much longer in the state…purely because they see a lot of people.*

Although HRT is often free of charge from a state institution, based on income, transgender people do have a fear that the medication is inadequate of below standard to aid in keeping costs down. P voiced her concern about the standard of HRT received in South Africa as follows:

> *I have been told by other people from other countries that the medication I'm taking is wrong. So it's like it's not enough, because, apparently according to some of these people the treatment standards that we use here are not adequate…which is something I need to work on.*

When accessing HRT, a wide gap seems to exist between the cost and quality of private and state care. Psychiatrist, Dr reflected on the impact of this cost implication of HRT that he noticed among his patients:

> *…the second one (challenge) is the cost of care, so that's very high. That's for anyone, but if people have a medical aid, they can get some of their hormone treatment, but it cost them quite a lot of money. If they go through the state, and they're unemployed, it's sort of freeish, and if you're on medical aid you actually pay for it, and it's very frustrating because the cost is so high.*

Apart from HRT, mental health care seems to take the least important aspect of wellbeing that transgender people are willing to spend time and money on. Charmaine confirmed the

observation of the latter. She described a general lack of finances among her transgender clients, to whom she offers a free support group at her private residence:

> *There are also individuals who cannot afford… I have people who cannot afford to come and see me, and then I will pay their transport to come and see me, cause I'm in Camps Bay. So I will pay for the MyCity bus, which stops just down the road, then I will pay them transport money to get here.*

In terms of socioeconomic status, the level of education among transgender people also seems to play a role in terms of accessing mental health care services. All participants, except for one who opted for HRT via public health care (P, the only tertiary educated participant), indicated that she got numerous opinions before she started her HRT. When asked whether she had any contact with mental health care professionals before starting HRT, P indicated: "Yeah, quite a bit, but it was sort of, kind of different people and, uhm, yeah, it would have been better if it was one person overseeing the whole process, ja". For P, commencing HRT was stressful due to having to see various mental health and general health care professionals prior to starting treatment (Figure 4.8). She is of the meaning that health care professionals are either ill-informed or stigma-inclined towards transgender people.

Figure 4.8: Hormones

The constant daily reminder of the trans way of life is constantly taking hormone replacement therapy medication… I felt anxious when starting treatment and a new type of anxiety when my body chemistry changed – P.

The findings suggest that transgender people do experience constant and heightened anxiety, which may put them at a higher risk of developing mental health issue such as General Anxiety Disorder and Depression. From a classical feminist perspective however, one might view the heightened anxiety among transgender people as a social construct of psychiatric conditions, which Allen (1986) argues is biased towards women. The findings suggest that participants often consulted mental health care professionals as a means of understanding their gender incongruence or accessing HRT. This suggests that anxiety may be a product of accepting and embracing gender identity, or a fear of being judged by the mental health care professional as not having enough evidence to start HRT. The participants experienced heightened anxiety when accessing mental health care, which suggest that transgender people might anticipate health care professionals to put more emphasis on their gender identity (McCullough et al., 2017) as opposed to their presenting issue.

Furthermore, the presence of these mental health challenges may suggest an anti-feminist view of a mental diagnosis, as it places the origin of mental diagnoses at an individual level while disregarding social and political effects on mental health (Allen, 1986).

Participants did not show any apprehension towards a diagnosis of Gender Dysphoria (GD), despite the label carrying significant stigma in the professional and general society. This is likely because a diagnosis of GD could see a patient accessing HRT to commence the re-affirming process. This finding is consistent with the argument of Swartz (2013), who concludes that a mental diagnosis may be useful in individual cases, as the absence of such a diagnosis might be harmful to the person. Important to note is the indication of individual cases, as, from a feminist perspective, it can be argued that mental health diagnoses of the broader, marginalised community (such as transgender people) might ignore the intersection of social and political impact on mental health. The key-informants in the study had mixed responses about GD diagnosis, as most indicated that it is necessary to access mental health care, HRT, and gender reaffirming surgery. This is despite the ethical dilemma of possibly 'othering' or 'labelling' the client with a GD diagnosis.

Lastly, the findings suggest that the way participants experience, respond to, and cope with anxiety seems to intersect with their race as well as their financial status. Generally, the existence of anxiety seems to have made the participants more resilient over time. These notions are explored under the following theme.

4.3.2 Theme 2: Financial challenges - The role of socioeconomic status

Socioeconomic status can be described as the social position or class of an individual or group and is generally measured in terms of education, income and occupation (American Psychological Association, 2019b). Historically, the socioeconomic status of the South African public intersects very differently for, among others, gender minorities.

P is currently considering gender reassignment surgery, albeit spending a significant amount thus far on HRT and laser hair removal. P is educated at tertiary level and employed full time, but reports becoming increasingly anxious every day, as she is getting closer to retirement age:

> *"You can never have enough, to fully meet your…your gender identity needs. Money is the major limitation. I mean, I spent like…what…R60 000 but still…nowhere. If you (sic) one of these rich people like Caitlin Jenner then it's fine, but if you….I mean people elsewhere in the world, they got these…uhm, you know, like a go-fund-me page where they ask people to help them pay for what they need…cause it's expensive, you know. It's a combination of the financial security…for me…is, is, uhm…it's about being able to…trying to reverse what nature…or, what you didn't want nature to do. And the other problem is…uhm…it's a very fine thread…between losing it all. I mean, if anything would go wrong at work now…it would be very difficult, or even impossible to find another job, because you can be good at what you do…uhm…but if you a LGBT person, people just focus on that…you must…you know…obviously be stupid.*

Resilience occurred as a frequent theme when participants discussed their position in terms of an uncertain financial future. Didi, who is educated to high school level, has always ensured an income from rendering private services in her community as a hairdresser and dressmaker. She advised that she is still planning to continue to generate an income for herself and work towards getting a place of her own, despite her age being against her:

> *I got lots of financial problems…I am strong, but I would not say I'm safe…you know, cause when you're a queen, like in our situation, you must live alone. So I'm not there yet, because, If I could work I would be there, but I can't work because of health…and of my age as well. I went to a few interviews…they tell me I'm too old…you know what I mean…*

Scorpio added that since he works mostly with the lower socioeconomic strata of older transgender clients, he often notices a general lack of funding to commence or complete the gender reaffirming process:

I have a lot of clients who only socially transitioned and maybe be on hormones…so many of them, not having accessed gender-affirming surgery…and still struggling with that. One of the struggles I often hear articulate…you know…I'm gonna eventually die and not be me completely, cause at that age they (are) kind of aware now that they're older and…you know…death is not that far off.

Due to transgender people putting a high value on their physical needs, their mental health often takes less priority. Accessing private services can be costly, while state services are often over-burdened or not equipped well enough to be able to deal with transgender mental health challenges. According to E, the bulk of his transgender clients would put less focus on the mental wellbeing:

Often because people struggle to work and struggle to function optimally, they need to find ways to cope that are expensive sometimes. So they struggle financially, and what concerns me really about that sometimes is that they…they place mental healthcare as the absolute optional extra.

However, all participants indicated using their gender identity to their advantage, suggesting a resilient outlook to life in terms of an indefinite financial future.

4.3.2.1 The golden years: "Age does count against you"

The issue of income, or rather the lack thereof was a recurring theme throughout the research. Participants commented on the excessive cost of gender reaffirming surgery, HRT, and financial issues particularly facing older transgender people including care-taking facilities. Age UK (2019) pronounces that older transgender people are generally faced with exclusive financial issues pertaining from legal service fees, specialised care services to consider their intricate social or bodily needs relating to their gender reassignment, and payments of pensions.

Adriana is currently unemployed and spends most of her days looking after the elderly mother of her partner. She indicated that she spent a lot of money during her gender reassignment process. A new challenge for Adriana now is how she will continue her current livelihood after 60: "I have a fear of what to do after 60. Where to live, where to get money. Pension for me is only due when I'm 60. I'm currently unemployed and worry constantly about money".

Most participants indicated that they are subjected to higher instances of anxiety due to worrying about finances, due to their age. Transgender people generally struggle to find

proper employment, as attested by X:

> *I found that trans and gender-diverse persons…(sigh)...would start taking drugs in order to cope…uhm, not all of them can find work easily...and with that…er…we would see that they would do sex work...and with that comes other challenges…and other stressors…*

Despite the findings suggesting that gender identity seems to have a minor impact on financial security, the intersection of age and socioeconomic status seems to add increased anxiety as they continue to get older. Scorpio indicated that he often experiences anxieties regarding money among his older transgender clients as they reach retirement age.

> *There's a clear sense of...I'm gonna retire with very little financial resources...so where am I gonna go? So that sense of…How am I going to survive…getting older where my income capacity is gonna be even lower than it was before and there are limited to no resources that I can rely on.*

P indicated that she becomes depressed when thinking about her financial future (Figure 4.9), however feels strong that she has made a right decision in terms of living her true gender identity.

Figure 4.9: Money, money, money!

I spent a lot of money on my transgender journey. I sometimes felt depressed about not having enough cash for doing what I want to do. Age does count against you. My current job advised that after 60 we have to be 'out of the door' – P.

The findings suggest that anxiety is further exacerbated by the worry about lack of finances among older transgender people. Financial challenges seem to affect transgender people even more as they are aging. Participants recurrently expressed their concern about their financial

security as they are nearing retirement age. Participants recurrently spoke about the high cost of access to HRT and gender reaffirming surgery, despite their socioeconomic status not always allowing them to access such interventions.

These aspects all intersect to add to their constant anxiety, which is a precipitating factor in the diagnosis of Anxiety Disorder and Depression. Furthermore, the findings suggest participants are less likely to make use of state mental health care services due to bad experience (Didi and Sam). Socioeconomic status plays a key role in accessing health services, e.g. P seeing private mental health care practitioners and having the means to get various opinions.

However, the participants contextualised their hardships due to the lack of finances by evidently becoming increasingly resilient, as their socioeconomic status intersects with their gender identity.

4.3.3 Theme 3: Coping strategies – Resilience of transgender people

Participants and key-informants alike concurred that transgender people are often more resilient than the general population. The intersection of factors such as race, socioeconomic status, and age with their gender identity seemed to make them much stronger in the face of adversities. Psychologist E gave his opinion on how race, age, and income play a role in terms of intersectionality for transgender people: "I think trans people are some of the most aware or awake people out there, exactly because of that intersections..."

The findings suggest that participants showed resilience across racial borders. Sam, who is a well-respected coloured trans woman in her community, spoke about her position in her community at the Cape Flats and her resilience towards intimidation: "I suppose it's the respect man…nuh, 'cause you know…ek skree baie hard". Adriana, a white trans woman spoke about her resilience in terms of her gender identity and how it impacted her relationship with her family:

> *I am definitely more powerful in terms of my mental capacity…my confidence was also boosted. I don't have to fights against my inner feelings. I am me…which feels wonderful. My family rejected and later disowned me, but I don't regret my decision. This surgery was a second change God gave me to be true to myself…who I intended to be…a woman.*

Two sub-themes emerged which shed light on how the participants used strategies to cope with the stressors of being an older transgender person, discussed next.

4.3.3.1 Substance use: "Ek suip myself smoordronk[11]"

Most of the participants indicated that they have used substances as a coping strategy either currently or at some point in their life. All key informants indicated that substance abuse is one of the major challenges experienced by their transgender clients. Didi spoke about how she used to deal with the distress caused by constantly running from the police during Apartheid:

> *I bought myself a can of Autumn Harvest…en ek suip myself smoordronk[12] to forget. then…where do I run to…a bottle of Vodka, and I had Vodka with water, and I get drunk and go to sleep. And when there's no vodka I go buy myself a drug…they had those things called rocks, I sommer[13] buy me 10 rocks…and because of that I lost a beautiful great friend of mine…she died of an overdose of rocks.*

Similarly, P reflected on her use of substances as a method of coping. P was once addicted to cigarette smoking, and due to this addiction feared becoming an alcoholic later (Figure 4.10).

Figure 4.10: Jack Daniels

This is one of my symbols of addiction and self-destructive behaviour. I gave up drinking in 2016 but it's still very difficult to cope with dysphoria and anxiety without alcohol – P.

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[11] Drink until I am very drunk
[12] Drink until I am very drunk
[13] just

P described her coping mechanism as less of hazardous to the body, but detrimental to the mind:

> *…something that was very dominant in my life was gambling….as it takes your mind away from a lot of things. You're mind just empties…it take (sic) your attention away from other problems…then you don't worry about GD anymore, but it's a self-destructive behaviour, a kind of coping mechanism. Therefore, I asked to be banned from casinos while living in Switzerland to help control this behaviour.*

Psychologist E attributes substance use among his transgender clients an attempt to moderating anxiety. He reflected on substance use across all age and race cohorts:

> *In a sense, you surrender agency to your body. I think people are so focused on coping, I think that's why the anxiety is downplayed. It's not that it's not there, it's just very well hidden. What do you do when you don't cope? You get very sad or you start numbing the pain…*

Participants described building resilience that could offer some relief from their hardships through various coping methods, albeit essentially not contributing towards addressing their stressors. Most of the participants indicated some form of substance use at some point, which is consistent with the report by key informants of high rates of substance use among transgender clients. However, the findings suggest that resilience was built, as participants had to navigate years of stigmatisation and marginalisation based on the gender identity, irrespective of other intersections such as race or social class. This deduction is substantiated by the findings of McNeil et al. (2013), where the authors concluded that transgender people around the world are at a higher risk of substance abuse.

4.3.3.2 Social and professional support

A key finding in coping strategies was the existence of support from family and friends as well as health professionals. The acceptance of gender identity is considered a unique challenge experienced by transgender individuals. This is not usually the case for other members of the LGB community. Coming to terms with gender identity is often a prolonged process that affects mental wellbeing significantly. To help transgender individuals come to terms with their gender identity, mental health care professionals play a key role in rendering support.

Participants indicated that a sense of understanding from health care professionals is us usually enough to make them reach out for the service. This finding is substantiated by the narratives of the key informants.

Psychiatrist Vanya stated that:

> *I'm not transgender, so I have to speak on behalf of a group of people that I know better than other people. I view Transgenderism as a variation of human beings, and the main problem is that society have (sic) certain views about people.*

Although professional support was a key indicator of coping strategies for the participants, many key informants agreed that social support is imperative to the mental wellbeing of transgender people. Likewise, Scorpio reflected on his clients' notion of their gender identity and accepting their true selves:

> *I often get involved in working with family members in coming to terms with their family member's gender identity. Other big issues is then the workplace, it's a big issue…you know I want to live my authentic self, but fearing…uhm…facing discrimination and prejudice in their workspaces.*

As a counselling psychologist for mainly transgender clients, X pointed out that his transgender clients often find it hard to cope with stress and anxiety due to the lack of social support:

> *…the first thing is social support. For people who are married or in relationships, that relationship strain. Friends who are not as supportive as they need to be. So that's what I mean with social support. Secondary to that, under the same kind of idea of social support is the issue of transitioning at work or at school and negotiating that. That places a very heavy burden on people.*

The findings suggest that support (or the lack thereof) from family and significant others had a major impact on the participants' ability to cope. Adriana reflected on how her family disowned her after her gender reaffirming surgery. She indicated however that she manages to cope with her feelings of depression and daily stresses by mustering support from her partner (Figure 4.11). Lack of support from family was also echoed by Dolphin, who reflected on the photo of her immediate family at the dinner table (Figure 4.12) and how she perceived them as being supportive:

> *I was always called the black sheep. Never listened to when I offered up a sentiment or opinion. Disciplined and disgraced in front of family and strangers…undermined for nearly anything. Never complimented or encouraged in anything. Everything i did was always a problem or not part of their normal social behaviour. Taking away my self-confidence, which made me more aggressive and stubborn and I refused to do what they wanted me to do when they wanted it. So that's all the adult skills I learned from them and then they expected me to be endearing to everyone…*

Figure 4.11: My partner

I draw my support from my partner…we are not in a romantic relationship, but he has stood by me for the past 25 years. You can't go through life alone. You need to get somebody to be with you when you get to old age – Adriana.

Figure 4.12: My family

My family was never really appreciative of my talents…or me., my perception maybe – Dolphin.

Although the findings suggesting support from the wider community as less important to that of family and significant others, it seemed to add to coping strategies of the participants. Sam proudly reflected on her position as an elderly transgender woman on the Cape Flats (Figure 4.13): “I get a lot of respect in my community. People look up to me. No one seem to care about my gender. The young children call me ‘Auntie’ and always greet”.

Figure 4.13: My neighbourhood – Sam

Similarly, Didi is respected in her community as an older transgender woman. She described her community as generally understanding and advised that this is a major contributor to her ability to cope. Didi renders dressmaking (Figure 4.14) and hairdressing service within her community, which she feels makes her more resilient when facing adversities.

Figure 4.14: Dresses

I am famous for dressmaking in my community. I get a lot of support from schools and also run a support group for older people in my area – Didi.

The findings suggest that the acceptance of gender identity by family members and their communities can build a person's resilience and add to their coping strategies in an inherently heteropatriarchal society. Likewise, support from health care professionals plays a key role in aiding such a marginalised community to cope with daily stressors. These resilient coping strategies seem to stem from adversity and strengthen their determination, as proposed by Fredriksen-Goldsen (2014). The importance of such support structures is a recurring theme discussion, which advocates health care professionals' role to build current support structures (Gerwe, 2019). This finding particularly holds true; however, it is important to note that professional interventions should be adjusted based on the transition status of transgender clients (Budge, Adelson & Howard, 2013), as participants indicated that they often stopped seeing mental health professionals after the gender affirming process.

4.4 Summary of discussion of themes

Three main themes and four sub-themes emanated from the findings. The first main theme reflects on the experiences of older transgender people in the Cape Metropole, suggesting a high rate of minority stress due to transphobia and marginalisation. This in turn leads to transgender people remaining invisible in order to avoid these stressors. Due to minority stress, high rates of anxiety are present, particularly when transgender people need to access mental health care. The next main theme points to financial challenges faced by older transgender people because of a lack of social support and excessive costs of quality healthcare and HRT. The third theme reflects on coping strategies by older transgender people in the face of daily adversities. Participants seemed to be more resilient due to using coping strategies such as substance use. Participants also seemed to cope better when they had social and professional support available.

CHAPTER 5: CONCLUSION

5.1 Introduction

This study demonstrated an endeavoured to prove that older transgender people have unique experiences and needs in terms of mental health care. As age, gender identity, and socioeconomic status intersect, older transgender people present a unique set of lived experiences. In this chapter, the researcher presents the conclusions and recommendations that originated from this study, which aimed to explore and describe the lived experiences of older transgender people in the Cape Metropole.

Transgender people are inherently exposed to higher instances of minority stress due to marginalisation. Furthermore, their gender identity intersects with their age, race, and socioeconomic status to add to higher instances of anxiety. These intersections however do render older transgender people to be more resilient by using various coping strategies. In this chapter, the aims and objectives of the study and a brief overview of the research methodology used are summarised. The conclusions recap the literature reviewed and provide an overview of the main themes that emerged. Finally, the limitations in the study are elaborated on and appropriate recommendations and suggestions for future researchers, practitioners, and policy makers are made.

5.2 Summary of the aims and objectives of the study

The aim of this study was to determine the mental health care challenges experienced by older transgender people in the Cape Metropole, Western Cape. The aim was achieved through three objectives, namely:

- To explore and describe the unique challenges faced by older transgender people in the Cape Metropole, Western Cape – This objective was achieved using PAR as a qualitative research methodology to elicit in-depth lived experiences of the unique challenges faced by older transgender people in the Cape Metropole. By using photo voice and interviews as a data collection method, the participants described their first-hand experience of increased anxiety due to minority stress and on-going financial challenges through photographs, journals and focus groups
- To explore and describe the experiences of older transgender people when accessing mental health care in the Cape Metropole, Western Cape – This objective was achieved though exploring and developing a theme on increased anxiety experienced

by participants when accessing health care services

- To explore and describe strategies of addressing mental health care needs of older transgender people in the Cape Metropole, Western Cape – This objective was achieved through the analysis of photographs and focus group transcriptions, which concluded that older transgender people using coping strategies such as substance use and resilience in response to increased anxiety and depressive episodes

5.3 Overview of the main themes

Three major themes and four sub-themes originated from this study. The findings for each major theme are summarised below.

5.3.1 Theme 1: Experiences of being trans in the Cape Metropole – "Meneer daai is 'n man in vrou klere"

This theme reflects on the experiences of older transgender people in the Cape Metropole, suggesting a high rate of minority stress due to transphobia and marginalisation. This in turn leads transgender people to remain invisible in order to avoid these stressors. Due to minority stress, high rates of anxiety are present, particularly when transgender people need to access mental health care**.** The importance of coping strategies was highlighted by most participants. This lends support to the view that people who are oppressed or stigmatised develop skills to compensate for the stigma (Shih, 2004) by becoming more resilient in the face of adversity (Fredriksen-Goldsen, 2014). It has been shown that anticipatory stigma, i.e. expecting and preparing for prejudice and discrimination, has been highlighted by the participants (Mizock & Mueser, 2014; Rood et al., 2017). This could explain the suggestion by the participants that they experience high rates of anxiety when accessing mental health care. The good practice guidelines for care for older LGBT people proposed by Almack and The National Council of Palliative Care (2016) offer a useful model for thinking about the care for older transgender people when accessing elderly health care services. However, additional theoretical and empirical research will be required if intersectional approaches to transgender healthcare are to deliver the outcomes required for changing LGBT elderly care in South Africa. The intersection of race and gender identity seems to have affected the coloured participants more so than the white participants during the Apartheid era. However, the race of the participant would see a vastly different picture of experiencing minority stress for the white participants during the Apartheid era. Two of the white participants, Adriana and P, indicated that they experienced less stigma from governmental institutions based on their gender identity. The

story however is much different for them now in a post-apartheid South Africa. In terms of socioeconomic status, the level of education among transgender people also seems to play a role in accessing mental health care services.

5.3.2 Theme 2: Financial challenges - The role of socioeconomic status

This theme brought to light the financial challenges faced by older transgender people, which are primarily attributed to a lack of social support and excessive costs of quality healthcare and HRT.

Gender identity seems to have a minor impact on financial security, whereas the intersection of age and socioeconomic status appears to add increased anxiety as transgender people continue to grow older. This suggests that older people in South Africa are not sufficiently supported in terms of financial support from the government.

Participants also reported increased anxiety when they need to access HRT, ass this treatment is imperative for gender reassignment to ensure mood stability, and the inability to source HRT due to financial constraints is highly significant. The intersection of race and social class plays a major role, as the majority of white participants would access private, more costly health care as opposed to the coloured participants who would opt for free state service.

5.3.3 Theme 3: Coping strategies – Resilience of transgender people

This theme focuses on coping strategies of older transgender people in the face of daily adversities. Participants seemed to be more resilient when using coping strategies such as substance use. Participants also seemed to cope better when social and professional support was available.

Transgender participants presented a form of learned resilience. This could be due to them having to navigate years of stigmatisation and marginalisation based on their gender identity. The intersection of race or social class seems not to have as much of a major impact on building resilience as their acceptance of their gender identity. However, the intersection of age and gender identity seems to build a more resilient person in their older age.

Substance use appears to be a coping strategy of choice for many of the participants. However, none of the participants indulges in substances currently, but admitted that they have indeed at some point in the life. Participants reported that it has taken years to accept their gender identity, and that substance use formed part of dealing with adversities in their

younger years. The intersection of race and gender identity likely played a minor role, as participants of diverse racial backgrounds all reported prior use of substance as a coping mechanism.

Support from family and significant others had a major impact on the participants' ability to cope. This includes support from family in terms of accepting their gender identity, as well as the warm, accepting, non-judgemental approach from health professionals, which leads to the assumption that awareness and education of the wider community on transgender health issues could be a major contributor in reducing transphobia and minority stress. This in turn may see a decline in continuous anxiety and depression among transgender people in general.

5.4 Limitations of the study

All studies have limitations no matter how well structured and constructed. The researcher has therefore noted the following limitations:

i) **Population sample:** The sampling methodology only included one geographical location, the Cape Metropole, thereby limiting generalisation of the findings. This especially holds true given the unique characteristics of the Western Cape as an ethnically diverse area with more liberal views on the LGBT community. The study focused on older transgender people residing in the Cape Metropole, therefore the findings of the study may only be applicable to this area. The findings are expressive and successfully meet the objectives of the study. However, these findings may not be translated to younger transgender people or transgender people in general. Photo voice could only be afforded using a small sample size, due to the lack of funding for being able to recruit a sufficiently large group to ensure diversity. The sample therefore did not include any black participants, as none responded during the initial recruitment process or from snowball sampling, which could point to cultural bias. The sample also did not include any psychiatric diagnoses, specifically to avoid any bias towards the general non-diagnosed population.

ii) **Qualitative data collection:** The use of photo voice and the camera was at times technical and the process was time consuming, as training had to take place before the project could commence. Not all participants had the same strengths in terms of taking photos, being interviewed and writing journals.

iii) **Lack of available data**: The researcher initially aimed to involve at least 10 older transgender participants, but the sample size comprised only five older transgender people, mainly due to the transgender community often 'going invisible' due to fear of

stigma. However, reliable data were extracted from these five participants. Recommendations to overcome this limitation for future research are indicated in section 5.5.3.

iv) **Lack of prior research studies on the topic:** The older transgender community is an understudied population, which results in limited available empirical research. The researcher however utilised existing literature as well as the experiences of older transgender people in terms of minority stress, transphobia, and accessing health care. The literature was reviewed through an intersectional lens to determine the impact of the intersection of race, age, and socio-economic status on the wellbeing of the individual. This literature was deemed sufficient for this study.

5.5 Recommendations and suggestions

Considering the limitations identified and the conclusions of this project, recommendations were established for i) practitioners; ii) policy makers; and iii) future research on the topic.

5.5.1 Recommendations for practitioners

The transgender participants reported persistent oppression, pressure due to societal expectations, and internalised transphobia across all racial and socioeconomic cohorts. These intersections caused increased anxiety and depression. Based on this, practitioners should consider an approach sensitive to these experiences whilst being cautious not to overemphasise gender identity during intervention. Social workers in particular should be more rigorously trained in terms of on-going transgender sensitive approaches, especially as social workers are often the first responders to traumatic experiences.

From a macro intervention perspective, focus should also be placed on social workers educating the general community on transgender issues. The role of social workers as per the code of ethics to question social injustice should include challenging transgender invisibility in order to ensure acceptance and eradicate the impact of minority stress on gender diverse people.

Mezzo social work intervention should include a strength-based person-in-environment approach to have an improved understanding of how the client functions within their family and community based on their age, race, and socioeconomic status.

Micro interventions with transgender people should focus on educating instead of eradicating, i.e. transgender clients should be educated on mental and general health issues before, during, and after the gender reaffirming process. A non-judgemental approach should be essential to these interventions where guidance is provided, instead of advising the client what to do. This will ensure that bodily autonomy is respected.

5.5.2 Recommendations for policy makers

Current old-age homes and retirement as well as home-based carers should receive in-depth, on-going training in terms of transgender mental healthcare needs, HRT and gender sensitisation. It is not recommended to establish old age homes specifically for transgender people, as this might add to the idea that transgender people are different to the public. The focus should rather be on inclusion. Such amendments in facilities should be closely monitored and evaluated by external stakeholders to ensure true compliance and avoid corruption.

Amendment of the Older Person's Act specifically to mention the unique needs of transgender people should be considered. Moreover, old age homes should factor in costs of HRT in their programmes.

The definition of gender and transgender people should be clearly explained in the Constitution as well as included in school curriculums.

Depathologisation of gender identity disorders could shift the focus away from gender incongruence and rather address the generic issue of mental health care needs, e.g. anxiety and depression.

Public facilities should consider inclusion of gender fluid bathroom facilities. This practice might however be challenging due to current high occurrences of gender-based violence. However, such a practice might instil the idea of gender equality and thus address the root cause of gender-based violence.

5.5.3 Recommendations for future research

This research proved that many factors intersect to determine how transgender people experience and navigate their daily lives. For example, some participants were reluctant to commence their gender reaffirming surgery due to a lack of education on the procedure and possible psychological and physical implications. To understand the implications of these

results better, future studies could emphasise the Intersectionality Theory. Using intersectionality could see the collaboration of various fields, such as humanities, psychology, and medicine.

Although the research was not specifically focused on the culture of the participants, it was evident that participants from various cultures refrain from accessing mental health care services due to cultural believes. For example, participants from the white participants (predominantly Afrikaner heritage) indicated that they were more likely to access mental health care services as opposed to the coloured participants (of Khoisan and Arab decent). Further research is needed to determine the relationship between transgender identity and the way mental health issues are perceived in the plethora of cultures present in South Africa.

The research indicated that participants experience increased anxiety as they near the age of retirement, particularly accessing retirement homes. Many respondents stated that they would rather live with family; however, extraordinarily little research had been done on the experience of older transgender people in home-based care. Future research could determine the perceptions of older transgender people on home-based care and their particular needs.

The sample size was small due to transgender people often 'going invisible' in fear of stigmatisation. Future research could aim to overcome this limitation by involving health care practitioners to assist with the recruitment of respondents in a safe and confidential space such as their consultation rooms.

Focus should be placed on increasing the number of transgender researchers to conduct qualitative research on transgender samples. This would allow for the researcher to probe deeper into sensitive issues that might be overlooked or deemed less important by a cisgender researcher.

5.6 Conclusion

This research described the mental health care challenges experienced by older transgender people in the Cape Metropole, Western Cape. Based on a qualitative analysis of photographs, journals and semi-structured interviews in response to the question of what the mental health care challenges of older transgender people in the Cape Metropole are, it can be concluded that older transgender people have a unique lived experience, which is influenced by minority stress and financial challenges. While the small sample group limited the generalisability of the results, this approach offers new insight into the lived experiences of older transgender

people based on the intersection of their race, age, and socioeconomic status. The results indicate that race, age, and socioeconomic status intersect in determining how older transgender people experience high rates of anxiety and use various coping strategies to address these challenges.

By analysing and describing the lived experiences of older transgender people and mental health care professionals in the Cape Metropole, this study confirms a lack of service delivery from both policy makers and mental health professionals when rendering services to older transgender people. The research however also raises the question of why social workers who render services to address the unique needs of transgender clients are ‘invisible’.

The participatory nature of the research supported the researcher with gaining valuable insight into the intricate lives of older transgender people and inspired an on-going critical introspective process, which is an important quality for a social worker. It aided in reflecting on the researcher’s own social position and values in a country where discrimination against minorities is still rive.

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ANNEXURE A: FOCUS GROUP SESSIONS

Session No.	Theme	Objectives
1 (120 min)	Introduction to the Photo Voice Project & Training	Conduct an icebreaker activity. Describe what photo voice is; Review goals of photo voice project; Articulate participant roles; Develop a contract for group norms; Discuss issues related to photography power, ethics, and legal issues; Conduct photography 101 training; Define tasks for next session; Complete post-session feedback.
2 (60 min)	Camera Training	Conduct icebreaker activity. Review Session One activities; Review photo voice project theme; Assign cameras to participants; Conduct camera 101 training; Determine the number of photographs for photo voice project.
3 – 7 (90 min)	Upload photos and select ones for sharing	Reflect on previous sessions and photographing process: • Discussion on selected photos • Do as many photos as possible in time allotted Review themes Work in pairs: • Write title and narratives for photos discussed as group General discussions on wellbeing of participants
8 (60 min)	Discussion of collective themes	Emerging themes are presented to the group by facilitator. Underlying feelings of participants are discussed.
9 (60 min)	Presentation of collective themes	Facilitator and participants have an open discussion on emerging themes and what it means for their community.
10 (90 min)	Termination	Reflection on project Farewell lunch

ANNEXURE B: SHOWeD METHOD

1. What do you **S**ee here?

2. What is really **H**appening here?

3. How does this relate to **O**ur lives?

4. **W**hy does this condition **E**xist?

5. What can we **D**o about it?

(Adapted from Gant et al., 2009)

ANNEXURE C: SEMI-STRUCTURED INTERVIEW SCHEDULE FOR KEY INFORMANTS

UNIVERSITY OF THE WESTERN CAPE

Private Bag X17, Bellville 7535, South Africa

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INTERVIEW SCHEDULE FOR SOCIAL WORKERS & KEY INFORMANTS

This interview schedule is to address the following research title: **"Exploring the mental health care needs of older transgender people in the Cape Metropole: A participatory photo voice research project"**

The objectives of the study will be:

- To explore and describe the unique challenges faced by older transgender people in the Cape Metropole, Western Cape
- To explore and describe the experiences of older transgender people when accessing mental health care in the Cape Metropole, Western Cape
- To explore and describe strategies of addressing mental health care needs of older transgender older people in the Cape Metropole, Western Cape

Please make sure that you have given your written consent before taking part in this research study. Also, note that everything shared during this interview will only be used for the research project and pseudonyms will be used to insure anonymity.

Date of interview: ________________________

Pseudonym: ________________________

Interview questions

1. Please describe your role and responsibilities in your organisation.
2. How long have you been with the organisation?
3. What is your understanding of the term transgender?
4. What is your understanding of the Gender Dysphoria diagnosis (DSM-5)
5. What are your experiences with older transgender people?
6. To what extent do you think older transgender people's mental health needs differs from their cisgender counterparts?
7. Can you please describe the community's general knowledge about older transgender people?
8. Are there specific challenges that you experience when working with older transgender people?
9. In your opinion, do you think that transgender people find it easy to express their gender?
10. How often do older transgender people present with mental distress originating from their adolescence to early adulthood?
11. How often do older transgender people present with mental distress with an onset after 50 years of age?
12. What are the three (3) most common mental illnesses among older transgender people?
13. How does your organisation ensure that an anti-discriminatory approach is followed?
14. What recommendations would you make to government and the community at large to improve service delivery to the older transgender community presenting with mental distress?

Thank you for your participation in this study.

ANNEXURE D: INITIAL LIST OF IDEAS AND THEMES

(Coded data underlined in Data Item column)

Profile	Data Item	Initial Codes
Focus Group Session 4 **11 May 2019** **Didi**	In the 80's in Joburg, all my drag queen friends were thrown out of buildings. The polices (sic) either take you to the highest building in Joburg…which was Ponting and they say you committed suicide or otherwise they take you to Weather pan…you go into the water and they shoot you from behind…they say a (sic) unknown body was washed up. Yes, the cops was (sic) evil. I have a friend of mine, it's a pity she's not here, she's now 51. They took her to the Jewish cemetery, and they hit her with a baton….and her head fell…er, head hit against the slab, unconscious. Two hours later the rain woke her up…she crawled back to the hotel where she was staying. She phone (sic) family to come and get her, when she came to Grootte Schuur, they had to put her in a wheelchair…that's why she survived to tell the tale.	Time period Place and setting Age Police Violence and transphobia Family Community Support
Focus Group Session 5 **25 May 2019** **Dolphin**	**Interviewer:** At what age did you go to a psychiatrist? **Dolphin:** I was still a teenager, I think before 16. Ja before 16, but the reason why I told my mother that was because I came from church that day, and I didn't want to wear a dress. So she asked me what is wrong, and I told her. And they didn't accept it obviously, because they were very conservative. So I was in and out of psychiatrist rooms, and my mother did not accept anything. And things just got from bad to worse, because I acted out in everything that I did. It's a very long story. I acted out by doing what I wanted to do, and not what they wanted me to do. Wearing what I wanted to wear. In standard 3 I refused for them to buy me clothing. I wanted to buy my own clothing. That was in standard 3, and they wouldn't buy me clothing. So I thought to myself, I'm still gonna wear what I wanna wear.	Young age Family Support Stress Resilience Gender Identity
Key Informant Interview **11 June 2019** **Vanya**	**Interviewer:** So it sounds like more older transgender people are presenting mental healthcare challenges. Would that be a correct statement? **Vanya:** No, that's not my experience. From my perspective, I don't see them, so I don't know. We act as an entry point psychiatry. We don't necessarily follow people up. My role is largely assessment, and then referral on for gender affirming care. Lots of people just disappear, so I don't necessarily need to be involved. I just tell them they have capacity to consent to treatment. I think one of the challenges is, there's no money, so if you gonna spend your money on the doctor and you going to spend it on your hormones, or save for your surgery, why do you need to see a psychiatrist. The days of us trying to provide therapy for people and have ten years of therapy before you can go on hormones, that's like 70's, and there are still people who do that, and I help them from time to time. I think don't think that older people necessarily have more psychiatric problems, I think they're spending their money where they get the most value for it, and that's on hormones.	Support Assistance Money Cost HRT Surgery Time period Service quality

ANNEXURE E: THEMES APPLIED TO SECTIONS OF CODES

Codes	Themes
Time period Place and setting Age Police Violence and transphobia Family Community Support	Support structure Violence Acceptance
Young age Family Support Stress Resilience Gender Identity	Coping Resilience
Support Assistance Money Cost HRT Surgery Time period Service quality	Therapy Money Age

ANNEXURE F: PARTICIPANT INFORMATION SHEET

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INFORMATION SHEET FOR PARTICIPANTS

Exploring the mental health care needs of older transgender people in the Cape Metropole: A participatory photo voice research project

What is this study about?

The LGBT community inherently and historically suffers oppression the world over. Furthermore, lateral oppression towards transgender people is common in the LGBT community. LGBT discrimination has been indicated as a key factor in the onset of mental health issues later in adulthood. Older adults are generally at a higher risk of developing mental disorders. The older transgender community with mental health care needs thus often suffers multiple oppression within the heteronormative society. The research will aim to determine what the mental health care needs of older (50+) transgender people are in the Cape Metropole, Western Cape, with specific focus on the unique challenges faced by older transgender people, their experiences when accessing mental health care and to describe strategies of addressing their mental health care needs.

What will I be asked to do if I agree to participate?

The participant would be required to take photographs (disposable camera will be supplied) and write memos that express their experience of their own mental health and accessing mental health care services as an older transgender person.

Would my participation in this study be kept confidential?

Yes, the participant's information will remain confidential and in the process sign a letter of consent outlining the stipulations and processes of the research. Including protection, the identity of the participant with use of pseudonyms.

What are the risks of this research?

The engagement might illicit some traumatic and upsetting issues, for which the participants may require counselling services. The researcher will in this case refer the participant for counselling via Gender Dynamix. The risks to the research should also be mentioned.

What are the benefits of this research?

The participant will be allowed to uncover concerns on the mental health care needs of older transgender people. By using PAR and photo voice, the participant will be empowered to lobby for their marginalised communities, by sharing their experiences first hand.

Do I have to be in this research and may I stop participating at any time?

The participants are by no means obligated to participate in the research project and can withdraw from the research project with no consequences. This point is made clear in the consent form.

What if I have questions?

If you have any questions about the research study itself, please contact:

Ricardo Rossouw
Tel: 021949 8562
Cell: 062 988 9951
Email: 3105667@myuwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department of Social Work
Dr. M. Londt
University of the Western Cape
Private Bag X17
Bellville 7535
mlondt@uwc.ac.za

Dean of the Faculty of Community and Health Sciences
Prof Rhoda
University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

ANNEXURE G1: PARTICIPANT CONSENT FORM

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PARTICIPANT CONSENT FORM

Title of Research Project: **Exploring the mental health care needs of older transgender people in the Cape Metropole: A participatory photo voice research project**

The study has been described to me in a language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that information will be recorded. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name: ________________________

Participant's signature: ________________________

Date: ________________________

ANNEXURE G2: KEY INFORMANT CONSENT FORM

UNIVERSITY OF THE WESTERN CAPE

Private Bag X17, Bellville 7535, South Africa

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KEY INFORMANT CONSENT FORM

Title of Research Project: **Exploring the mental health care needs of older transgender people in the Cape Metropole: A participatory photo voice research project**

The study has been described to me in a language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that information will be recorded. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Key Informant's name: ________________________

Signature: ________________________

Date: ________________________

ANNEXURE H: GENDER DYNAMIX MEMORANDUM OF UNDERSTANDING (MOU)

Annexure D

Gender DynamiX
Collingwood Place
10 Anson Street
Observatory
7925

14 November 2017

Research assistance for MSW student: RICARDO JULIAN ROSSOUW

Student Number : 3105667

Proposed title : Exploring the mental health care challenges of older transgender people in the Cape Metropole: A participatory photo voice research project.

In line with the MoU between Gender Dynamix and the UWC LGBT Ageing and Care Project of the UWC Social Work Department, Gender Dynamix undertakes to provide the following research assistance for MSW Student, Ricardo Julian Rossouw (Student Number: 3105667):

- Provision of participants to be used in snowball sampling
- Contacts of key-informants to be used for questionnaire
- Providing ethical guidance
- Training in gender sensitization
- A safe space to conduct focus groups
- Ongoing guidance and support to the MSW Student throughout the course of the study.

Glenton "Liberty" Matthyse
National Advocacy Officer
Gender DynamiX
Email: advocacy2@genderdynamix.org.za
Tel: 021 447 4797

ANNEXURE I: FOCUS GROUP CONFIDENTIALITY BINDING FORM

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FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: **Exploring the mental health care needs of older transgender people in the Cape Metropole: A participatory photo voice research project**

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Focus Group maintaining confidentiality.

I hereby agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

Participant's name: ________________________

Participant's signature: ________________________

Date: ________________________

ANNEXURE J: ETHICS AND SAFETY

Exploring the mental health care challenges of older transgender people in the Cape Metropole: A participatory photo voice research project

Ethics and Safety Guidelines

Voluntary Participation

- In what way can I show respect for a person's decision to be photographed?
- How do I get consent to take their picture?

Do No Harm

- What is my purpose for taking this photo?
- Am I creating and using photos in a manner that will do no harm to persons appearing in the photos?

Fairness/Justice

- Am I using photos in a way that fairly represents the real situation, subject identity, or physical location of the image?
- Am I respectful of the people, places, and things that I am photographing?

Image Ethics

Four distinct but important areas of privacy that must be taken into consideration when participants take photographs during their photo voice experience:

- Intrusion into one's private space
- Disclosure of embarrassing facts about individuals
- Being placed in false light by images
- Protection against the use of a person's likeness for commercial benefit

Photographer Safety

~ Maintaining your personal safety is of highest priority. No photo is worth personal danger.

ANNEXURE K: PHOTOGRAPHY POWER, ETHICS & LEGAL ISSUES

Photography Power, Ethics, and Legal Issues Activity

This worksheet will be used to generate individual reflection and group discussion when teaching about Photography Power, Ethics, and Legal Issues.

Scenario 1: Frank is in his home, eating supper. He happens to look out his window, and sees someone on the sidewalk near his house. The person keeps looking up and down the street nervously. He seems to be looking at Frank's house. Finally, this person pulls out a camera, takes a picture of the house, and runs away.

- What seems to be happening here?
- What is going wrong?
- What could be done differently?

Scenario 2: Judy has to work an early morning shift. She did not sleep well, and has not had her coffee yet. She is tired and cranky, having just dragged herself out of bed. She is standing at the bus shelter waiting for her bus. Someone across the street is watching her. This person all of a sudden pulls out a camera and takes her picture.

- What seems to be happening here?
- What is going wrong?
- What could be done differently?