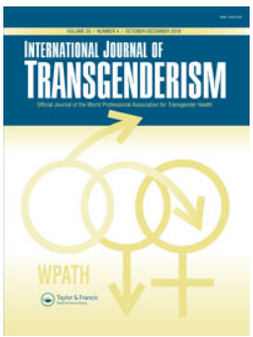

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Seeking help when transgender: Exploring the difference in mental and physical health seeking behaviors between transgender and cisgender individuals in Ireland

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ABSTRACT

Background: While there is growing awareness of the need to support the physical and mental wellbeing of transgender people, some may be reluctant to seek help from healthcare professionals. Little is understood about the mechanisms that influence help-seeking behavior in this group.

Aims: This study aimed to compare transgender and cisgender participants in their likelihood to seek help for both physical and mental health conditions, and to explore whether this help-seeking behavior is predicted by a range of sociodemographic and psychological variables.

Methods: 123 participants living in Ireland (cisgender= 67; transgender= 56) completed a questionnaire which included demographic questions, as well as measures of optimism (LOT-R), self-esteem (RSES), psychological distress (GHQ-12), attitudes towards seeking psychological help (ATSPPH-SF), and attitudes towards seeking help for a physical health problem (Attitudes Towards Seeking Medical Help Scale- Action/Intervention subscale). Associations between predictor variables and mental and physical health seeking were explored using correlation analysis and stepwise regressions.

Results: Transgender participants were less likely to seek help for a physical health issue than cisgender participants, but did not differ in mental health help-seeking behaviors. Results suggest that this may be due to differences in optimism, self-esteem and psychological distress. Transgender participants had significantly lower optimism and self-esteem, which were two factors linked to poorer physical health seeking behaviors. Optimism also emerged as a significant predictor in mental health seeking behaviors.

Discussion: The lack of a significant difference for mental health help-seeking between the transgender and cisgender participants is encouraging, as it suggests that there is less stigma surrounding mental illness than expected, however findings also contradict previous findings suggesting that physical health is less stigmatized. This could be due to stigma relating to gender-specific healthcare and suggests that healthcare professionals should acknowledge the specific healthcare needs and concerns among transgender individuals.

KEYWORDS

Transgender health; help seeking behavior; physical health; mental health; wellbeing; stigma; Ireland

Introduction

The World Health Organization describes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 2005). This state can vary significantly between individuals and can be influenced by health behaviors which are carried out by people in order to improve or maintain their physical or mental health. These include health seeking behaviors, such as seeking the services of a healthcare professional when in need (Mahmood, Iqbal, & Hanifi, 2009). Studying the factors that influence health seeking behaviors can give a greater insight into how these behaviors may be encouraged and therefore improve both global and individual health. However, while a number of studies have attempted to explore the key influences on health seeking behaviors among the general population, the health seeking behaviors of transgender people have received less research attention.

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Transgender is an umbrella term referring to individuals whose gender identity or expression does not match the sex they were assigned at birth (Haynes & Schweppe, 2017; Drescher, Cohen-Kettenis, & Winter, 2012). For example, a transgender man is someone who was assigned female at birth but identifies as a male, while a transgender woman is someone who was assigned male at birth but identifies as female (McNeil, Bailey, Ellis, Morton, & Regan, 2012). In contrast, the term used to describe someone who is not transgender is cisgender (Drescher et al., 2012).

While variations in health seeking behaviors - in particular those relating to physical health - between transgender and cisgender people has not been widely studied (e.g., Persson Tholin & Broström, 2018), it is known that these behaviors can vary with other demographic characteristics (Johansson, Long, Diwan, & Winkvist, 2000; MacKian, 2003). For example, individuals who use health services the most are young children and the elderly (Meara, White & Cutler, 2004), while women have been shown to use health services more frequently than men (Fuller, Edwards, Semsri, & Vorakitphokatorn, 1993). In terms of mental health seeking behaviors however, another study found that younger people, especially men, were less likely to seek help for a mental health problem than their older counterparts (Biddle, Gunnell, Sharp, & Donovan, 2004). These studies point to considerable sociodemographic variations in people's tendencies to seek help, with differences occurring in help seeking for mental and physical health issues.

Aside from demographic factors, perceived stigma has been shown to be a major influence on help seeking behaviors (Clement et al., 2015; Eisenberg, Downs, Golberstein, & Zivin, 2009; Heng, Heal, Banks, & Preston, 2018; Salkas, Conniff, & Budge, 2018). According to Bauer et al. (2009), transgender people are one of the most stigmatized groups in society. In addition to this, many transgender individuals may also be part of other marginalized groups. Some transgender individuals face a particular type of discrimination known as transphobia, which is the fear, dislike or hatred of people perceived to be transgender (Haynes & Schweppe, 2017). In 2017 alone, 325 transgender individuals worldwide were reported as having been murdered (Transgender Europe, 2017), while in Ireland 62 hate crimes against transgender individuals were reported between 2014 and 2016, including physical attacks, rape and death threats (Haynes & Schweppe, 2017). Stigma, such as that resulting from transphobia, may create a barrier to healthcare for many marginalized groups (Brown, Kucharska, & Marczak, 2018; Nadeem et al., 2007), however stigma can also result from attitudes towards a particular health issue. For example, mental health issues may be more stigmatized in society than other health issues (Corrigan, 2004; Rüsch, Angermeyer, & Corrigan, 2005), possibly explaining why the majority of people with mental health problems do not seek help for their conditions (Clement et al., 2015). This may be a particular concern for transgender individuals, given that the rates of mental health problems are much higher than among cisgender individuals (e.g., Bouman et al., 2017; Jones, Bouman, Haycraft, & Arcelus, 2019; Witcomb et al., 2018). One large-scale study ($n = 279$) of the Irish transgender population, for example, used the DASS-21 to measure levels of depression, anxiety and stress (Higgins et al., 2016). This study calculated the scores by doubling the final scores for each item so that they could be scored according to the DASS-42. The findings were that 33% suffered from severe levels of depression (a score of 21–27) while 35% suffered from severe levels of anxiety (a score of 15–19) (Higgins et al., 2016). Furthermore, 75% reported having considered suicide, with 35% having made an attempt, and 49% having self-harmed (Higgins et al., 2016). While the higher rate of mental health problems in transgender individuals suggests that this group should seek psychological help, this may not be the reality. As evidence of this, Ellis, Bailey, and McNeil (2015) reported that 40% of Irish transgender people did not seek help for urgent mental health problems because of negative past experiences such as being told they were not really transgender or being discouraged from exploring their gender identity.

While certain types of physical health issues, such as HIV (Kalichman & Simbayi, 2003) and

tuberculosis (Dodor, Neal, & Kelly, 2008), come with stigma attached, it is generally thought that, physical health is less stigmatized than mental health (Corrigan, 2004). Because of this, studies investigating help seeking behaviors tend to focus more on factors influencing mental health seeking rather than physical health seeking behaviors. However, people with mental health problems are more likely to have a physical illness than those without mental health problems (Ewart, Bocking, Happell, Platania-Phung, & Stanton, 2016). For individuals with both physical and mental health problems, help seeking may be particularly difficult. This group often report feeling disempowered and have negative experiences with medical services, as their physical illness can be dismissed due to their diagnoses of mental health problems (Ewart et al., 2016).

In addition to their stigmatized status in society, transgender individuals often have a unique set of physical healthcare needs known as gender affirming healthcare (Lombardi, 2001). This can consist of gender affirming hormone therapy and/or surgeries (Wagner & Asbury, 2016). If they are to access gender affirming healthcare, these individuals need to interact with healthcare services much more frequently than the general public. In order to be referred to an endocrinologist for gender affirming hormone therapy in Ireland, for example, a diagnosis of gender dysphoria is required from either a psychiatrist or clinical psychologist (American Psychiatric Association, 2013; Health Service Executive, 2018). This means that both mental and physical health services are required in the process of medical transition. After a diagnosis of gender dysphoria, transgender people are referred to a regular endocrinology department. As there are currently only three endocrinologists in the country with adequate knowledge to prescribe cross-sex hormones, the waiting list is currently between 29 and 35 months long (Dean, 2019). There is a gap in the literature exploring transgender healthcare in Ireland. The majority of research into transgender healthcare has focused on the United Kingdom (UK) and United States of America (USA), both of which have many more resources available for transgender individuals wishing to medically transition, such as transgender health clinics, as well as more endocrinologists and psychologists, who have greater experiences with transgender issues (Ellis et al., 2015; Lombardi, 2001). Although Ireland was one of the first countries to introduce gender recognition by self-declaration (Szydlowski, 2016), transgender healthcare in the country lags behind the UK and the USA. It is one of the few developed countries remaining without a dedicated transgender health clinic (McNeil et al., 2012).

More generally, transgender people may be discouraged from seeking the help they need due to a lack of resources and a lack of knowledge among health professionals (McNeil et al., 2012). These individuals often describe having to educate healthcare professionals on transgender issues (Bauer et al., 2009). Hearing about negative experiences other transgender people have had can also discourage them from seeking help (Lombardi, 2001). Some health professionals may not believe that transgender identities are legitimate and view procedures such as gender affirming hormone treatment and surgeries as unnecessary (Szydlowski, 2016). This may consequently lead to refusal of treatment. Meanwhile, mental health professionals may misattribute mental health problems as stemming from, or causing, transgender identity, which may result in the avoidance of help seeking behaviors for mental health problems among some transgender individuals (Bauer et al., 2009). McNeil et al. (2012) report that 11% of GPs have refused to treat transgender patients in Ireland.

However, despite evidence suggesting that transgender people may be less likely to seek help for various mental and physical health conditions, it is possible that certain psychological factors may impact positively on their health seeking behaviors. For example, optimism has been found to positively influence health seeking (Aspinwall & Brunhart, 1996; Carvajal, Wiatrek, Evans, Knee, & Nash, 2000; Lai & Cheng, 2004), with optimistic younger individuals more likely to take measures to protect their health (Lai & Cheng, 2004), and less likely to take risks (Carvajal et al., 2000). Similarly, those with higher levels of self-esteem are more likely to engage in behaviors to maintain mental health (Torres & Fernández, 1995), while individuals with low levels of self-

esteem are less likely to seek counseling or psychological help for mental health problems as a result of self-stigma (Lannin, Vogel, Brenner, & Tucker, 2015). Exploring the role that these factors may play in encouraging help-seeking within transgender individuals is merited.

Aims and objectives of the current study

Transgender people have been found to have high rates of psychological distress (Higgins et al., 2016), however findings show that the mental health of these individuals improve when they receive gender affirming healthcare (Dhejne, van Vlerken, Heylens, & Arcelus, 2016; McNeil et al., 2012). Although the need to medically transition, as well as the higher rates of psychological distress indicate that this group should interact with health services more often than the general population, previous findings suggest that they often avoid seeking help (McNeil et al., 2012). This study aims to build on existing literature which has found that stigma is often a barrier to health seeking behaviors (Clement et al., 2015; Eisenberg et al., 2009; Salkas et al., 2018) by examining health seeking behaviors among transgender people.

The overall aim of the study is to examine health seeking (both physical and mental) behaviors among the transgender individuals in Ireland. Sub-objectives were to (i) compare the mental and physical health seeking behaviors between a transgender and cisgender sample, and (ii) explore possible predictors of mental and physical health seeking behavior among the transgender sample. Of particular interest were the possible associations between health seeking and various sociodemographic characteristics and psychological factors among the transgender sample. Gender identity, age, employment, and education were chosen as potential predictors/controls, in addition to specific factors relating to gender transition such as whether individuals had legally (name and/or gender marker change) or medically transitioned.

It is hypothesized that transgender participants, as members of a stigmatized group, will have more negative attitudes towards both mental and physical health seeking behaviors than cisgender participants. The role of sociodemographic characteristics and psychological factors (specifically levels of optimism, self-esteem and psychological distress) in health seeking behaviors will also be explored. By focusing on health seeking behaviors in Ireland, a country with so few transgender-specific medical resources, the findings may give insight into the kind of improvements that could be made in order to increase help seeking behaviors and reduce the rates of depression and anxiety among transgender people.

Materials and methods

Participants

Following ethical approval from the Department of Psychology at Maynooth University in Ireland, a total of 123 participants (67 cisgender, 56 transgender) were recruited using convenience sampling. In order to recruit a large enough number of transgender participants for comparison in this study, information about the study was posted in a number of online transgender support groups based in Ireland, as well as via the Transgender Equality Network of Ireland. The participants had to be aged 18 or older to take part in the study and the age range was 18–70 ($M = 25.29$; $SD = 8.79$). Informed consent was obtained from all participants included in the study. The consent form stated that participation was voluntary, that all data would remain confidential and that participants had a right to withdraw. In addition to this, contact details were provided in case participants had questions or concerns about the research. The data were stored on a password protected and encrypted laptop and were only accessible by the researchers. As some of the questions related to mental health, a number of relevant helplines were listed at the end of the questionnaire.

Measures and procedure

Participants were invited to take part in a study on health seeking behaviors by completing an online questionnaire. The questionnaire was designed and hosted on an online questionnaire creator software, Qualtrics. With the exception of two additional questions for the transgender

participants, all participants were asked the same set of questions which are detailed below.

Sociodemographic characteristics

Firstly, information on participants' age, gender identity (see below), employment status, and education level were gathered. As the healthcare system in Ireland is two-tiered, with public and private options, participants were asked whether they held a medical card (a card which entitles people below a certain income threshold to free or lower cost healthcare) and/or whether they held private health insurance, both of which were included due to the possible influence on participants' ability to access affordable healthcare in Ireland.

Suggestions from individuals in the transgender support groups in which the study had been shared were acknowledged in the options presented for the gender identity question. These were the inclusion of two additional gender identity options ("genderfluid" and "agender") to represent people who felt that they did not fit the original categories of "man", "woman" and "non-binary", and an additional option for the question "Do you identify as transgender?" The additional option was "I don't identify with the gender I was assigned at birth, but do not consider myself trans". However, as the definition of transgender used in this study was any individual who does not identify with the gender they were assigned at birth (Haynes & Schweppe, 2017), participants who selected this option were included as part of the transgender group for the purposes of analysis.

Transgender participants were also asked if they had legally transitioned (defined as having either name and/or gender change) and/or if they had medically transitioned, including whether they planned to medically transition.

Self-esteem

Self-esteem was measured using the most widely used measure of global self-esteem, the Rosenberg Self-Esteem Scale (RSES) (Rosenberg, 1965; Schmitt & Allik, 2005). This is a ten-item scale which measures positive and negative views about the self (e.g. "On the whole, I am satisfied with myself", "At times, I think I am no good at all") where participants rate their agreement on a 4-point Likert scale (1 = Strongly Disagree; 4 = Strongly Agree). After negatively phrased items are recoded, responses are summed, with higher scores indicating higher levels of self-esteem. The Cronbach's Alpha for this scale was .903 in our sample, indicating a high level of reliability.

Psychological distress

The 12-item short form General Health Questionnaire (GHQ-12) was used to assess participants' current levels of psychological distress. This was developed from the original 60 item GHQ, which is designed to detect mental illness in the general population (Sánchez-López & Dresch, 2008). The GHQ-12 is widely used and is the most commonly used version of the GHQ (Kalliath, O'Driscoll, & Brough, 2004). Participants rate their agreement with a number of statements about how they have been feeling over the past few weeks (e.g. "Been able to concentrate on what you're doing?") using a four-point Likert scale (0 = More than usual; 1 = The same as usual; 2 = A little less than usual; 3 = Much less than usual). Higher scores indicate higher levels of psychological distress. The Cronbach's Alpha was analyzed to measure the reliability of this scale and was found to be .864.

Optimism

Optimism was measured using the Life Orientation Test Revised (LOT-R), which is a ten-item scale that measures dispositional optimism- the belief that, in general, outcomes will be positive (Burke, Joyner, Czech, & Wilson, 2000). Participants rate their agreement with statements (e.g. "I'm always optimistic about my future") on a 5-point Likert scale (0 = I disagree a lot; 4= I agree a lot). Responses to items are summed with higher scores indicating higher levels of optimism. It was adapted from the original LOT, which was revised by removing two items in order to focus more on expectations of positive outcomes than negative outcomes (Burke et al., 2000). The Cronbach's Alpha for this scale was .828.

Attitudes towards seeking mental health help

Participants' attitudes towards seeking psychological help were measured using the Attitudes Towards Seeking Professional Psychological Help Short Form (ATSPPH-SF). This scale was developed as a shorter version of Fischer and Turner's original 29 item ATSPPH scale (1970). This scale measures attitudes towards seeking psychological help for a mental health problem (Shea & Yeh, 2008) on a 4 point Likert scale (0 = Disagree; 3 = Agree), for example "If I believed I was having a mental breakdown, my first inclination would be to get professional attention.". Higher scores indicate more positive attitudes towards seeking professional psychological help. The Cronbach's Alpha for this scale was .686.

Attitudes towards seeking physical health help

To measure participants' attitudes towards seeking help for a physical health problem, the action/intention medical help-seeking subscale of the Attitudes Towards Seeking Medical Help Scale was used. This is a 12-item scale which measures attitudes towards seeking help for a physical health problem (e.g. "I would rather live with some physical problems than go through a lot of medical tests and checkups") on a 4 point Likert scale which was scored 3= Agree; 0= Disagree for pro help seeking items, and 0 = Agree; 3 = Disagree for anti-help items (Fischer, Dornelas, & DiLorenzo, 2013). Responses are summed with higher scores indicating more positive attitudes towards seeking help for physical health problems. The Cronbach's Alpha for this scale was .905.

Data analysis

For the purposes of analysis, data were inputted into IBM SPSS v24 (IBM Corp, 2016). Firstly, descriptive statistics and frequencies were computed for all variables. After testing for normality, independent t-tests were then conducted to examine differences between the transgender and cisgender groups for attitudes towards seeking help for mental health problems and attitudes towards seeking help for physical health problems, as well as differences in the other continuous variables measured in the study, with the exception of age, which was non-normally distributed. A Mann-Witney *U* test was used in this instance, Chi-square tests of independence were also conducted to compare differences between the transgender and cisgender participants on the various categorical socio-demographic variables. Effect sizes were computed using Cramer's V (for categorical variables) and Cohen's d (for continuous variables).

After this, correlational analysis using Pearson's r was conducted to ascertain the relationships between mental and physical health seeking behaviors and the other variables measured. Separate analyses were conducted for the transgender and cisgender samples here. This informed the development of two multiple regression models; one in which the dependent variable was attitudes towards seeking help for a physical health problem, and one in which the dependent variable was attitudes towards seeking help for a mental health problem. Prior to this, preliminary analyses were carried out to ensure that the data did not violate the assumptions of normality, homoscedasticity and linearity. In order to increase power, only variables which bore significant relationships to health seeking behaviors in the correlational analysis were included in the regression models.

Results

Descriptive statistics and comparisons between cisgender and transgender participants

Tables 1 and 2 display the descriptive statistics for the sample, as well showing the comparisons between the cisgender and transgender groups. Overall, there was a total of 123 participants (47 men, 51 women, 20 non-binary, 3 genderfluid, 2 agender; or 67 cisgender, 56 transgender) with an age range of 18–70 (M = 25.29, SD= 8.789). Thirty-eight % of participants indicated that they identified as transgender, 55% did not identify as transgender, and 7% selected that they did not identify with the gender they were assigned at birth, but did not consider themselves transgender, however as mentioned previously, for the purposes of analysis these individuals were included within the transgender group given that they fit with the established definition of

Table 1. Comparisons between cisgender and transgender participants on categorical variables.

Variable	Transgender N (%)	Cisgender N (%)	χ^2	Cramer's V
Gender identity				
Male	28 (50%)	19 (29%)	65.973***	0.7
Female	3 (5%)	48 (72%)		
Non-binary	25 (45%)	–		
Education				
Secondary level or below	26 (47%)	15 (23%)	7.933*	0.3
Third level	30 (54%)	52 (78%)		
Employment status				
Employed (full or part-time)	24 (43%)	40 (60%)	3.468	0.2
Not employed	32 (57%)	27 (40%)		
Medical card/health insurance				
No	16 (27%)	23 (34%)	0.467	0.1
Yes	40 (71%)	44 (66%)		
Legally transitioned				
No	34 (61%)			
Yes	22 (39%)			
Medically transitioned				
No, and no plans to	16 (29%)			
No, but plans to	26 (46%)			
Yes	14 (25%)			

***$p < .001$; **$p < .01$; *$p < .05$.

Table 2. Comparisons between cisgender and transgender participants on continuous variables.

Variable	Transgender M (SD)	Cisgender M (SD)	t	*df*	*d*
Mental Health Help Seeking	20.17 (4.10)	21.13 (4.54)	1.140	106	0.2
Physical Health Help Seeking	19.34 (9.14)	24.91 (6.63)	3.553**	101	0.7
GHQ (psychological distress)	22.24 (6.23)	18.81 (5.49)	−3.086**	109	0.6
Self-esteem	23.06 (5.45)	27.52 (5.23)	4.481***	113	0.8
Optimism	8.56 (5.01)	13.07 (5.72)	4.481***	103	0.9
Age	23.94 (6.65)	26.43 (10.16)	*U = 1324; p = 0.172*		

***$p < .001$; **$p < .01$; *$p < .05$.

transgender (Haynes & Schweppe, 2017). Of the transgender group, 71% either had begun medically transitioning or had plans to medically transition. The majority of participants indicated that they were students and over two thirds of the participants held a medical card or private health insurance.

Cisgender and transgender participants did not differ in terms of their age, employment status or whether they held a medical card or health insurance, however the cisgender sample had a higher likelihood of holding a third level qualification (i.e. higher education at college or university) ($\chi^2 = 7.933$; $p < .01$). In the transgender group, 28 identified as male, 25 as non-binary and 3 as female. Gender identity was thus imbalanced between the two samples, with a greater number of cisgender participants identifying as female ($\chi^2 = 65.973$; $p < .001$).

When examining the continuous measures used in the study (see Table 2), transgender participants were shown to differ to cisgender participants on all measures, with the exception of mental health seeking. Specifically, transgender participants had lower levels of physical health help seeking ($t = 3.553$; $d = 0.7$; $p < .01$), higher levels of psychological distress ($t = -3.086$; $d = 0.6$; $p < .01$), lower levels of self-esteem ($t = 4.481$; $d = 0.8$; $p < .001$) and lower levels of optimism ($t = 4.481$; $d = 0.9$; $p < .001$). Observation of the effect sizes suggests that the magnitude of all these differences was large.

Correlational and regression analyses

Table 3 displays the results of the correlational analysis for the transgender participants. As can be seen here, only optimism was shown to positively correlate with mental health help seeking ($r = 0.35$; $p < .05$), however all psychological measures correlated with physical health seeking. Specifically, physical health seeking was positively related to self-esteem ($r = 0.50$; $p < .001$) and optimism ($r = 0.48$; $p < .001$), and negatively related to psychological distress ($r = -0.41$; $p < .001$). Age was also positively correlated with likelihood to seek help for a physical problem in the transgender sample ($r = 0.36$; $p < .05$). By means

Table 3. Correlations between all variables in the transgender sample.

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Mental Help Seeking	**1**												
2. Physical Help Seeking	**.34***	**1**											
3. Age	**0.22**	**.36***	1										
4. Education [0 = secondary or below; 1 = higher level]	**−0.14**	**−0.17**	0.10	1									
5. Employed [0 = no; 1 = yes]	**−0.21**	**−0.22**	0.01	.81**	1								
6. Medical card or insurance [0 = no; 1 = yes]	**0.06**	**0.26**	0.20	−0.11	−0.25	1							
7. Male [0 = no; 1 = yes]	**0.00**	**0.13**	0.09	−0.14	−0.22	0.00	1						
8. Non-binary [0 = no; 1 = yes]	**−0.10**	**−0.23**	−0.27	0.12	0.17	−0.07	−.90**	1					
9. Legally transitioned [0 = no; 1 = yes]	**0.08**	**0.05**	0.17	−.28*	−.40**	0.18	.44**	−.43**	1				
10. Medically transitioned [0 = no; 1 = yes]	**−0.07**	**−0.08**	−0.08	0.05	0.11	−0.08	−.39**	.45**	−.39**	1			
11. Psychological distress (GHQ)	**−0.24**	**−.41****	−0.07	0.13	0.20	0.09	−0.21	0.17	−0.05	−0.03	1		
12. Self-esteem (RSES)	**0.24**	**.50****	0.22	−0.06	−0.11	0.14	0.03	−0.09	0.09	−0.13	−.45**	1	
13. Optimism (LOT-R)	**.35***	**.48****	0.22	−.29*	−.30*	−0.01	0.14	−0.16	0.14	−0.14	−.47**	.68**	1

*$p < 0.05$; **$p < 0.01$.

Table 4. Correlations between all variables in the cisgender sample.

Variables	1	2	3	4	5	6	7	8	9	10
1. Mental Help Seeking	**1**									
2. Physical Help Seeking	**.30***	**1**								
3. Age	**−0.02**	**0.21**	1							
4. Education [0 = secondary or below; 1 = higher level]	**−0.21**	**0.11**	−0.18	1						
5. Employed [0 = no; 1 = yes]	**−0.15**	**0.16**	−0.05	.65**	1					
6. Medical card or insurance [0 = no; 1 = yes]	**0.15**	**−0.04**	0.00	0.14	0.11	1				
7. Male [0 = no; 1 = yes]	**−0.18**	**−0.12**	0.24	0.18	0.11	−.03	1			
8. Psychological distress (GHQ)	**−0.21**	**−0.20**	−0.22	−0.03	−0.16	−0.02	.33*	1		
9. Self-esteem (RSES)	**0.01**	**0.20**	0.25	0.11	0.01	−0.02	−.36**	−.53**	1	
10. Optimism (LOT-R)	**0.19**	**0.21**	0.15	0.04	−0.03	0.09	−.40**	−.39**	.75**	1

*$p < 0.05$; **$p < 0.01$.

Table 5. Multiple regression analysis investigating predictors of mental health seeking in transgender sample.

Variable	*β*	*p*	*t*	B	*SE*	CI 95%	
Optimism (LOT-R)	.345*	.016	2.490	.282	.113	.054	.510
Total R^2 = 0.12*							

*$p < .05$.

Table 6. Multiple regression analysis investigating the predictors of physical health seeking in transgender sample.

Variables	*β*	*p*	*t*	B	*SE*	CI 95%	
Age	.253	.061	1.931	.347	.180	−.017	.711
Psychological distress (GHQ)	.166	.362	.923	.302	.328	−.360	.965
Self-Esteem (RSES)	.240	.186	1.346	.401	.298	−.202	1.004
Optimism (LOT-R)	−.201	.181	−1.362	−.295	.216	−.732	.143
Total R^2 = 0.37*							

*$p < .05$.

of comparison, the correlational analysis for the cisgender sample has also been included in Table 4. Interestingly, no significant relationships emerged between any of the measures and the two-health seeking behaviors here.

Guided by the results of the correlational analysis, two stepwise regression analyses were conducted to investigate the predictors of both mental and physical health seeking scores in the transgender sample. One predictor (optimism) was entered into the model of mental health seeking, which explained a significant 12% of the variance ($F = 6.199$; $df = 1,14$; $p = .016$). As can be seen in Table 5, optimism emerged as a significant predictor of mental health seeking ($\beta = .345$; $p = .016$). Four predictors were entered into the model of physical health seeking (age, self-esteem, optimism and psychological distress). While this model was significant, explaining 37% of the variance ($F = 5.744$; $df = 4,36$; $p = .001$), no single variable emerged as a significant predictor here (see Table 6).

Discussion

The results of this study provide an interesting insight into both the mental and physical health-seeking behaviors of transgender individuals in Ireland. Most notably, we found that while our transgender sample did not differ from the cisgender sample in their likelihood to seek help for a mental health condition, they were less likely to report seeking help for physical health problems. This indicates that there may be barriers to physical help seeking behaviors in this group, which need to be acknowledged by healthcare professionals.

Our finding that there was no difference in attitudes between transgender and cisgender

participants towards seeking help for a mental health problem was unexpected, and contradicts previous findings suggesting that mental health is more stigmatized than physical health (Corrigan, 2004). The fact that there was no significant difference in attitudes towards seeking help for a mental health problem between transgender and cisgender individuals is encouraging, as it suggests that mental illness may not carry as much stigma as had been thought. This may be due to the context in which the research was carried out. Ireland has a number of national campaigns set up to raise awareness of mental health issues, such as the Health Service Executive (HSE)'s mental health and wellbeing campaign, which shares evidence-based ways of maintaining positive mental health through national advertising (Health Service Executive, 2018).

However, we also found that transgender participants with lower levels of psychological distress held more positive attitudes towards seeking help for a mental health problem. This reflects previous findings that those most in need of psychological help do not seek it (Clement et al., 2015; McNeil et al., 2012). So, although it appears that help seeking for mental health problems is less stigmatized, this help is still not being sought out by those who need it most. Cisgender participants had significantly lower levels of psychological distress than transgender participants, however this bore no associations with their health-seeking behaviors. This suggests that interventions to encourage help-seeking behavior should be developed and aimed at transgender individuals specifically.

In addition to the higher levels of psychological distress, transgender participants also had significantly lower levels of optimism and self-esteem. In other words, although they did not differ overall in their attitudes towards seeking help for a mental health problem, they experienced poorer mental health overall than cisgender individuals. These findings echo a study by McNeil et al. (2012) who found that transgender individuals in Ireland had much higher rates of mental illness than the general population, but did not seek help for these issues. This may be due to the problematic pathway of medical transition in Ireland (McNeil et al., 2012), or perhaps due to the prevalence of transphobia in society (Haynes & Schweppe, 2017).

The fact that attitudes towards seeking help for a physical health problem were more negative among transgender participants is worrying, as physical health is thought to have less stigma attached to it than mental health (Corrigan, 2004). Although these findings contradict previous literature, they make sense when one considers areas of physical healthcare which are not inclusive of transgender identities. Unlike mental health, certain aspects of physical health are gendered. For example, many transgender men retain a typical female reproductive system, and therefore would require gynaecological healthcare. An issue arises, for example, when considering that Cervical Check, Ireland's national screening program for cervical cancer offer cervical checks for "women aged 25 to 60" (Health Service Executive, 2018). This language may be perceived to exclude transgender men and non-binary people with a cervix, and also may leave transgender men who have legally changed their gender to either be excluded from this free health check, or alternatively be forced to 'out' themselves. Similarly, transgender women who have a prostate may have greater difficulty accessing healthcare relating to the symptoms of prostate cancer, as national awareness campaigns about this associate prostate cancer with cisgender men (Irish Cancer Society, 2019). As transgender people often wish to be rid of their primary and/or secondary sex characteristics (American Psychiatric Association, 2013), it may also be the case that many transgender individuals will not seek help for gender specific healthcare. The problem is not only the distress this can cause transgender individuals due to the contradiction between gender identity and gendered healthcare (Rachlin, Green, & Lombardi, 2008), but it can also cause difficulties if the individual has legally changed their gender or has medically transitioned. An even bigger issue is that these individuals could be refused treatment. For example, one transgender man, died of ovarian cancer due to being denied treatment by 26 medical professionals (Rachlin et al., 2008).

The findings of this study emphasize the need for further research into this area, as well

highlighting the need to put interventions in place in order to increase and support help seeking behaviors in the transgender community. This could include a national program to educate healthcare professionals on transgender identities and their specific health needs. Subsequently, medical professionals who have received training on transgender issues could advertise their practices as transgender friendly in order to encourage transgender patients to utilize the service. This would prevent the refusal of treatment to transgender individuals that has been discussed in previous studies (McNeil et al., 2012; Rachlin et al., 2008). Another way help seeking could be encouraged would be through awareness campaigns organized by healthcare organizations and/or transgender organizations. These could relate particularly to gender specific care, for example on the importance of prostate checks for transgender women and chest checks for transgender men. General awareness campaigns about gender specific health problems could also be more inclusive of transgender people in their campaigns and language. This may encourage more transgender people to seek out this preventative healthcare and would not only reduce discomfort for these individuals, but also normalize seeking out this healthcare as a transgender person.

Of particular note is that our study also suggests that any differences in attitudes to seeking help for a physical health condition may be partly attributable to psychological factors, including levels of psychological distress, optimism and self-esteem. Our analysis suggests that by fostering more positive appraisals of well-being, and alleviating mental distress, transgender people may be more willing to seek help for physical problems.

Strengths and limitations

One of the strengths of this study is that it addresses a gap in the literature. Few studies have looked at health seeking behaviors among transgender people, and those that have are predominantly based in the UK and the USA (Heng et al., 2018; Salkas et al., 2018). This is the first study to date to examine health seeking behaviors among the Irish transgender community. The significant difference in attitudes towards seeking help for physical health problems is a novel finding and suggests that this is an area that requires further study. Another strength of the study is that the sample had a roughly equal amount of transgender (45.5%) and cisgender (54.5%) participants due to efforts made to reach a wide number of transgender people during recruitment, however unfortunately there was a lower number of transgender females that took part in the study in comparison to those identifying as male or non-binary. As such, the results of this study are somewhat limited in their generalisability. In addition to this, the transgender sample was explored as a whole, however it is important to note the sample was not homogenous, in that a large amount were treatment seeking. This was a limitation as individuals at different stages of medical transition may vary in their levels of mental health. However, it is also notable that transition status bore no relationship to physical or mental health seeking in this study.

The study may have suffered from some methodological limitations, including for example, the fact that the Cronbach's Alpha for attitudes towards seeking help for a mental health problem was low compared with the other measures. Another issue was that information on participants' assigned gender at birth was not collected, which may have influenced results. Both regression models only explained a small amount of the variance, and for the physical health seeking model, no one significant predictor emerged. Overall, this study could be improved by exploring additional variables such as assigned gender at birth, health status, and other factors such as the provision of social support.

Another issue with this study is that it examined attitudes towards help seeking behaviors, but it did not examine specifically why participants held these attitudes. Possible reasons for these attitudes may include previous negative experiences with healthcare providers or expectations about the healthcare service. In future studies, qualitative research could be useful to explore this further. Although possible reasons for the difference in attitudes towards help seeking for physical health problems have been suggested

here, interviews and focus groups could give a better insight into the reasons behind this by asking participants why they have positive or negative attitudes towards help seeking. The study was also limited in that it only examined current attitudes towards help seeking. It may be of use to ask participants if their attitudes have changed. This study could also be improved on by following up the participants and examining whether their attitudes change over time. As well as this, it may be of use to examine whether participants are members of other marginalized groups to see how if this also influences attitudes towards help seeking.

Nevertheless, this study highlighted a number of factors which may impact on attitudes to help seeking, in particular pointing to the valuable role of psychological well-being and optimism in mediating the relationship between transgenderism and health-seeking behavior.

Conclusions

This study gives an insight into the attitudes that some transgender people in Ireland hold towards help seeking, but also highlight the barriers faced and the changes that need to be made to the current healthcare system in order to become more accessible to transgender individuals. The findings related to attitudes towards seeking psychological help are encouraging however, and perhaps with further research and change, the attitudes towards seeking medical help will improve among the transgender community and rise to a similar level as among the cisgender community. Our analysis also suggests that a number of other variables, most notably aspects of psychological wellbeing and outlook, may influence both types of health seeking behavior so interventions designed to support transgender individuals may focus on fostering these positive traits.

Disclosure statement

The authors declare they have no conflict of interest.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

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