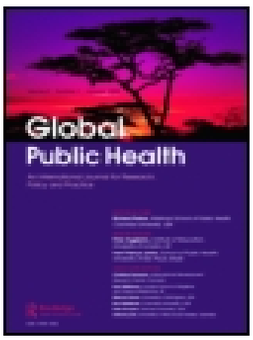

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'This family rejection harmed my health as well': Intersections between the meanings of family and health for trans people and family members in a trans healthcare service in Brazil

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ABSTRACT

Transgender people deal with intense discrimination in every aspect of life. These experiences increase when they face family rejection. The research on social and family environment surrounding gender transition has been largely overlooked. We examine the meanings of family and health, and how these intersect, among trans people and their family members in a health service in Brazil. We conducted a qualitative study (between December 2017 and July 2018), an ethnography with the triangulation of three sources: interviews with 8 transgender men, 8 transgender women and 5 family members; a focus group with another 8 transgender men and approximately 100 h of field observation. Our study shows that family and health are interpreted as ideal protective environments, and seen as causes of disappointment, abandonment and illness. The meanings of family and health are interconnected and constituted in relation to each other. We also found that there are differences within these meanings of family and health when we consider the ethnicity and the economic status of the participants. The participants reported that the society education towards transsexuality is fundamental to improving trans people's quality of life. Our results challenge health services to provide comprehensive healthcare and assure health equity for transgender people.

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Transgender; family; healthcare; qualitative study; ethnography

Introduction

Transgender people, also known as trans people, may be considered by others in society as sexually deviant, morally corrupt, unnatural, or mentally disordered (Winter et al., 2009, 2016). They deal with intense discrimination in every aspect of life – and poor mental health and psychological distress are much higher among this population (The Lancet Public Health, 2020). Many are even killed for expressing their gender identities (Balzer et al., 2016).

Trans people experience poverty, unemployment, housing instability, job discrimination, workplace harassment, violence, trauma, and inadequate access to health, mental health, and social services (Clements et al., 1999; Grant et al., 2011; James et al., 2016; Lombardi et al., 2001; Veldorale-

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Griffin & Darling, 2016; Willging et al., 2019). As pointed out by a Brazilian study, their access to health services is marked by discrimination, disrespect, and the need for education and training on the part of health professionals so that they have a better understanding of the specific life and health circumstances of the trans population (Monteiro & Brigeiro, 2019).

The U.S. Transgender Survey showed that 33% of trans people had suffered negative experiences, including being verbally abused and excluded from medical treatment because of their gender identity. Additionally, 23% said they did not look for healthcare because of fear of being mistreated (James et al., 2016).

Research carried out in the UK shows that transgender and non-binary young people tend to avoid primary healthcare services. The authors state that this probably happens due to dysphoric feelings provoked by their previous experiences of living gender non-affirmative lives (Carlile, 2020; Fae, 2018; Harris, 2018).

In a sample of transgender people in Brazil, 55.2% reported experiences of discrimination in their lives with 49.7% of them describing episodes of discrimination in the family environment (Sousa et al., 2018).

Negative health impacts increase when trans people face family rejection (Veldorale-Griffin & Darling, 2016). Conversely, family acceptance has been shown to be an important protective factor for their health (Grant et al., 2011; Riggs et al., 2020; Shiffman et al., 2016; Simons et al., 2013; Veldorale-Griffin & Darling, 2016).

Research relating to trans people tends to focus on medical care, particularly in terms of mental wellbeing (Dierckx et al., 2016). The social and family environment surrounding gender transition has been largely overlooked (Dierckx et al., 2016; Giovanardi et al., 2018; Hines, 2006; Whitley, 2013). Family research regarding sexual and gender minorities has mainly focused on lesbian, gay and bisexual (LGB) young people, with limited data on trans people (Le et al., 2016).

Understanding what family and health means for trans people can help to design and improve healthcare policies focusing on their needs. This study aims to examine the meanings of family and health, and how these intersect, among trans people and their family members in one of the first health services established for transgender healthcare in Brazil.

Transgender healthcare context in Brazil

Since 1988, the Federal Constitution of Brazil has stipulated that healthcare is a citizen's right (Brasil, 1988). Thus, from 1988 onwards, it is instituted a network of public services in Brazil, attending, with universal access, three levels of care (primary, secondary and tertiary).

In order to guarantee the right of transgender people both to sex reassignment surgery and to healthcare during gender transition, in 2008 (Ordinance no. 457/2008) – and updated in 2013 (Ordinance no. 2803/2013) – the 'Transexualizing Process' in the Unified Brazilian Health System (Sistema Único de Saúde, SUS) was created (Brasil, 2013). This process includes health services of reassignment surgery and other healthcare procedures, such as hormone therapy, psychological support, and clinical follow-up, during gender transition for trans people and their family.

In 2018, there were 10 public healthcare services qualified to offer the 'Transexualizing Process' in SUS, 6 of them in the Southeast Region, the richest region of Brazil (Rocon et al., 2019).

According to the 'Transexualizing Process', transgender healthcare can be carried out by a multi-professional team who must promote comprehensive healthcare considering social determinants. Although healthcare is a citizen's right in Brazil, and the 'Transexualizing Process' in SUS is a public policy that has been in existence for more than 10 years, Brazil is still the country with the highest absolute number of murders of trans people (Balzer et al., 2016). Within this context, it is important to understand the construction of meanings that emerge from the dynamics of family relationships and the identity performances of transsexual people being cared for in a health service devoted exclusively to the comprehensive healthcare of

transsexuals and transvestites. We consider that this research carried out in Brazil could be of benefit to other countries facing a similar reality and contribute to the development of a comprehensive healthcare for trans people.

Methods

Ethics

The sampling method and research design of this study were approved by The Ethics Committee on Human Research of the Faculty of Medicine of the University of São Paulo (USP), CAAE 64944417.1.0000.0065, approval number 2.001.841. Informed consent was obtained from all individual participants included in the study. The informed consent specified that we would exclude identifying information (such as names and locations) from publications, replacing them with fictitious information in order to protect anonymity.

Study design

We conducted a qualitative research, performing an ethnography study (Laplantine, 2004). This ethnographic research was based on the classification proposed by Denzin (1989), which includes the triangulation of three information sources for data construction – focus group, interviews, and field observation. Together, these three sources offer a wide perception of the family and health meanings that are analysed in this research.

Focus groups do not follow a rigid script and can reveal how opinions are generated and, in particular, how they are changed, defended and discarded in social exchange. They can also be understood and used as simulations of daily discourses and conversations, serving to study the generation of social representations or general social knowledge (Flick, 2009).

The purpose of the interviews is to understand the participants on their own terms and how they construct the meanings of their own lives, experiences, and cognitive processes (Yin, 2010). The interviews and focus group do not follow a rigid structure, being based on a semi-structured script, adhering to a conversational style.

The interviews and focus group had five topical clusters: (a) social identification, (b) meanings of family, health, and transsexuality, (c) memories relating to transgender identity, (d) memories relating to family and transgender identity, and (e) family and healthcare.

The field observation was carried out in the health service during consultations to detect the social interactions of trans people and their family members, between each other, and with the health professionals. Every observation was registered in the field diary, following a semi-structured script of participant observation. In this field diary, the researcher made descriptions and reflections of what emerged from the research field.

Population

This health service is part of the SUS Healthcare Network of a city in the Southeast Region of Brazil. This city has about 600,000 inhabitants and 108 SUS health establishments. About 540,000 of the resident population are literate, and the value of the average monthly nominal income of permanent private households in the urban area is of R$ 3,119.74, around US$ 574 at the time of writing (IBGE, 2010).

The health service receives patients (trans people) that come through their own initiative or are referred from Primary Healthcare Units of SUS. At the first consultation, each trans person is asked if he/she/they would like to have a family member present to talk, meet the health team and learn more about the health service dynamics. When the person expresses the wish or the health service

identifies the need for a family member to be present, a written invitation is sent, signed by one of the health professionals.

Data collection

We collected data between December 2017 and July 2018 in one of the first health services created in Brazil for trans people's comprehensive healthcare. This is a multi-professional public healthcare service that provides care in the areas of medicine, psychology, nursing, civil rights, and social work, referring, whenever necessary, to other health, social, and law services.

The inclusion criteria were: (a) ≥18 years old; (b) being a patient or a declared family member of a patient of the health service. The exclusion criteria were: (a) being unable to participate for any reason.

We defined our sample by theoretical saturation of data. The data collection stopped when we were able to articulate the research problem with the related theoretical objectives and references, rendering additional input from new participants redundant for our understanding of these concepts (Glaser & Strauss, 1967; Guest et al., 2006; Tran et al., 2017).

Procedure

The initial stage of our study involved the setting up of the focus group. Since the group took place in the health service, those patients and/or family members who had had more than two appointments with any health professional of the service in the preceding 6 months were considered for invitation. All invitations for the focus group were made through phone calls. We interrupted invitations when eight attendance confirmations were reached.

The second stage of our study consisted of individual semi-structured interviews, carried out one at a time. For these interviews, we recruited, orally within the health service, patients who were waiting for consultation with any of the professionals of the health service.

The observation of the health service's routine was a constant throughout the time the lead author spent in the research field.

People who were invited to participate in this research were first introduced to what it entailed, being informed of the length, content, and intent of his/her/their participation and then invited to participate or not, as they preferred. On agreeing to participate, each signed an informed consent, with all the information concerning the research, its ethical aspects, the researchers' information, and the option to cease participation at any time. The data was collected by the lead author of this manuscript.

Each interview lasted between 1 and 2 h and the focus group lasted for about 2 h. All interviews and the focus group were audio recorded and transcribed by a professional shortly after they occurred and checked by the main author later on. Approximately 100 h of observation were carried out and registered in the field diary. To ensure respondents' confidentiality, we use pseudonyms throughout this article.

Qualitative analysis

The analysis was performed by a systematic and iterative approach to interviews and group transcriptions, and to the field notes, based on the constant comparative method (Charmaz, 2014). At first, each interview, audio recording, and field note was comprehensively examined to find the main topics of its contents. Secondly, we searched for similarities and differences in the data collected. Continually comparing and contrasting, we defined and characterised emerging meanings and themes. We used an inductive coding method, initiated line-by-line coding, tagging every topic that arose in the data. In the second part, we did the axial coding, integrating

preview codes into thematic categories. Finally, we went back to all the data, recoding it based on this new schema to finally construct the categories of analysis that will be presented in this article.

Results

Participants

For the focus groups, eight trans men, three trans women, and no family member attended the invitations. We undertook semi-structured individual interviews with eight transgender men, eight transgender women and five family members. Considering this, individual interviews helped to deal with the absence of family members in the focus groups, allowing us to understand how they signify the transition processes of their relatives.

Only four of the trans people interviewed identified their ethnicity as white, with the other 10 participants identifying as people of colour while 2 had no ethnicity answer. Only two participants had attended college/university, and none had graduated from college. Participants ranged from 18 to 54 years of age with the majority (10) falling in the 18–30 age bracket. Their family monthly income ranged from less than the minimum wage to 6 times the minimum wage, with the majority (12) having a family monthly income of up to 2.5 times the minimum wage (by the time we collected the data, the minimum wage in Brazil was equivalent to approximately US$ 287).

Of the family members interviewed, two were mothers of transgender men (teenagers), two were mothers of transgender women, and one was the father of a young person (18 years old) who was transitioning from a male identity. One family participant identified her ethnicity as white, with the other four identifying as people of colour. Only one family participant had attended and graduated from college. Family members ranged from 37 to 67 years old. Their family monthly income ranged from 1 to 10 times the minimum wage, with the highest income being that of the only person who identified as white and with a college degree.

Meanings of family

We found a 'positive' meaning of family expressed as an ideal of protection and support and involving consanguinity, with no differences between trans men, trans women, and family members:

> [Family] is fundamental, totally. Blood!! They are people I love! Like my mom and my dad, who are with me all the time. (Andressa, 42, trans woman)

Moreover, in the poorest social classes – as those who, temporarily or permanently, do not have access to a minimum level of goods and resources, not merely material, but also spiritual, moral, and political (Yazbek, 2018) – mostly people of colour, there was an important element of mutual help included in this 'positive' meaning:

> For me, that is what family is about, people who help each other. We must help each other! (João Lucas, 23, trans man)

However, a 'negative idea' about family was also observed. Thus, family also emerges from our research field as something that has not been achieved (disappointment) or from negative experiences of limited acceptance or lack of support (abandonment).

> My father cut me out of his life. He even took me out of school. He said that if I ate his food, he wouldn't give food to the rest of the family anymore. (João Lucas, 23, trans man)

Acceptance seemed different from support. For example, trans people referred to 'acceptance' from family members but at the same time also spoke of still being called by their birth names and the male/female pronoun associated with it:

> My mother only introduces me by 'the birth name', and I say: 'do not introduce me to others. Or, even better, let me introduce myself.' (Sérgio, 20, trans man)

For family members, we identify that this negative meaning of family is expressed through stories of disappointment over unfulfilled dreams and expectations, and the difficulty of 'letting a loved one die' and having a 'strange one' at home.

> I wish it hadn't happened (crying). I lost a son, he's dead to me. (Ivone, 49, mother of a trans woman)

We did not find any differences between trans men and trans women in this 'negative' meaning of family. However, when considering questions of ethnicity and economic income we did find differences, in the sense that people of colour and people with lower incomes were more likely to suffer this disappointment/abandonment in terms of family.

Through the observation of the routine of the health service, we realised that family is something that mobilises ambiguities, such as the sense of belonging *versus* abandonment; the identity reference *versus* value breakdown; family support and health; family abandonment and illness.

As our analysis does not represent a static family process, we point out that the relationships between trans people and individual family members may be different. As an example, we have the history of Amanda (who wanted to be called by his birth name), a trans man who told us that he had the support and acceptance of his father and brother, but not from his mother; or Daniel, a trans man of 21, who regrets that his family did not provide the protection he would like, but found that his cousin was always supportive.

Thus, we realise that the dynamic of family relations of trans people is nuanced, as be exemplified by what Ivone told us:

> I am ready to face her death. As a mother, I will tell you what I wish for her: I even wish that – God forgive me – that [she] could die. A tree that does not produce fruit and occupies land and space, will have to be removed. And my daughter is that tree. No, I do not want [her to die]. But as they say, if God allows her to die, I am ready. Because then, the problem is gone. She is at rest. But I hope that she finishes her studies, that she gets a job, that she comes to this city, that is her dream, so that she lives her life. She does not even need to visit me. And let me live my life as well! (Ivone, 49, mother of a trans woman)

The disappointment of the family members with the gender transition of their relatives lies not only in the unfulfilled expectations for a son or a daughter but also in the frustration of not undertaking a family project. Having a transgender relative is not only challenging but also often accompanied by feelings of guilt and relational conflict (Dierckx et al., 2016). Families containing a trans person may feel that they are dealing with something that can barely be mentioned (Wren, 2002).

Finally, we observed that, although consanguinity plays an important role to signify the family relations of trans people, other people, such as friends and in-laws, can form part of what they consider a family, as expressed by Maria Eduarda:

> [My family is] my everything. It is very big (laughs)! There is my mother, my father, my sister, my nephews, and brothers-in-law, and my closest friends. [My family is] wonderful, despite the bad moments. Wonderful!! (Maria Eduarda, 31, trans woman)

This is in line with the review by Hailey et al. (2020) in which they point out that for African American LGBTQ youth, chosen families can be a strategy to cope with rejection and prejudice, and that these networks can mimic nuclear family structures, with various rules and relationship dynamics, with the potential to impact on the health and wellbeing of this population.

Meanings of health

We also found that there is a 'positive' meaning of health:

> I think health is being well. It's feeling good, you know? (Nice, 27, trans woman)

We did not find any differences between trans men, trans women, and family members in this 'positive' meaning of health. However, when we analyse meanings of health from poorest social classes, it expresses that health is signified as the absence of illness:

> I think health is the absence of illness. (Suzana, 22, trans woman)

Meanwhile in the group with higher socioeconomic status, health is signified as a state of wellbeing:

> Health is psychosocial wellbeing. It is not the absence of illness! (Tereza, 46, mother of a teenage trans)

Regarding the health, there is also a 'negative' meaning that tells of something that was not achieved when seeking health services (disappointment), which is usually related to Primary Healthcare and Emergency Room Services:

> In the Primary Healthcare Unit, they refused to treat me by my name, and I left, even though I was sick. (Murilo, 23, trans man)

This is also seen when there is an expressive lack of support from the family in situations of illness or need for care (abandonment):

> When I was a kid, I got ill by aspiring a great amount of agricultural poison. But neither my father nor my mother took care of me. I had other brothers and sisters that got ill at the same time for the same reason. My parents took good care of them. And for me, nothing! I suffered a real lot! (Elizabeth, 54, trans woman)

We did not find any differences between trans men and trans women in this 'negative' meaning of health. However, considering the aspects of ethnicity and economic income we found differences, in the sense that people of colour and people with lower incomes suffer this disappointment/abandonment more in terms of health.

In the interviews and focus group, we did not find the health service, where the research took place, to feature negatively. However, through the observation of the routine of this service, we were able to identify some tensions, when the patients could not find there the level of protection they were hoping for. This happened in situations when they were referred to other health services to treat specific health conditions or when their consultation took too long to happen. We also observed that the majority of the healthcare professionals in this health centre guided their clinical practice according to binary concepts of gender.

Intersections between the meanings of family and health

We found being healthy comes from having an 'ideal' meaning of family (consanguinity or not):

> The family is fundamental for good health. The family is the base and as a base it is all: a psychological, emotional, and affective base. And all these components are essential for our health. (Andressa, 42, trans woman)

This disappointment with the family was identified as the cause of illness and demands for care in the health service for trans people:

> When I told my father I was trans I suffered with his prejudice. I lost weight, I didn't feel like going out. I didn't feel like living. So, this family rejection harmed my health as well. (João Lucas, 23, trans man)

> My family members hurt me a lot. Because of their prejudice! And I think my depression was caused by them. So I blame my brothers for my depression. (Elizabeth, 54, trans woman)

There is also an important intersection between family and health, since the healthcare service where the research took place appears as a place to fulfil the expectations regarding the health and the family:

> Here in the health service I have very good care from the health team. I think everyone here is a family. I feel protected here. I feel at home. The family that I don't have outside, I have here. (Murilo, 23, trans man)

Considering the disappointment with the family that does not conform to the 'ideal' being identified as a cause of illness and demands for care in the healthcare service, we point out that trans people often suffer from what is called 'minority stress'. This kind of stress is induced by prejudice, stigma, and discrimination that increase rates of psychological distress, contributing to poor health and wellbeing (Bockting et al., 2013; Winter et al., 2016). This was seen in the interviews and observation of consultations of trans people, when they told us about how the family made them ill or how the difficulty in accessing health services turned them away from comprehensive healthcare.

Finally, through the interviews and the observation of the health service routine, we found that the main demand in the intersection of the meanings of family and health is for health education, for both health professionals and the general population:

> [I think we must] have more knowledge [in order to support our trans relatives]. To seek support from other people. (Tereza, 46, mother of a teenage trans)

> [I think we must] seek help, because without help we cannot do anything. And that's why I'm here [at the transgender healthcare service], for my daughter, for me, for us to get knowledge to solve these 'things'. (Renata, 37, mother of a teenage trans)

Discussion

In our research, we found that a model of family as perfect, hermetic, and ideal, is aspired to. Thus, individuals resist, respond to, and reproduce this family ideology and its structures according to the rules and norms that enable its survival and wellbeing, as seen in the research of Galán (2009) with LGB families. This 'ideal family', frequently related to consanguinity, does not exist for most of the trans participants in this study, and perhaps this gap between what the family 'should be' and what it actually is can contribute to constructing a meaning of family that includes disappointment and abandonment.

This ideal of family is a moral ideal in which gender appears as a central category in the construction of relationships. It is practically unbearable for the family as a 'moral ideal' to face the ruptures of the social rules that define the parameters of binary gender concepts. In order to act as an ideal protection, the family must also respond to collective expectations, too demanding to be met without pain, rupture, and tension.

Based on our research, we propose that family acceptance is different from family support in the experience of transsexuality. Le et al. (2016) point out that trans people (in their study, trans female youth) need support beyond acceptance for things like health insurance and transgender health services access.

In our study, this is a significant path towards an understanding of trans people's family relations. Acceptance, then, seems to indicate a 'blind, deaf, and dumb' tolerance. Perhaps morally obliged not to abandon their sons, daughters and family members, many mothers, fathers, and other family members accept trans people because they 'have to'. Abandoning them implies breaking the normative code of a family. As such, support materialises in 'seeing, listening, and speaking', and even facing the difficulties side by side with the transsexual person.

We observed that being called by the chosen name remains a barrier to the healthcare of trans people. However, not being called by the chosen name is often tolerated in the family environment by transgender people, perhaps as a strategy to belong and to not be abandoned by those whom they

recognise as family. Nevertheless, not being called by the chosen name in healthcare services becomes inadmissible, often turning transgender people away from comprehensive healthcare.

We believe this happens because the healthcare service is signified as a family, perhaps to replace what has not been found in the 'families that should be'. Thus, being supported in a healthcare service would be the last possible chance, the last hope for care, protection, support, belonging, and recognition of trans lives. Therefore, it is intolerable not to be recognised and addressed by their chosen names in healthcare services.

The research conducted by Russell et al. (2018) showed that by adjusting personal characteristics and social support, transgender youth who were able to use the chosen name in various contexts reported fewer depressive symptoms and less suicidal ideation and behaviour. The affirmation of a gender performance is very important to the mental health of trans people. So, enabling them to express their lived identity is fundamental to improving their health and wellbeing (The Lancet Public Health, 2020).

Regarding ethnicity, we have known that most trans people of colour were vulnerable to lower income and lower educational attainment (Grant et al., 2011; James et al., 2016). In our research, when we considered ethnicity and the economic income, we observed that white people with better economic status tend to have more resources – such as access to information and healthcare regarding transsexuality – to deal with this disappointment/abandonment, as Grant et al. (2011) and James et al. (2016) have shown in national surveys at the US.

Although we have not found differences in the 'positive' meanings of family and health, considering ethnicity and monthly income, we identified that family, for those that are poorer and people of colour, is considered a source of mutual help, especially in the context of the lack of resources such as money or in situations of illness.

So, this meaning of family for those who are poorer and people of colour in our research lies in the domestic activities of daily life and in reciprocal assistance networks (Fonseca, 2005; Sarti, 2011). It is assumed that the family that remains together, as an established alliance between its members (Lévi-Strauss, 2010; Sarti, 2005), has a greater chance of achieving the good things attributed to it. We believe this could make the transition process more difficult for poorer and black trans people, since the absence of family support may have a greater impact when they go through a difficult time, related or not to being transgender, such as unemployment or being ill.

Other family members can be a fundamental support for transgender people, such as siblings (Riggs, 2019). As we have seen in Amanda's report, his mother did not support him whereas his brother was supportive towards his gender transition. It is important to consider that this study reveals how the meanings presented here do not represent a static process and that gender and sexuality are related to a person's specific developmental trajectory (Harvey & Fish, 2015). Therefore, family can be a mixed source of disappointment and support.

The generational differences are important aspects when discussing the relationship between transgender people and their families, since these may be a factor that differentiates family relationships of transgender people from younger generations compared to those from older generations. For younger generations, it might be easier to have access to information and support (Silva et al., 2015). There is a positive relation between strong family ties and the health and wellbeing of younger transgender people which have initiated gender transition recently or in youth (Brown et al., 2020).

Taking into consideration the meanings of health, for those that are poorer or people of colour, the absence of illness is an important aspect to signify health, since their bodies are necessary to produce and provide for them and their families (Oliveira, 1998). Therefore, although the World Health Organization (WHO) has proposed since 1946 that health is a state of wellbeing and not just the absence of illness, this is not a reality for the poor or trans people of colour who participated in this research.

Facing a very difficult life context, trans people see the healthcare service as a space of recognition of rights, as a place to become a citizen, seeking to materialise what public policies aims to guarantee. However, as we have observed there are still difficulties and limitations that can be found in this specialised health centre, such as the binary conceptions showed by some of the healthcare professionals. Moreover, trans people recalled not being called by their chosen names when accessing other healthcare centres.

Being able to access comprehensive healthcare is a great problem for trans people around the globe (The Lancet Public Health, 2020). The difficulty in accessing health services beyond the ones devoted exclusively to transgender care can increase the costs to the healthcare systems, resulting in overuse of emergency departments, contributing to high levels of morbidity and mortality (Jaffee et al., 2016). These authors point out that the education concerning transgender health will enhance future physicians' knowledge and confidence in serving the trans population (Jaffee et al., 2016).

Current research regarding transgender people and the dynamic of their family relations shows that family members must have affirming and informative sources of support so that they can reach the understanding necessary to support their transgender relatives (Riggs et al., 2020). This also applies for teachers, health leaders and health professionals (Carlile, 2020). We also point out that health education concerning gender and sexuality issues, as highlighted by family members, could be a path to materialise in the healthcare the right to health. We were able to identify in our research the need to produce knowledge in a dialogic, interactive, and meaningful way in order to provide comprehensive healthcare for trans people.

Study limitations

There are some limitations to this study, and we must point out that in our society, trans people constitute a small and hidden group. This makes representativeness a challenge in terms of research regarding this group (Dierckx et al., 2019). As such, we focus our study on a population undergoing treatment in a health service, and that is the first limitation of our research, because those more ill may have had more difficulties to access the specialised health centre. Secondly, the researcher who carried out the study has to be taken into consideration; that is, he is a white, middle-class man, a physician, and university professor. Therefore, the perceptions analysed here could be affected by the social demographical characteristics of the researcher.

The limitations of this analysis also indicate new possibilities for future research. Reproducing this research in other contexts could help to broaden results. Also, other subjects' attitudes could amplify perceptions of the field under study.

Conclusions

This ethnographic study provides an analysis to discuss transsexuality, the 'transexualizing process' and the (intended) depathologisation of transsexuality. Moreover, the public health service where this research was carried out, allows us to understand the dynamics of family relationships of trans people and their intersections with healthcare.

Our study shows that family and health are signified for trans people and family members in a 'positive' way, but also in a 'negative' way. The idea of being healthy begins with having a supportive family, but most of our population, especially those poorer and trans people of colour, has a long trajectory of family abandonment and rejection, which is associated with illness. Despite the family rejection, trans participants in this study show a strong desire for reconnection with the consanguineous family, which is perceived as essential for health care.

The 'positive' meaning of family being attributed to the health service and their professionals reinforces the connection between family and health. For trans people, the health service, most of the time, is a last hope for care and wellbeing, which may not happen in other populations

that do not go through gender transition processes. The participants reported that society education towards transsexuality, including health professionals, is fundamental to improve trans people's lives.

We believe that the results of this research can contribute to benefit the health care of transgender people. Health services can provide a comprehensive care for the trans person and his/her/their family members, if health professionals are aware of the meanings of family and health of trans people. Health professionals should be able to identify which family members, consanguineous or not, play an important role in trans peoplés lives in order to integrate these members in the care process of each transgender person. Therefore, these results challenge health services to adapt their practices to the meanings of family and health analysed here if they intend to provide comprehensive healthcare and assure health equity for transgender people.

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