The Application of Self-discrepancy Theory to the Mental Health Outcomes of Transsexuals who are Living in Their Preferred Gender.

Ashley Van Houten  
BA MSc (Psych) M Psych (Clinical)

School of Applied Psychology  
Griffith University

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THE APPLICATION OF SELF-DISCREPANCY THEORY
Abstract

Gender Identity Disorder (GID) is a mental health diagnosis that is currently treated through a triadic medical model which involves hormone therapy, the real life experience, and various forms of surgery, including genital surgery. The aim of treatment is to ameliorate the dysphoria and anxiety symptoms associated with being gender incongruent. Surgical options have grown and improved over the last four decades and most of the research conducted in the area is associated with transsexuals who seek this treatment option. The findings of previous research have generally shown high satisfaction with surgical outcomes. However, limitations of the current treatment model are identifiable. Notably, due to the invasive and irreversible nature of surgery, the guidelines for inclusion in surgical procedures are stringent and exclude many transsexuals. Many studies have focussed on identifying risk and protective factors that predict good surgical outcomes. However, this process has not reflected the mental health outcomes of many transsexuals who do not seek the triadic medical model of treatment. Additionally, there has been a lack of theoretical application from a psychological perspective to guide treatment protocols. The present project used a theoretical framework based on the two core components of this disorder, gender and identity, by utilising identity theory and self-discrepancy theory to help explain the interplay between being gender incongruent and achieving gender congruence post transition. The project was the first study of its genre conducted with an Australian and New Zealand sample. The project utilised a subjective definition of transition which is different to the objective definition of transition defined by the medical model as engaging in hormone therapy, living as the preferred gender and the completion of sex reassignment surgery (SRS).

The first study identified common features of what living in your preferred gender (LPG) meant for transsexuals. Through a qualitative focus group and interview process, the first study developed an inventory, the Living in Your Preferred Gender Inventory (LPGI), that could then be used in subsequent studies to measure key features of LPG. Five transsexuals volunteered to participate in the study. Open-ended interviews identified common markers that constituted living in the preferred gender. These markers were then matched against questionnaire items that were developed by the researcher for the LPG Inventory. The inventory was validated for content, cultural sensitivity and ease of administration and was used as a measure in Study 2.

Study 2 explored the mediating effect of self-discrepancy on mental health utilising the LPGI, together with other psychometric scales. There were 135 participants, all of whom self-identified as transsexuals who were now LPG. Ninety eight participants (73%) had not undergone sex reassignment surgery (SRS); 76% of these 98 participants planned to do so and 24 % never planned to undergo SRS. The mean age at which they commenced living in their preferred gender was 32.30 (SD = 13.16). Contrary to previous research the participants’ mean scores on the Depression Anxiety Stress Scale (DASS), The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) and the
Kessler Psychological Distress Scale (K10) were within the normal ranges. Seven models were tested using data from 120 participants whose mean age was 40.12 ($SD = 12.99$). Only one model adequately fitted the data – the DASS trimmed model. The model was significant $F\ (3,\ 116) = 5.08,\ p < .001$. The independent variables accounted for 14.9% of the variance. The adjusted $R^2$ was 12.9%. The standardized betas of the three independent variables tested were significant using alpha of .10: number of supports ($p = .001$), bisexual or asexual prior to LPG ($p = .037$), and self-discrepancy ($p = .087$). Although a significant independent variable, self-discrepancy was not a mediator variable as had been hypothesised.

The third study used semi structured interviews to explore the core concepts of transition, passing, social supports and feelings about having transitioned. There were 13 participants who ranged in age from 18-76; three had had SRS. Four were male and nine were female. The findings showed that from the transsexual’s perspective, transition was not related to SRS. Not one of the participants mentioned SRS as a marker for transition. None of the participants regretted having transitioned and they all reported being happy after they had transitioned. Although some acknowledged having mental health problems, none attributed this to their transsexualism. Having a supportive social network was reported as being important to the participants.

Many of the results did not confirm previous research. The exception was the importance of social support to mental health. The evidence suggests that the emphasis on SRS as a transitioning marker and the medical model needs to be revisited not only because SRS from this study was not identified as a benchmark in the transition process but also because a considerable number of transsexuals who are LPG may not ever undergo SRS. The results also suggest that health care professionals working with transsexuals need to work from more of a client centred approach rather than a prescribed template.
Statement of Originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

(Signed) ________________________________

Ashley Van Houten BA MSc (Psych) M.Psych (Clinical).
Dedication

I dedicate my PhD to Mr Fitzroy Valentine van Houten and Mr Angel Carrasco two of the most important people in my life who have taught me so much and who have given me so much love and support throughout my life.

The first is my father Fitzroy Valentine van Houten. He was needed in heaven when I was still quite young. He was a man who never gave me a father-to-son talk. He never told me what was wrong or right. He simply taught me through his lived example. He was a hardworking man dedicated to his family. He never complained about anything. He never spoke ill of anyone and he never judged anyone. He accepted life for what it was. From being himself, he taught me a way of life that no university course could ever teach me. The most surprising thing for me was after having worked all his life as an accountant he told me just a few months before he died that he always loved Psychology. For a man of his generation I found that outstanding and a great support for my career. So here in his memory is a body of work that I am sure he would have enjoyed reading and about a population he would have thoroughly accepted and supported.

I also dedicate my PhD to my partner of 25 years Mr Angel Carrasco. He came into my life as though he were guided to me by my father. Even though he never met my father he has shared my love for him and has given loving homage to his memory. He has been such an immense source of support to me in giving me the time and freedom to pursue my education. He has assisted me in my PhD in reading my work, numerous discussions and many debriefings and motivational talks. His pride in my research is like no other. Throughout the years he has been there for me to witness my journey and to laugh and cry with me and to make my life complete. We both share a profession devoted to helping others achieve their maximum potential. We both also share a love for spirituality that guides everything we do in life. His love for me is immense. Indeed without his love, support and pride in me this project would not have been possible. It is befitting that my PhD is completed in the year of our 25th anniversary. I thank him for being the person he is and for all that he brings to my life.
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To get to the level of completing a PhD I needed to have an early foundation of secondary school education. There was a time in my life at a very young age that I had no one to guide me and no one to offer me a home. I thank my sister Christine Hard and my brother-in-law Terence Hard for being there to help me with finishing my schooling when I had no one else and my very education was threatened. They lovingly provided me with a home and a quiet place for me to finish my secondary schooling. The love, support and home that they provided me they did with true altruism, unconditionally.
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Chapter 1

Transsexualism and Gender Identity Disorder

This chapter reviews the current literature on definitions, diagnosis, treatment and treatment outcomes of transsexualism. In doing so it introduces the key concepts researched in the literature that are relevant to this thesis. These include the components of the diagnosis of transsexualism as a mental health disorder, prevalence, satisfaction with Sex Reassignment Surgery (SRS) and what satisfaction with surgery means as a measure of mental health. Additionally, it examines the variables used in previous studies such as age of onset, sex at birth, sexual orientation and social support to predict satisfaction with SRS. The chapter explains how transition is defined in this study. The chapter presents the research question: “Does the construct gender congruence conceptualised by self-discrepancy theory and measured by the self-lines measure (SL) act as a mediator in the achievement of mental health in transsexuals who are living in their preferred gender?” The chapter concludes with a brief overview of the chapters that follow.

Prior to commencing this dissertation, the researcher had a long association with the transsexual community which spanned over 30 years. This was based on personal contacts and professional experiences as a Clinical Psychologist. During this time, the researcher observed that, despite transsexuals having gone through sex reassignment surgery (SRS), some transsexuals continued to exhibit symptoms associated with compromised mental health. Difficulties such as depression, anxiety, substance use, HIV/AIDS, transphobia, violence, and relationship problems appeared to be occurring at elevated rates for transsexual people, even if they had completed SRS. The research literature bore out these anecdotal observations, with elevated risk of problems such as depression, anxiety and suicidality being highlighted in many studies (Bockting,
Robinson, Benner, & Scheltema, 2004; Carroll, Gilroy, & Ryan, 2002; Clements-Nolle, Marx, Guzman, & Katz, 2001; Cole, O'Boyle, Emory, & Meyer, 1997; Couch et al., 2007; Megeri & Khoosal, 2007; F. Pauly, 1993; Vitale, 2005). In Australia and New Zealand, the levels of depression in transsexuals have been found to be much higher than the level of depression in the general population (36.2% and 5.1% respectively), with one in four reporting suicide ideation in the two weeks prior to the Couch et al. (2007) study. Substance use and HIV/AIDS have also been found to be disproportionately high amongst transsexuals (Carroll, et al., 2002; Clements-Nolle, et al., 2001; Cochran & Cauce, 2006; Nemoto, Luke, Mamo, Ching, & Patria, 1999).

The above results were concerning for the reason that they suggested that there might be other factors apart from SRS that affect transsexuals achieving positive mental health outcomes. An individual diagnosed with Gender Identity Disorder (GID) may experience mental health problems such as depression and anxiety associated with dysphoria prior to SRS due to their experience of gender incongruence, i.e., the disparity between their birth sex and their inner gender identity (American Psychiatric Association, 2000). Therefore, post SRS, one might expect that after a period of adjustment the symptoms of dysphoria would be ameliorated as a result of achieving gender congruence through SRS.

In examining the research literature it seemed there was limited information regarding the issue of post SRS mental health. Much of the research in transsexualism has investigated whether the surgical outcomes in SRS have been successful, where successful surgical outcomes have been equated with satisfaction with surgery rather than subsequent amelioration of the symptoms of mental health distress (Bodlund & Kullgren, 1996; Cohen-Kettenis & Gooren, 1999; Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Additionally, studies that did investigate mental health pre and
post SRS and found high satisfaction with SRS found no significant difference between pre and post SRS regarding levels of depression and anxiety (Megeri & Khoosal, 2007) or were unclear whether transsexuals were psychologically better off post SRS (Newfield, Hart, Dibble, & Kohler, 2006). Other studies found that there may have been other factors that contributed to mental health such as identity validation and empowerment (Nuttbrook, Rosenblum, & Blumenstein, 2002) and the ability to pass in the preferred gender (Carroll, et al., 2002; Collyer & Heal, 2002; Fee, Brown, & Laylor, 2003; Maguen, Shipherd, & Harris, 2005; Maltz, 1998; Pauly, 1990; Ross & Need, 1989). Wilson (2002) noted in a study conducted in Australia that being able to pass in the preferred gender in public was seen by transsexuals as legitimising their claim to the identity of their preferred gender. Wolfradt & Neumann (2001) reported that it was important for post-operative transsexuals to be accepted as their preferred gender within society. Other studies have found that transsexualism is an isolated diagnosis and not part of a pathological syndrome (Hoshiai et al., 2010).

Although previous research has contributed to our knowledge of some aspects of the transsexual experience, there are other important areas that are insufficiently understood. For example, descriptively-focused research has not provided a solid theoretical understanding of what might be the possible causes or mediators of mental health in the transsexual population. Moreover, much of the existing research has not addressed the significant number of transsexuals who are living in their preferred gender and have not undergone SRS. For example, in a 2007 Australian and New Zealand study, only 25% of the males-to-females of the 253 respondents (MF) and 1% of females-to-males (FM) had undergone some type of surgery with regards to their gender reassignment (Couch, et al., 2007). SRS has been part of what is considered the standard treatment approach, termed the triadic treatment model (Myer et al., 2001).
Definitions of gender transition as requiring completion of the triadic treatment model and or SRS therefore exclude many if not most transsexuals.

As the name implies, the triadic treatment model consists of three stages: the real life experience (RLE), hormone therapy, and SRS. This model defines transition as living full time in the preferred gender and, most importantly, assumes that SRS is the natural endpoint (Coleman et al., 2011; Couch, et al., 2007; Myer, et al., 2001). The RLE involves the transsexual living for twelve months to two years in their preferred gender (Jain & Bradbeer, 2007). This involves key areas such as with family and friends, in work and student environments and in general social contexts. It also involves the adoption and use of a gender appropriate name. Hormone therapy includes the administration of hormones such as estrogen or testosterone to assist in the development of the characteristics of the preferred gender. Sex reassignment Surgery involves the construction of a penis (phalloplasty or metoidioplasty) and breast removal in FM and the construction of a neo vagina (vaginoplasty) and breast augmentation for MF (Cohen-Kettenis & Gooren, 1999; Coleman, et al., 2011; Goldberg, 2006; Rachlin, 1999). Given that not all transsexuals seek treatment within this model, and given that researchers have been hesitant to study transition for transsexuals who do not pursue SRS, we do not have a model of the pathway taken by transsexuals who do not want or plan to undergo SRS.

This project developed a broader definition of transition. The aim was to be more inclusive of transsexuals who perhaps transition in other ways including but not limited to SRS (Brown, 2010). Additionally, in doing this, the proposed study allowed for comparisons between transsexuals who had transitioned through the triadic treatment model and those who had transitioned using other means.
Drawing upon previous research findings, this project identified areas within previous research that warranted further investigation so as to gain a better understanding of what affects the mental health of transsexuals who are living in their preferred gender. Firstly, there was the concern that there was a narrow definition of transition and treatment that was limited to the medical model and therefore biased the sampling of previous research to clinical populations. This excluded transsexuals who did not choose the triadic medical model as a treatment option. Not all transsexuals seek or find the medical model helpful (Olsson & Möller, 2006; Pauly, 1990; Ross & Need, 1989). The present project chose to include all transsexuals who stated they were living in their preferred gender. This therefore opened up the project to a field based sampling process rather than a clinic based model (Hoshiai, et al., 2010). Having noted the ambiguity between SRS and mental health that is primarily associated with GID, this project intended to address this by providing a theoretical framework, utilising identity theory and self-discrepancy theory for studying the mental health of all transsexuals who were living in their preferred gender irrespective of whether they had undergone SRS. A theoretical framework was expected to assist understanding of the transsexual experience and could assist in the development of appropriate treatment protocols to address mental health well-being.

The remainder of this chapter will discuss the prevalence of transsexualism; the use of satisfaction as a dependent variable and its use as a measure of mental health and the limitations associated with this; the main variables investigated in the research; and the selection of identity theory and self-discrepancy theory as the framework for the study. Finally, the 3 studies included in this dissertation will be previewed.
Definitions and Diagnosis

The study of GID has problems associated with the nomenclature. There are inconsistencies in the nomenclature between the use of the terms transgender, transsexual and gender identity disorder. It is therefore important to clarify these terms so there is no confusion as to the specific population being studied.

Transgender, transsexual, transvestism, cross-dressers, drag queens, drag kings, gender benders, cross sexed, inter-sexed, hyperplasia, and hermaphrodite, are terms used scientifically and colloquially to refer to the expression of gender. The term “transgender” is often used as an umbrella to describe individuals who do not fit the binary gender categories of male and female (Heyes, 2003; Lurie, 2003; Maguen, et al., 2005). It is used explicitly to describe a group of individuals who demonstrate gender variance and gender incongruence (Maguen, et al., 2005). These individuals, it is argued, do not comply with the binary system of male and female (see also Edwards-Leeper & Spack, 2012; Pinto, Melendez, & Spector, 2008).

Goldenberg (2003) includes in this definition all individuals who express gender variance that contravenes the dichotomous social model of male and female. These include cross dressers, drag queens, drag kings, transsexuals, people who are androgynous, individuals who are bi-gendered and individuals who are multi-gendered (Bockting, Rosser, & Coleman, 1999). In the last decade there has been a greater emergence of expressions of gender variance. Individuals have sought to define themselves as bi-gendered, dual gendered, mixed gendered, gender blended and queer gendered (see also Drescher & Byne, 2012; Karasic & Drescher, 2005). While within these categories of divergent gender expression, individuals may seek various “treatments” to enhance their preferred gender expression, not all seek SRS (which is sometimes referred to as “confirmation surgery”). There is a great diversity of gender
variant individuals who seek a variety of treatments and are transgendered but who are not diagnosed with GID. Therefore, within the transgender spectrum of gender identity variants, some are non-pathological expressions of gender (Arcelus & Bouman, 2000.; Rachlin, 2002).

While the term “transgender” is a generic term describing groups of individuals who are gender variant, “transsexualism” term referring to the group of specific interest for this study. Transsexualism is the term used specifically for individuals who meet diagnostic criteria for GID. Within transsexualism there are subgroups that are based on gender, (e.g. Male to Female (MF) and Female to Male (FM)), on sexual orientation, (e.g. homosexual, heterosexual, bisexual and asexual), and age of onset (e.g. early onset and late onset). Additionally, there is a broader sub group within transsexuals that relates to those who are pre transition and those who are post transition.

Gender Identity Disorder is only a recent diagnosis in the Diagnostic and Statistical Manual (DSM). The first DSM was published in 1952 and the DSM II was published in 1968. Both editions refer to “Transvestism” as a diagnosis. However neither edition mentions gender identity. In the DSM III, published in 1980, there was inclusion of a new category of disorders termed “the Psychosexual Disorders.” Within the four subsections, GID is included as a specific subsection. It is noteworthy that in the DSM III, GID specifies several disorders in the sub category. These are transsexualism, GID of Childhood and Atypical GID. The common feature of the sub groups is the experience of incongruence between the biologically assigned, anatomically determined sexual differentiation, and the extent to which one feels one’s maleness or femaleness, known as gender identity (Vitale, 2005).
As stated in the DSM IV, the term GID describes individuals who exhibit a strong and persistent discomfort with their anatomical/natal sex and a belief that they were born with the wrong biological sex. In order that a diagnosis of GID be confirmed individuals have to meet the following four criteria:
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A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
   In children, the disturbance is manifested by four (or more) of the following:
   (1) Repeatedly stated desire to be, or insistence that he or she is, the other sex.
   (2) In boys, preference for cross dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing.
   (3) Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex.
   (4) Intense desire to participate in the stereotypical games and pastimes of the other sex.
   (5) Strong preferences for playmates of the other sex.
   In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequently passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B Persistent discomfort with his or her sex or a sense of inappropriateness in the gender role of that sex.
   In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.
   In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C The disturbance is not concurrent with a physical intersex condition.

D The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.


The first issue that confronts individuals, health professionals and researchers is the minefield of terminology that may be confusing and sometimes when used inappropriately can be disrespectful and offensive. The terminology includes transvestic fetishism, drag queens and drag queens, intersex, gender queer and gender questioning.
and those who would correspond to a DSM diagnosis of Gender Identity Disorder (GID) which is more commonly referred to as transsexualism.

**Prevalence of Transsexualism**

Prevalence statistics for transsexuals are difficult to estimate. There are a number of factors that could contribute to underestimates of prevalence. One factor is that, as a marginalised and discriminated group, some transsexuals may choose not to seek treatment (Bockting, et al., 2004) and seek to identify in only trans supportive environments (Pinto, et al., 2008). Another factor is that prevalence statistics are often calculated from those who seek treatment through SRS (Cohen-Kettenis & Gooren, 1999) and do not take into account the large number of transsexuals who seek to live in their preferred gender through other non-medical pathways (Couch, et al., 2007; Olsson & Möller, 2003). Couch et al. (2007) noted that prevalence statistics for transsexuals are usually calculated by counting the number of surgical procedures and dividing by the population of that country. A third factor is that in some countries, for example in Australia and New Zealand, prevalence rates may also be underestimated as many transsexuals go overseas for SRS. Although SRS has been performed in Australia since the 1950’s, surgeons and clinicians who perform SRS are few, possibly due in part to the stigma associated with working in this line of speciality which is considered as being not respectable (M.Wilson, 2002).

A study conducted by Olsson and Moller (2003) in Sweden found that the sex ratio in transsexualism had changed from 1:1 in the 1960’s to 2:1 in favour of MF in the 1990’s. The study analysed data of applications for SRS to the National Health and Welfare Board against the number of people who undertook SRS. The change in ratio in favour of MF was explained due to a greater proportion of non-homosexual transsexuals
requesting SRS. Prior to this it was believed that the majority of transsexuals who sought treatment were transsexuals who had a homosexual orientation prior to SRS.

Studies in the UK suggest a prevalence rate of 1:4,000 men and 1:10,000 women (Midence & Hargraves, 1997). Other studies suggest rates of 1:10,000 for men and 1:30,000 for women (Cohen-Kettenis & Gooren, 1999; Green, 2000). Males approximate a 3:1 ratio to females and this is consistent in most Western countries (van Kesteren, Gooren, & Megens, 1996). However, in eastern European countries, where females show a higher ratio of 5:1 the gender ratio appears to be reversed. It is suggested that this is changing with the advent of the fall of communism in these countries, suggesting a socio-political factor for this gender difference (Herman-Jeglinska, Grabowska, & Stanislaw, 2002; van Kesteren, et al., 1996; Yuksel, Kulaksizoglu, Nuray, & Sahin, 2000).

The main epidemiological study conducted in Australia on transsexualism was published by Ross, Walinder, Lundstrom, and Thuwe (1981). This study used questionnaires mailed to psychiatrists who subscribed to the Australian and New Zealand Journal of Psychiatry and 263 of the potential 907 respondents provided information. The study indicated a prevalence rate of 1:24,000 in males and 1:150,000 for females (Ross, et al., 1981). A further recent study in New Zealand (Veale, 2008) using passport holder declaration of transsexualism indicated a prevalence rate of 1:6364, with a 1:3639 for MF and 1:22714 FM transsexuals. Veale suggested that these figures should be regarded as underestimates, as not all passport holders openly declare their transsexual status on their passports. Veale highlighted an enquiry conducted by the Human Rights Commission which found that many transsexuals did not declare their transsexualism on passports for fear of having to explain their situation to immigration officials in countries which may not be sympathetic (Human Rights
The study by Veale (2008) was also hampered by the fact that transsexuals may not have been aware of the option to declare their status on their passports. Additionally, what the author did not highlight is that not all transsexuals have passports. Therefore, the study having been restricted to New Zealand passport holders, while interesting is limited and not representative. In addition, there are reports of prevalence being higher in recent years due to accessibility of treatment and awareness of transsexual issues (Veale, 2008).

In summary, transsexualism is a DSM diagnosis that comes under the spectrum of transgender studies. There is a low rate of prevalence based on current measures of prevalence which are largely calculated through transsexuals’ participation in gender clinics. The treatment used to ameliorate the dysphoria associated with the disorder is SRS, which is the endpoint of the triadic treatment model. As such, satisfaction with SRS is often researched and this in turn has been equated with good outcomes in mental health (Bowman & Goldberg, 2006; Cohen-Kettenis & Gooren, 1999; Collyer & Heal, 2002; Lawrence, 2003). However, selected research findings using reliable and valid psychometric tests of anxiety and depression have reported no change in mental health functioning pre and post SRS (Megeri & Khoosal, 2007). Additionally, some research suggests that even though there is high satisfaction reported with the outcomes of SRS, it is the physical aspects of the birth gender that cannot be changed through SRS that appears to cause concern and distress to transsexuals (Carroll, Gilroy, & Ryan, 2002; Collyer & Heal, 2002; Rakic, Starcevic, Maric, & Kelin, 1996).

Satisfaction with SRS

Satisfaction with surgery has been the measure most often used to determine the success of SRS. Most studies have reported high satisfaction with the outcome (Bowman & Goldberg, 2006; Cohen-Kettenis & Gooren, 1999; Day, 2002; Devor,
1997; Kuiper & Cohen-Kettenis, 1998; Lawrence, 2003; Lothstein, 1984; Michel, Ansseau, Legros, Pitchot, & Mormont, 2002; Pauly, 1968; Rakic, et al., 1996; Rehman, Lazer, Benet, Schaefer, & Melman, 1999) even though as Collyer and Heal (2002) have stated there is no consistent way in which satisfaction with SRS is measured. A study in Belgrade, using only “homosexual identifying” transsexuals, showed that 100% of the sample of 32 were satisfied with the surgical operation. However, this study, while indicating complete satisfaction post-surgery, also indicated a discrepancy between surgical satisfaction and body image satisfaction. In the study, 62% reported that they were satisfied with the appearance of their bodies post-surgery (Rakic, Starcevic, Maric, & Kelin, 1996). A study by van Kesteren, Gooren, and Megens (1996) in the Netherlands found in their long-term follow up study of 1285 transsexuals that 5 MF transsexuals expressed regret after SRS. Not all the transsexuals in the sample of 1285 had undergone SRS. The reasons for the regret that was expressed by the 5 participants were not part of the research so what factors led to this regret is not known. Furthermore, it is not known if satisfaction within this sample meant better mental health and if participants felt that they passed in their preferred gender. This finding together with others on SRS outcomes were of interest for designing the research described in this dissertation, since the finding pointed out that SRS, which gives the transsexual the genitalia of their preferred gender, is only one method of achieving gender congruence, which, despite advances in surgical techniques, may not provide for all transsexuals the level of gender congruence they may seek to live in their preferred gender. Given that the core aim of SRS is to ameliorate the dysphoria and mental health distress associated with being gender incongruent by changing the appearance of the body to resemble the preferred gender, the finding above that indicates 38% were dissatisfied with their body’s appearance post-surgery (Rakic, Starcevic, Maric, &
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Kelin, 1996) is noteworthy. Specifically, the dissatisfaction was associated with aspects of their body that could not be changed by the SRS process and which related to being gender congruent, e.g. large feet and hands, Adam’s apple and voice timbre. These specific sources of dissatisfaction were reported more in MF. However, overall dissatisfaction with body in relation to the outcome of SRS was found more in FM (Rakic, et al., 1996).

Another study by De Cuypere et al (2005) involving 55 transsexuals (32 MF and 23 FM) showed high sexual satisfaction post-surgery, with improved surgical procedures permitting secretion of vaginal fluid from the Cowper’s gland for MF’s and better erections with erection prosthesis for FM’s. Orgasms were reported to be more intense than previously reported and with overall greater sexual satisfaction (De Cuypere et al., 2005). Bodlund and Kullgren (1996) found in their follow-up study of people approved for surgery, that 12 out of a sample of 19 had completed SRS with most having reported satisfaction with SRS. Three cases (16%) found the outcome unsatisfactory with one of the 3 cases reporting SRS as a “failure”. Lobato and colleagues (2006) in a study of 19 MF, utilizing their own satisfaction survey, found that one year after follow-up family relationships had improved in 26.3% and partnerships had increased from 52.6% pre surgery to 73.79% post-surgery while sexual experiences had increased 83.3% post-surgery. From these results, the author concluded that SRS was effective. A survey conducted in New South Wales, Australia with 57 participants found that 86% (49/57) of the individuals who had undergone surgery between 1998 and 2000 were satisfied with their surgical outcomes. The survey found that people were happy with their genitalia, and generally felt that surgery was a good outcome with 53% reporting positive social outcomes. However, the study also reported that 4% (2/57) found that their lives had been unchanged by SRS and 2% (1/57)
reported less satisfaction with their life after SRS. The survey also reported that age was not a significant factor in outcome with only a small association between age and overall satisfaction. Satisfaction was reported by 92% of those in the 21-35 year old age bracket. Overall surgery was found to have a positive outcome for all ages (Collyer & Heal, 2002). However, not all studies have found age-equivalence in treatment outcomes. In Western countries, transsexuals who have undergone triadic treatment later in life have shown a poorer prognosis, with regret and suicide shown to be higher in a late treatment context (van Kesteren, et al., 1996).

**Satisfaction as a Measure of Mental Health**

Reported high satisfaction with SRS does not necessarily equate with a good prognosis in mental health well-being. The study by Megeri and Khoosal (2007) which utilized several psychometrically sound measures for a sample of 40 MF showed no significant change in anxiety and depression between pre and post SRS and Ross and Need (1989) found no decrease in distress and suicidality post SRS. Newfield et al., (2006) utilizing an internet method, with 447 respondents, concluded that it was unclear whether firstly, the mental health distress reported was due to internal conflicts or due to external discrimination and alienation and secondly, whether those who seek medical interventions are psychologically better off than those who do not. The authors recommended the use of qualitative methods to further enrich the data (Newfield, et al., 2006). A study by Nuttbrook, Rosenblum and Blumenstein (2002) with a sample size of 47 found that identity validation and personal empowerment were the critical factors in mental health well-being. Rakic et al. (1996) with a sample size of 32 and utilizing their own measure of adjustment to SRS found that there was a 100% satisfaction rate with SRS. However the study also found that, despite 100% being satisfied with SRS, respondents still reported dissatisfaction with the aspects of their body that could not be
changed by SRS and hormone therapy. Furthermore, a study by Ross and Need (1989) with a sample of 14, found that factors that made it difficult for transsexuals to “pass” or that reminded them of their birth gender were associated with poorer mental health. These studies highlight that satisfaction with SRS of itself is not a valid measure of mental health. The studies suggest that there are other factors external to SRS that could contribute to mental health. Many of these factors are associated with how the transsexual individual perceives their ability to pass in their preferred gender (Ross & Need, 1989).

Another validity problem with using satisfaction as a measure of mental health is what is called the “honeymoon effect”, whereby possible post-surgical regret is obscured by the dramatic change achieved by SRS. This is evidenced by a long term follow study conducted by Olsson and Moller (2006) which found that SRS was not for all and long-term regret (over 15 years after SRS) can have complex adjustment concerns. Additionally, there might be fear of reporting regret to authorities such as gender clinics as the transsexual may require further follow-up and ongoing support from these establishments. Furthermore, transsexuals who have invested a great deal of psychological, social and financial commitment may not be willing to report regret regarding a condition that is unchangeable (Kuiper & Cohen-Kettenis, 1998; Pauly, 1990). While hormone therapy and SRS may ameliorate the gender dysphoria it cannot always fulfill the person’s desire to have been born in the other gender (de Vries & Cohen-Kettenis, 2012).

As the triadic treatment model developed as the preferred treatment option for some transsexuals, research emerged that sought to investigate whether there were “types” or “sub types” that predicted better prognosis post-surgery. The variables most
studied were age of onset, birth gender, social supports and sexual orientation. The impact of these variables is discussed below.

**Age of Onset**

The significance of age of onset of GID is approached with caution because cross gender behaviour in children is often part of a developmental trajectory and therefore may be a phase that the child will eventually grow out of (de Vries & Cohen-Kettenis, 2012; Pauly, 1990; Zucker, Bradley, Doering, & Lozinski, 1985; Zucker, Wood, Singh, & Bradley, 2012). Researchers in the area of transsexualism have been concerned about appropriately identifying the age of onset because an early diagnosis can lead to early intervention that can halt the development of the secondary sexual characteristics of the birth sex and therefore prevent further distress to the transsexual (Bradley & Zucker, 1990; Cohen-Kettenis & Gooren, 1999; de Vries & Cohen-Kettenis, 2012; Delemarre-van de Waal & Cohen-Kettenis, 2006; Drescher & Byne, 2012; Edwards-Leeper & Spack, 2012; Hewitt et al., 2012; Zucker & Bradley, 1995). For those who do not go through or do not wish to go through the triadic treatment model this variable may not be relevant. It is a controversial variable when applied to the diagnosis and development of early intervention and treatment protocols in children and adolescents who exhibit symptoms of transsexualism (Zucker & Spitzer, 2005). The concerns associated with child and adolescent transsexualism include the validity of the diagnosis in minors, the fact that often parents are involved in the determination and validation of the diagnosis as noted by the number of parent report measures developed (Bradley & Zucker, 1997), the uncertainty over when gender constancy is achieved in children (Coolidge, Thede, & Young, 2002; Drescher & Byne, 2012; McConaghy, 1979; Zucker et al., 1999; Zucker, et al., 2012) and the belief that most children with cross gender identity will not become transsexuals in later life (Cohen-Kettenis,

Evidence suggests that, with early onset, where parents report gender identity conflicts in their children and a subsequent early diagnosis is confirmed, individuals may enter a treatment regime which would include the halting of the development of secondary sexual characteristics which occur in puberty. As mentioned previously, this treatment strategy is undertaken to halt the development of the secondary sexual/body characteristics of the birth gender which can be distressing to adolescents at a vulnerable time in their development (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker, et al., 2012).

Witholding this treatment which is reversible is considered more harmful in the long-term (de Vries & Cohen-Kettenis, 2012). The delay in puberty is achieved by the administration of gonadotropin-releasing hormone (GnRH) analogues (Cohen-Kettenis, et al., 2008; Meyenburg, 1999; Smith, van Goozen, & Cohen-Kettenis, 2001). Additionally, since the ability to pass in their preferred gender is important for adult transsexuals (Ross & Need, 1989) and ability to pass is diminished with late treatment (Cohen-Kettenis & Gooren, 1999; Wren, 2000), early intervention is seen as enabling the prevention of some adverse psychological consequences associated with not achieving gender congruence.
Halting the development of secondary sexual development might prevent young transsexuals from experiencing psychological problems such as depression, anxiety, suicidality, and social phobia as they mature into adulthood and commence the development of secondary sexual characteristics such as breasts, stature, body hair and size of hands and voice timbre (Cohen-Kettenis & Gooren, 1999; de Vries & Cohen-Kettenis, 2012; Delemarre-van de Waal & Cohen-Kettenis, 2006; Hewitt, et al., 2012; Ross & Need, 1989; Sobraiske, 2005; Wren, 2000). It also makes redundant some forms of surgery to reverse some of these characteristics later in life. Wren (2000) argues that if adolescence is a period of consolidating the adult identity, then the pressure on gender dysphoric children and adolescents to conform and live in their birth sex may be preventing them from having a productive and useful adolescence. The rational for treatment refusal becomes problematic (Wren, 2000). Furthermore, pubertal suppression gives the treating team time to make a proper diagnosis and differential diagnosis (Cohen-Kettenis, et al., 2008; de Vries & Cohen-Kettenis, 2012; Hewitt, et al., 2012; Smith, et al., 2002; Spriggs, 2004). Delamare-van de Wall and Cohen-Kettenis (2006) in their paper on the clinical management of adolescent transsexuals caution against the use of such treatments without thorough diagnostic assessment (see also Cohen-Kettenis & van Goozen, 1997; de Vries & Cohen-Kettenis, 2012).

Therefore, this variable has important implications for the diagnosis and treatment of transsexualism. Failure to properly diagnose the condition could lead to inappropriate early intervention that could lead to regret and further distress. This is particularly the case when the diagnosis fails to account for cross gender behaviour in children which is part of a developmental phase (Cohen-Kettenis & van Goozen, 1997). On the other hand an accurate early diagnosis, it is argued, can prevent the individual from experiencing unnecessary distress associated with their birth gender. It is easy to
deduce that a treatment that will eventually assist a transsexual to pass in their preferred
gender would subsequently reduce their dysphoria and therefore be a welcome and
preferred outcome (Cohen-Kettenis & van Goozen, 1997). However, there is also
research that reports that many children who display cross gender behaviour go on to
lead lives where they do not identify as transsexual as adults with only a small
percentage going on to meet the diagnostic criteria of GID (Cohen-Kettenis & van
Zucker, et al., 2012). In summary the issue of age of onset is controversial and
problematic. There is uncertainty with regards to gender constancy, conclusive
diagnosis and age of consent.

**Sex at Birth**

Studies have shown that within the transsexual population there is a difference
in mental health outcomes post-surgery depending on whether the pathway is MF or
FM. FM individuals have been shown to demonstrate less mental health distress and
greater satisfaction with living in their preferred gender than MF. For example Smith,
vан Goozen, Kuiper and Cohen Kittenis (2005) found in their study of 104 MF and 58
FM that FM felt less gender dysphoric and also felt that they had more support for
their new gender role. Several studies have reported MF as having greater suicide
ideation and lowered sexual drive, and being more histrionic, less stable socially, more
psychologically disturbed, and more regretful about surgery than FM (Lothstein, 1984;
their 5 year follow-up of 19 transsexuals (10 MF and 9 FM) that FMs consistently rated
satisfaction higher than MF transsexuals. Additionally, FMs have been found to have a
greater capacity to establish and maintain stable partnerships compared to MF. One
explanation for this is based on early socialisation of girls in caring and bonding (Lewins, 2002).

Other differences between MF and FM have been associated with the social desirability and acceptability of masculine traits, which to some extent sanctions and supports females adopting masculine traits (Herman-Jeglinska, et al., 2002; Lewins, 2002; Penor Ceglian & Lyons, 2004). Green (cited in Lewins, 2002; I. Wilson, Griffin, & Wren, 2002) stated that there is more leniency shown towards females in their pursuit of cross gender roles. Moreover, masculine behaviour in girls is seen more favourably than feminine behaviour in boys by peers, parents and establishments such as schools (Zucker, et al., 1997). Devor (1997) offers a valuable overview of gender roles for women within society and their impact on identity. Women wearing trousers and shirts and suits have been commonplace since the women’s liberation movement of the 1970s. Successful women are often described in terms of masculine characteristics. Adopting gender traits and confidently appearing as the preferred gender is an important factor in mental health outcomes for transsexuals. Often FM appear more confident in their preferred gender and do not carry the misconceived stigma of “doing drag” often associated with MF transsexuals (Lewins, 2002).

In addition, male hormones such as testosterone are very effective in changing the female body and giving the person masculine characteristics such as a large body mass, increased musculature, deep voice, body hair and facial hair, changes in skin texture, and fat redistribution, making it easier for the FM to live in their preferred gender (Lewins, 2002; Rachlin, 1999; Slabbe Koorn, van Goozen, Gooren, & Cohen-Kettenis, 2001). Although externally-administered (“exogenous”) female hormones also alter body characteristics, Michel, Ansseau, Legros, Pitchot, and Mormont (2002) stated that certain characteristics of the birth gender remain more identifiable in MFs than
FMs, e.g., voice timbre, body size, and size of hands and feet. An interesting fact is that while the operation to reconstruct a penis (phalloplasty) is less successful surgically than genital surgery for MFs, satisfaction with surgery is higher in FM than MF as noted in several studies (Fleming, MacGowan, & Costos, 1985; Hastings & Markland, 1978; Herman-Jeglinska, et al., 2002; Kenny & Isabel, 1997; Lawrence, 2003; Rachlin, 1999; Smith, et al., 2002; van Kesteren, et al., 1996).

**Sexual Orientation**

As noted by Edwards-Leeper & Spack, (2012) sexual orientation and gender identity are often confused even though they are two distinct constructs (see also Monro, 2000; Zucker & Spitzer, 2005). Being transsexual is independent of sexual orientation (Wester, McDonough, White, Vogel, & Taylor, 2010) but the two constructs are sometimes confused (Zamboni, 2006). To clarify the difference, a FM transsexual who is attracted to women would likely identify as lesbian prior to transition. Studies that have explored the sexual orientation of transsexuals prior to commencing living in their preferred gender and prior to medical transition and how this variable affects mental health outcomes have concluded that transsexuals who are homosexual in orientation prior to transitioning into their preferred gender have better mental health outcomes than those who are considered to be “heterosexual” prior to transition (Smith, et al., 2005). Of those who were homosexual, having a partner prior to transition was a factor in better mental health outcomes. The homosexual MF sub-type noted in Smith et al. (2005) identified as transsexual at a younger age, had a more feminine appearance, had engaged in cross-gender dressing more often and from a young age and had not gained sexual arousal from cross-dressing, and generally functioned better psychologically than other transsexual sub types. Adult FM transsexuals tended to be predominantly homosexual while adult MF transsexuals showed a more even
distribution between a heterosexual and a homosexual orientation (see also Blanchard, 1994; Lawrence, 2005, 2010).

**Social Support**

Social support plays a vital role in mental health outcomes in transsexualism. In the transsexual population a salient factor in achieving positive mental health outcomes is the support received from social networks such as intimate partners, children, parents, siblings and friends (Ehrensaft, 2012; Gagne, Tewksbury, & McGaughey, 1997; Maguen, et al., 2005; Nuttbrook, et al., 2002; Smith, et al., 2005; Yuksel, et al., 2000). Acceptance by a social system is tied to one’s identity system as will be discussed later in the section on identity formation. Research on social support has suggested that people who are regarded as credible within their social network are most likely to be seen as important in reaffirming the transsexual person’s situation (Nuttbrook, et al., 2002). Nuttbrook et al. (2002) appear to have been the first researchers to explicitly examine the notion of identity formation in their study of transsexual identity with a sample of 43 non-white transsexuals in America. The process of transitioning was seen as a process in which the person shifts through social support networks, avoiding those who may be critical of their preferred gender identity. The “celebrations of identity” where family and friends were seen as providing a much needed emotional support system and legitimising a gender variant lifestyle for the non-conforming gender variant individual was noted as protective in mental health functioning (Ehrensaft, 2012; Michel, et al., 2002). Other studies on transsexual identity and stigma indicate that transsexuals often have to compartmentalise their social support networks and experience greater incompatibility between social and family networks than non-transsexual individuals. This was evident in a study by Kando (1972) which found that, for 17 post-operative MF transsexuals, some social networks remained associated with
their past gender identity and some social networks were only familiar with their new gender identity and other studies that report an unwillingness to identify socially as transgender and limit their contact to only trans friendly people (Pinto, et al., 2008). Some who experience violence due to their cross dressing behaviour have subverted their transgender identity (Morgan & Stevens, 2012).

The coming out and “passing” process for the transsexual is not considered as a one off event but rather a continuous process. This segregation of social support structures, together with the continuous coming out process, may add further stress and affect mental health outcomes for the individual transsexual, as noted by Kando (1972). Social isolation and a lack of overall social support are regarded as common in transsexuals and are viewed as barriers to mental health outcomes through mechanisms such as lowered self-esteem and self-efficacy (Lesser, 1999; Maguen, et al., 2005).

The advent of the triadic treatment model with SRS as its endpoint has given rise to research that has sought to verify the success of SRS as a treatment. This has been done by reporting satisfaction with SRS and identifying factors that may be significantly correlated with high satisfaction. These variables have become part of the typology discussed below.

**Transsexual Typology**

The research findings discussed above suggest that there are other factors other than SRS, such as the ability for the transsexual to “pass” and be positively appraised in their preferred gender, that are of significance for a good prognosis for mental health. The findings highlight that while satisfaction with SRS is generally reported as high, there are other significant factors that could act as mediators between this variable and the mental health well-being for transsexuals.
As noted, the variables early treatment, birth gender, sexual orientation and social supports have been shown to have predictive power in relation to post-surgical SRS outcomes. From these studies a typology has emerged which suggests that transsexuals who are diagnosed and treated early, are female at birth, who have a homosexual orientation prior to transition or who have good social supports have the best prognosis for SRS. Although these studies have been of benefit in the development of a transsexual typology, this knowledge has not necessarily translated into practice with the development of treatment protocols specifically based around these findings. Furthermore, we do not know whether this typology holds true for transsexuals who do not follow the triadic treatment pathway.

**The Meaning of Transition for this Study**

The concept of being transitioned is a term borrowed from the medical model and was defined in this study as “living in your preferred gender”. It was operationalised by asking transsexuals if they believed that they were living in their preferred gender. Therefore, in this research, whether a person was transitioned or not was a subjective assessment made by each transsexual individual participating in the study (Ross & Need, 1989). It is acknowledged that transition is a process. However, a key focus of this study is the concept of “the transition moment”. The transition moment is a definite development marker that occurred in a transsexual’s life where the person believed they commenced living in their preferred gender. This definition implies that there is a definite pre transitioned period and a definite post transitioned period. Transsexuals are not viewed as being on a continuum or of being in a transitioning phase. It is understood that it takes a process for a person to reach the point at which they make a decision to live in their preferred gender. The process of what it takes for a
transsexual to reach the stage of deciding to live in their preferred gender was analysed in Study 3 through in-depth qualitative interviews.

Although each individual’s assessment as to whether they are living in their preferred gender is subjective, this study proposed to examine if there were common features in these assessments. A pilot study referred to as Study 1 sought to develop an inventory, which investigated whether there were common features of “living in their preferred gender” that were significant for all transsexuals, such as changing to a gender appropriate name.

**Summary and Research Question**

Previous research into transsexualism has mostly studied transsexuals who have presented at clinics and transitioned through the medical model and had SRS as their final outcome. This research has shown that satisfaction with SRS was rated very high. This chapter has also highlighted that there are limitations to using satisfaction with SRS as a dependent variable. Furthermore, satisfaction with SRS does not necessarily equate or correlate with a good mental health prognosis. While it has been previously noted that many studies using inconsistent testing measure have found high satisfaction with SRS, there are fewer studies that have looked at mental health pre and post SRS. These have shown, no significant difference between pre and post SRS mental health well-being. For example Megeri and Khoosal (2007) found no significant change pre- to post-surgery in relation to anxiety and depression. Additionally, as noted, studies have shown that there are other factors that impact on mental health such as the person being able to “pass” and to be socially accepted in their preferred gender that are not addressed through SRS (Gagne, et al., 1997; Nuttbrook, et al., 2002; Ross & Need, 1989). Some transsexuals have not been happy with the way their bodies looked, particularly in bodily features that were retained and were not able to be altered by
hormonal and surgical procedures (Rakic, et al., 1996). According to Wilson (2002) the aim is to affirm a positive appearance in the preferred gender and thereby achieve gender congruence, and be perceived by others as “normal”.

This project addressed these concerns by viewing transsexualism within its diagnostic classification as Gender Identity Disorder (GID). It drew from the paradigms of gender formation and identity formation, and utilised identity theory and self-discrepancy theory to investigate whether self-discrepancy played a mediating role in mental health outcomes. In addition, this study included all transsexuals who were living in their preferred gender, irrespective of the path they chose to achieve gender congruence, thereby offering a comparison in mental health well-being between those who had SRS and those who had not.

Utilising three different methodologies, this project addressed the mental health well-being of transsexuals who were living in their preferred gender. The three studies conducted addressed the research question: “Does the construct gender congruence conceptualised by self-discrepancy theory and measured by the self-lines measure (SL) act as a mediator in the achievement of mental health in transsexuals who are living in their preferred gender?”

The structure and content of the thesis is as follows: The following chapter discusses the central concepts of gender identity formation and identity formation together with self-discrepancy theory. The three studies which comprise this thesis are outlined in Chapter 3. The chapter explains the methodology of the three studies and how they form a wider picture of transsexuals living in their preferred gender. It also discusses the research participant participation model (RPPM) used in this study. Chapters 4, 5 and 6 comprise a detailed description of each study and present the results
of the project. The chapters are organised in a manner appropriate to the methodology used. Chapter 7 contains the overall discussion and conclusion.
Chapter 2

Theoretical Perspectives on Gender and Identity

This chapter introduces the concepts that are important in the research question: “Does the construct gender congruence conceptualised by self-discrepancy theory and measured by the self-lines measure (SL) act as a mediator in the achievement of mental health in transsexuals who are living in their preferred gender?” Most particularly the key theoretical concepts of gender and identity are discussed. Theories of gender identity are presented and how they may impact on transsexual identity development is explored. Similarly, research on the components of identity formation and their importance in the conceptual frameworks of Identity theory is presented. In addition Identity Control theory and Self-discrepancy theory are discussed. The research question and how it will be explored from a psychological conceptual framework utilising self-discrepancy theory is explained. The research hypotheses regarding transsexuals’ self-discrepancies are discussed and presented.

Transsexual identity encompasses two fundamental aspects of a person’s identity: their gender identity and birth sex identity (Zamboni, 2006). This is exemplified in the DSM IV’s diagnosis of Gender Identity Disorder (GID) which explains how the incongruence between a person’s actual birth sex identity and their ideal gender identity leads to a disordered condition (American Psychiatric Association, 2000).

Gender Identity Formation

Currently accepted definitions of gender distinguish between biological sex, as in genetic characterisation as being born male or female, and the social construct of gender, the expression of one’s being male or female which is influenced by history and
culture. From this perspective, historical, cultural, and socio-political factors explain the differences between the construct of natal/biological sex and the social construct of gender.

Gender identity is determined from an early age based initially on the birth sex of the child and then through processes of socialisation expressed in terms of gender specific behaviours. When the sex of a child is not known pre-natally often the first statement when the child comes out of the womb is “it is a boy” or “it is a girl”. From these early stages the child is socialised in gender specific ways. In western cultures girls are often given dolls, kitchen sets, dressed in pink and are spoken to in a manner that reinforces their gender. Boys on the other hand are more likely to be given cars, trucks, dressed in blue and are handled often in a more rough and tumble manner (Alexander, Wilcox, & Woods, 2009). The gender stereotyping is present from a very early age and reinforced with positive appraisals and rewards for adapting appropriate gender specific behaviours (Brannon, 1999; Fagot & Leinbach, 1993).

Researchers have developed a large theoretical base offering explanations for differences between the biological sexes of males and females. These include biological, cognitive and social theories.

**Biological theories.** Biological theories of sex differences posit that sex differences are explained through genetic differences between typically developing XX and XY individuals that are associated with anatomical, hormonal, and physiological differences between these two groups. By default, all human foetuses will develop as the XX “female” phenotype unless there are sufficient androgens (“male” hormones) present at a critical period during foetal development (Crooks, 2002). Usually the reason for these hormones being present is that the foetus has an XY genotype and therefore produces androgens. Variations can occur, such as extra or missing sex
chromosomes (e.g. XXY, XYY, XO), unusually high levels of androgens in individuals with any sex chromosome pattern including XX, or androgen insensitivity syndrome. Variations in foetal hormone levels (or responses to hormones) that are associated with differential development of genitalia and other anatomical structures, have also been associated with differences that have been found between in the anatomy of some brain structures between phenotypic males and phenotypic females (Berenbaum, 1998). In addition to this “organising” effect on brain development, sex hormones have also been demonstrated to have “activational” effects on acute activation of neural systems (Berenbaum, 1998).

Evolutionary theories (Lippa, 2002), with their basis in biology, further suggest the evolutionary process of selection for survival as an explanation for differences between the sexes. Evolutionary theories argue that because women have a limited capacity to bear offspring in their lifetime and have a higher gestation period, compared to men who have unlimited sperm and invest less time in sperm production, women have developed more nurturing, caring protective traits. In comparison, men, who can have theoretically thousands of offspring, have developed sexually aggressive, promiscuous traits that permit them to utilise their sperm for the development of the species (Lippa, 2002; Shaver & Hendrick, 1987). Other evolutionary factors include genes, DNA and differences in the brain and nervous system between males and females (Brannon, 1999; Shaver & Hendrick, 1987).

Researchers often attempt to establish the biological differences that may exist between males and females and then link these differences to behaviour traits, and masculinity and femininity. Many psychological tests have been developed to test for potential gender differences in traits such as intelligence, memory, creativity, musical ability, non-verbal communication, and aggressiveness (Brannon, 1999). These
measures not only seek to highlight differences in biological sex but they also are used to validate the existence of gender differences.

Critics of the biological approaches argue that there are some biological differences that are particular to the sexes, such as genital composition and reproductive cycles, including hormones, sperm and ova. Body shape and facial hair also separate the two sexes and these are related to hormonal levels. While these biological differences are accepted they are not seen as completely explaining differences in social structuring and behaviour between the sexes (Beall & Sternberg, 1993; Lippa, 2002).

Cognitive theories. Cognitive theories of gender purport that a child’s concept of gender is important in determining gender differences. Postulated originally by Kohlberg in 1961, gender development was viewed as analogous to Piaget’s theory of constancy in which children were said to gain gender constancy only when they had sufficiently developed their cognitive abilities (Beall & Sternberg, 1993). This suggests that children have to process environmental cues and feedback regarding what is gender appropriate in order to comprehend the constancy of gender differences. By the ages of 2-3 years children have a concept that they are male or female. Gender self-labelling, “I am a boy” or “I am a girl”, occurs at this early stage. They understand that people come in two varieties, boy or girl. However at this stage children only understand that the differences are in relation to external features such as hair length, toys and dress. Therefore at this stage children believe they can change gender simply by changing these external characteristics. This self-labelling does not constitute gender identity constancy (Brannon, 1999).

In later childhood children acquire gender constancy, that is, a sense of the permanence of gender and what is expected of gender conformity. This is usually achieved between the ages of 5-8 years. Children at this stage learn that sex cannot be
changed (Emmerich, Goldman, Kirsh, & Sharabany, 1977; McConaghy, 1979). They also learn that the development of gender stereotyping can be rewarding. For example boys learn that by acquiring male stereotypical behaviour they will be rewarded, such receiving increased peer or parental approval (Beall & Sternberg, 1993; Brannon, 1999; Lippa, 2002). They learn to act in consistent masculine ways in order to obtain rewards.

**Social theories.** Social learning theories state that gender differences are learned from the environment and social context. Gender is described as a social construct determined by classical conditioning, operant conditioning, and modelling from others (Beall & Sternberg, 1993; Brannon, 1999; Lippa, 2002).

Gender schema theory (Brannon, 1999) incorporates aspects of cognitive theory and social learning theory. Schemas (cognitive frameworks) are formed in childhood and help in the organisation and interpretation of information which form our core beliefs (Beck, 1995; Gilstrap, 2006). Schemas function to assist the person in viewing himself or herself in relation to the rest of the world. They can form absolute beliefs such as “a man is this and a woman is that” and when activated schemas can cause psychological distress when the person feels conflict between their schemas and other environmental cues (James, Todd, & Reichelt, 2009).

Gender schemas are developed from many influences on a child’s social system that distinguish gender. These influences include the cognitive processes and the collective cultural values of what is masculine and feminine (Beall & Sternberg, 1993; Brannon, 1999; Shaver & Hendrick, 1987) and thus can lend itself to the development of what is termed “gender stereotyping”.

Social psychological theories (Beall & Sternberg, 1993) point out the salience of gender stereotyping and its influence on gender differences. According to these
theoretical perspectives, once stereotypical expectations are formed people act according to the stereotypes and the expected behaviour of their stereotype. Gender either becomes a self-fulfilling prophecy based on the stereotypes of the culture and the schema that the individual then draws from the stereotype or it becomes something we do based on cultural norms.

The theoretical perspectives all assume that gender differences in western culture follow a binary system of male and female, masculine and feminine and what is salient is the “differences” between males and females and not the similarities. Therefore one gender is distinguished from the other as “the opposite sex” rather than simply “the other sex” (Beall & Sternberg, 1993) While what is masculine and feminine may change in historical contexts, differences still exist over time. Post natal care, the naming of the child, clothing, selection of toys, duties for children in the home, education of adolescents, parents’ socialisation, the content of children’s books, and the media all portray the presence of gender differences and suggest that gender differentiation is, at least in part, imposed from the outside environment (Clarke & Lawson, 1985; Shaver & Hendrick, 1987).

**Gender and Transsexualism**

In transsexualism the characteristics that feature in the diagnostic nosology refer to the individual experiencing persistent distress with their birth sex. The transsexual does not identify with their birth sex and from early childhood and into adolescence and adulthood the condition persists and intensifies until the person at some point seeks assistance. The distress is so extreme that the individual wishes to live and be treated exclusively as the gender opposite to their birth sex and the transsexual person transitions into their preferred gender, living exclusively as their preferred gender.
Extrapolating from what is understood about gender identity formation, the early socialisation of children contributes to the schemata children develop around the concept of gender. Therefore it can be said that the transsexual child, as they reach a stage of achieving a sense of gender constancy may experience distress as the individual starts to feel a sense of being different to what is expected of them in fulfilling their birth sex role. Additionally, the transsexual child may also experience distress from being positively appraised for being born male or female; the sex with which they feel incongruent. Furthermore, as the transsexual child makes attempts to achieve a sense of gender congruence by expressing cross sexed behaviours, the child may be punished and experience the distress of their parents who feel they have an abnormal child (Karasic & Drescher, 2005). This may result in the child from a very early age and over a long period of time experiencing negative appraisals from society for not conforming to the social norms of gender that are considered appropriate for their birth sex.

Identity Formation

The theoretical perspectives on gender provide an explanation of one dimension of gender identity disorder. The concept of identity is the second important dimension that provides insight into how this manifests in a disorder. Like gender, identity is posited as a social construct. The genesis of the construct of identity is attributed to the study of the consciousness of the self as proposed by James in the 1890’s (Ashmore & Jussim, 1997). According to Leary and Tangney (2005), James was the first psychologist to develop the concept of identity formation and to postulate the importance of social processes in the formation of identity. James developed the concept of reflected self, later known as the “looking-glass self”, to explain how identity and self-concept are derived from reflected appraisals. James maintained that the self was a product and reflection of social life.
Most identity theorists agree with James that identity is a social construct which encompasses personal identities as well as social identities. Identity is a process of self-discovery with self and others where the self is viewed as a social construct in an interactive process with others (Zaff & Hair, 2003). It is a social and psychological process incorporating aspects of the self and the social context (Cahill, 1998; Gagne, et al., 1997; Weigert, 1986; Wren, 2000) and involves how the person believes they are being socially appraised (Zaff & Hair, 2003).

Personal identity is based on the seminal identity question, “Who am I?” and includes the concepts of self and self-concept. Self-concept is defined in terms of identity and esteem; esteem forms the evaluation of self “am I worthy?” (Taylor, 2002). Social identity defines the individual in terms of shared similarities of the in-group, i.e., members of the same category, such as females or in the case of this project, transsexuals. It is a theory based on intergroup comparisons. A group is formed by a number of individuals categorising themselves into the same social category, and then seeking to identify their similarities and compare themselves to relevant out-groups. At least part of a person’s social identity is determined by this group membership (van Dick, Wagner, Stellmacher, Christ, & Tissington, 2005). An individual is likely to identify as part of many different groups with salience of different group membership varying in different circumstances.

Therefore on the one hand the individual has a sense of “I” and “who am I” but this identity is acted out and validated within a social context. Identity is both personal and it is public, experienced by the individual and acted out in social contexts (Alcoff & Mendieta, 2003.; Burke, Cast, & Stets, 1999; Higgins, 1987; Hogg & Terry, 2001; Stets & Burke, 2001; Thoits, 1983; Weigert, 1986). Therefore individuals, including
transsexuals, not only seek to have a sense of self, but they also seek to have the self-verified and validated within a social context.

Whatever the viewpoint of particular theorists, most concur that personal identity is not solely the domain of the individual acting in isolation nor is social identity exclusive to the collective without the input of the individual. Both are viewed as influencing one another. Individuals may create their own identity but not exclusively of their own choosing. The self is situated within society.

When we place the concepts of gender and identity together from what has been discussed the salience of the social context in the development and maintenance of gender identity becomes apparent. A transsexual has to adopt and adapt to a new set of schemas for their preferred gender and they need to have their gender identity validated.

The theories on personal and social identity have furthered understanding from both the individual and social domains. They have provided the link between the self and the social context and our understanding of self-concept. These theories have also provided the foundation for ICT and SDT which describe identity as the meanings an individual ascribes to what it means to be who one is (Burke, 1991; Stryker & Burke, 2000). ICT and SDT are discussed in more detail in the section below on ICT and SDT.

Drawing upon different theoretical perspectives such as ICT and SDT (Thoits, 1983), an individual’s identity has been linked to the development and maintenance of mental disorders including depression and anxiety (Higgins, 1987). Within a social context people play many different roles (mother, brother, friend, colleague, and so on) as they interact with one another (Stets & Burke, 2001). These interactions assist people in identifying who they are in different contexts and give purpose and meaning to their lives. The identity a person gets from being a mother, for example, guides their
behaviour in relation to that identity and the interactions they have (Stets & Tsushima, 2001; Thoits, 1983). Therefore, how a person acts is dependent on how they identify and the perceptions they have of themself with respect to the roles they are expected to play. There is also a reciprocal mechanism whereby the identity a person has, for example as a mother, is further magnified by their perceptions of what others perceive of them and expect of that role (Cast, Stets, & Burke, 1999; Stets & Tsushima, 2001). From this, as will be discussed in a later section in more detail, it is perhaps easy to see how a person may feel either anxious or depressed or both when enacting a particular role they strongly identify with within a social context that is not accepting of that person being in that role.

**Gender Identity: The Components of Transsexual Identity**

Gender and identity are social constructs which are dynamic and changing. Gender identity represents something that is socialised and learnt from a very young age. Gender appropriate norms are reinforced in early childhood development and rewarded. Transsexuals who are living in their preferred gender are confronted with the developmental task of integrating the traits and behaviour (a new schema set) of their preferred gender within a social context (Wolfradt & Neumann, 2001).

Gender therefore becomes a way in which the birth sex is expressed within social contexts. It is a person’s self-perceived endorsement of masculine and feminine traits (Palan, Areni, & Kiecker, 1999). Therefore, it is not an inner, silent process, a secret to be kept from others. Furthermore, a person’s development of gender identity is influenced by their perceptions of how others perceive them. It is therefore an interactive process. The notion of interaction is supported by Gagne et al. (1997), who stated that an alternative gender identity is legitimised through social interactions.
Transsexuals, when presenting their emergent preferred gender, seek recognition and reinforcement from society. However, many transsexuals operate in a climate of secrecy and fear. For example, one study found that there was a climate of fear and suspicion of gender variant people in Australia which affected the daily lives of transsexuals across Australia. This establishment and maintenance of secrecy has been described as having serious psychosocial consequences (Wilson, M., 2002).

It has been noted that the most significant validations of the emergent gender identity come from significant others (Nuttbrook, et al., 2002; Wren, 2000) and other authors have noted the impact of transsexual identity on families (Zamboni, 2006). Devor (2004) comments on the importance we place on the psychological engagement with others, emphasising therefore the powerful effects the opinions of others have on our psychological well-being. Devor (2004) further states that when this is perceived as invalidating of ourselves it can result in distress. Therefore, the social validation of the transsexual’s identity once they have commenced living in their preferred gender is important. This results in transsexuals seeking acceptance, primarily from people they are very close to, such as spouses and family members. It has been found that even the process of a transsexual’s disclosure of their gender incongruence often involves engaging in preparatory discussions about similar controversial topics with a significant other to test reactions before disclosure (Gagne, et al., 1997; Nuttbrook, et al., 2002). This could be regarded as experimentation to test social perceptions. Gagne et al. (1997) proposed that transsexuals experiment with identities until they find one that is comfortable. Cahill (1998) also offers an interesting perspective on the performance of gender, viewing it as a continuous process of performing, recognition and validation with a social context. The performance of gender within public social settings as seeking validation for the new transsexual gender identity was also noted in a study
done on transsexuals in Western Australia (M. Wilson, 2002). These authors all highlight the importance for transsexuals, despite their different expressions of gender, to be accepted within the general community.

The preceding paragraphs discussed various theories of what constitutes the formation of gender and identity which are the two main domains of a transsexual’s identity. However, in regards to the goal of this study, the issue is how these two concepts relate to the development of self-discrepancies and mood and anxiety symptoms in transsexuals.

**Identity Control Theory**

Embedded in symbolic interaction theory, ICT and SDT explain what occurs when identity enactment in social settings is either interrupted or invalidated (Burke, et al., 1999; Higgins, 1987). What these two theories provide is a means for accounting for both cognitive and emotional (affective) dimensions of identity formation.

To gain a better understanding of what living in their preferred gender and blending into society may involve, Burke’s identity control theory (Burke, et al., 1999) and Higgins’ (1987) SDT provide useful theoretical perspectives. According to ICT, the processes that are involved in an individual’s formation of a healthy identity are based on a regulated system of input-feedback and adjustment (Burke, 1991). Burke (1991) stated that an individual is said to have an “identity set” which is a set of values, attitudes and beliefs in relation to their identity and the expected roles they play in social contexts. The “identity set” based on how identity is formed is comprised of an individual’s notion of identity, some of which is biologically and culturally determined, together with society’s notion of identity based on social groupings, for example, transsexuals, Christians, psychologists, women, and men.
Under normal circumstances an individual is said to constantly monitor environmental feedback cues in relation to their identity and makes necessary adjustments to their “identity set” so that one’s identity is confirmed (Burke, 1991). The day-to-day interruptions to the “identity set” are self-regulated in an almost automatic manner and no mental health distress is experienced through these processes.

In transsexual identity change, the changes are dramatic and large and as Cohen-Kettenis and Van Goozen (1997) state, not all people are capable of dealing with these changes and this may result in mental health distress. A change as large and dramatic as is experienced in changing a person’s gender and commencing living in their preferred gender, would be likely to cause distress to the individual (Burke, 2006).

Negative body image, early childhood trauma, sexual minority status, and disclosing to family, friends, and work colleagues, are all factors that may contribute to the dramatic change the individual transsexual experiences. It is likely in these situations that the transsexual living in their preferred gender, despite achieving an internal sense of gender congruence, would continue to experience mental health distress (Nuttbrook, et al., 2002). While the transsexual may finally feel that they have achieved their goal and have achieved gender congruence, they may find that their new identity is continuously invalidated by their social context. For example Smith et al. (2005) found that 17.3% felt that they were being laughed at by others after surgery.

Initially, GID individuals experience an inner struggle of being gender incongruent. The appraisals the individual receives from social settings (both perceived and real) are viewed as being incongruent with the individual’s own beliefs. According to ICT, identity formation is interrupted and the self-regulatory system is unable to adjust, resulting in distress and poor mental health outcomes. Identity validation through
reflected positive appraisals has been noted as being crucial to mental health well-being (Burke, 1991).

Beginning to live in their preferred gender and changing of identity, according to identity theory, will result in the individual transsexual having to redefine themselves in social settings. According to Burke’s (2006) theory this would mean that the transsexual would have to change their identity standards and redefine who they are once they believed they had transitioned to their preferred gender. The identity change would result in change to the meanings of who the transsexual is. New standards would be formed to match the new identity with new dimensions of masculinity and femininity in gender schema. These new identity standards would be acted out in the transsexual individual’s social setting and appraisals would be received. The individual would make adjustments to their identity according to the reflected appraisals of others. However, when the appraisals are repeatedly non-confirming and rejecting the transitioned individual is believed to be at risk of identity interruption and at risk of experiencing mental health distress. As the discrepancy in the identity appraisal becomes large the individual feels distressed which impacts on their mental well-being (Burke, 2006; Nuttbrook, et al., 2002).

**Self-Discrepancy Theory**

SDT is grounded in theory which states that the reflected appraisals of others lead to the emotional states of depression and anxiety when self-verification is not achieved (Stryker & Burke, 2000). These factors make these theories particularly useful in understanding psychopathology such as depression and anxiety in relation to identity disorders such as GID, making them particularly salient above other theories such as Social Identity Theory and Self Categorization Theory. Self-discrepancy Theory and
ICT show how depression and anxiety arise out of the interruption or perceived negative appraisal of an identity within a social context. This is considered salient in GID as it has been noted that what is most important to the transsexual is the ability to “pass” successfully in their preferred gender (Carroll, et al., 2002; Rakic, et al., 1996; Ross & Need, 1989) and be validated and accepted by others (Cahill, 1998; Devor, 2004; Nuttbrook, et al., 2002).

Psychologists have established that individuals who experience conflicting views of the self are likely to experience psychological distress (Rogers, 1959). Rogers (1959) who first developed the concept of self-discrepancies asserted that there were many aspects to the notion of self, based on the phenomenological experiences of an individual. Rogers differentiated two representations of self, namely “self as experienced” (real-self) and “ideal-self” (Rogers, 1951, 1959). Based on these two representations, a person would experience congruence when the person’s actual self matches their ideal self. Conversely, incongruence would be said to occur when a person demonstrates self-discrepancies between their actual self and their ideal self and it would be expected that this would result in the person experiencing psychological distress, such as dysphoria and depressive symptoms.

To explain the mechanisms of the breakdown of normative identity formation and its result in mental health distress, Higgins (1987) developed self-discrepancy theory (SDT). SDT is a model of social evaluation (Strauman & Higgins, 1988). Thirty years after Rogers (1951) first developed the concept of self-discrepancies, Higgins posited that in addition to the dysphoric, depressive symptoms that are a result of incongruence between ideal and actual self, an individual would experience agitation and anxiety symptoms when there were discrepancies between the ideal and the ought self. Higgins (1987) developed SDT to examine how conflicts concerning identity can
cause mental health distress. Cast (2004) also offers insightful research findings into the negative impact on mental health when identity verification is disrupted or evaluated negatively (see also Schachter, 2002). Drawing from the theories of identity, Higgins postulated two cognitive dimensions which he believed underlined various self-stage representations. These were the domains of self, containing three basic domains of “actual self”, “ideal self” and “ought self” and the two standpoints (“own” and “others”) on the self from which a person can be appraised either positively or negatively (Higgins, 1987).

In applying SDT to understanding identity of a transsexual, the “actual self” refers to the salient attributes that the person believes they actually possess. The “ideal self” consists of the attributes that the transsexual would ideally like to possess and the “ought self” is the attributes that the transsexual believes they ought to have in order to fulfil their identity. SDT looks at the actual and ought self from two standpoints: the transsexual’s own standpoint and what the transsexual believes is the standpoint of significant others.

Figure 1 diagrammatically represents Higgins’s model. Combining the three domains with the two standpoints yields six possible self-representations: actual/own, actual/other, ideal/own, ideal/other, ought/own, ought/other (Cash & Szymanski, 1995; Higgins, 1987; Strauman & Higgins, 1988).
Figure 1 The six possible representations of self-discrepancy theory from the two standpoints of own and other: actual/own; actual/other; ideal/own; ideal/other; ought/own; ought/other.

Post transition transsexuals are expected to have resolved their internal conflict of gender incongruence through the process of transition after which they live as their preferred gender. The Actual/ Ideal states, in SDT, represent discrepancies where the individual’s actual attributes (from his/her “own” standpoint) does not match the “ideal” state that someone (self or other) wishes the individual to acquire. This discrepancy represents the absence of positive outcomes or the non-attainment of goals or desires which renders the individual vulnerable to affective mood states such as depression. Therefore for the transsexual, this would mean that after commencing living in their preferred gender, the transsexual believes they have not acquired the ideal “stereotype” of their preferred gender either of their “own” expectation or from an “other” significant individual. It is hypothesised that this discrepancy of the actual/ideal in the transsexual, would lead the individual to experience depressive symptoms, due to their perceived failure to achieve their desired goals in their preferred identity (Strauman & Higgins, 1988).

In the actual/ought discrepancy, the individual becomes vulnerable to agitation related emotions such as anxiety and stress. This condition is brought about when the
transsexual’s “Actual” attributes (from his/her standpoint) do not match what the transsexual believes they “ought” to have or when the transsexual believes there is a discrepancy between actual and ought attributes in the mind of significant others. This presence of negative outcomes based on expectations is believed to be what makes the individual vulnerable to anxiety disorders. The transitioned transsexual who experiences an actual/ought discrepancy, would believe that they have not fulfilled the expectations of their preferred gender by either their “own” appraisal or the appraisal of a significant “other” (Strauman & Higgins, 1988).

While the internal gender identity incongruence may be ameliorated by the individual transitioning, social self-appraisals providing vital feedback to the “identity set” according to ICT, may be negatively appraising of the preferred gender. Thus, the perceived or real appraisals of others are internalised by the individual to produce self-appraisals. The causal influence flows from self-perceptions to the “perceived other’s appraisals”. Therefore people may not see themselves exactly as others see them but rather how the individual perceives others see them. This is open to a great deal of cognitive distortion (Leary & Tangney, 2005). These appraisals being salient factors of identity formation, being constant, and being from significant others, may result in a breakdown in an individual’s identity formation, or according to ICT, identity interruption. According to SDT this discrepancy in identity formation is likely to lead to depression and anxiety. Having achieved identity congruence through transition and resolving their internal distress, the transsexual may experience further distress from the negative appraisals of their preferred gender identity from significant others in society. Smith, Cohen and Cohen-Kettenis (2002), while not referring directly to identity theory or SDT, referred to self and discrepancy in their study of post-operative functioning in adolescent transsexuals. The study made mention of the fact that many transsexuals
experience serious psychological discrepancy between their physical self and their “real” self which some find is ameliorated through surgery.

Utilising Higgins’ SDT, this project explores the extent to which, after commencing to live in their preferred gender, transsexuals continue to experience mental health distress and whether this can be attributed to issues concerning their gender identity. Specifically, this study explores the possibility that even after achieving an internal sense of gender congruence after living in their preferred gender, the transsexual individual may well have to contend with an external sense of gender incongruence that is mediated by conflicts among their perceptions of their actual, ideal and ought selves from the standpoints of how they view themselves or how they think significant others perceive them to be. Significant discrepancies between the transsexual’s actual self, post transition and the self-guides postulated by self-discrepancy theory are hypothesised to give rise to negative and agitated psychological states and result in mental health distress characterised by depression and anxiety, which are frequently experienced in transsexualism. The project sought to determine the extent to which depression and anxiety were characteristic of a sample of transsexuals who are living in their preferred gender and if so whether this may be explained by SDT, in terms of achieving gender congruence through identity validation.
Chapter 3
Overview of Project Design

This chapter introduces the model that will be tested in this thesis. It specifically looks at the predictor variables that were used in the research on satisfaction with SRS; age of onset, sex at birth, sexual orientation and social support; and discusses how these variables will be used in the models in this thesis to explain the mental health of transsexuals who are living in their preferred gender. The chapter provides a detailed overview of the three studies and the hypotheses to be tested. The chapter also introduces the research participant participatory model which aimed to involve transsexuals in core aspects of the research through the formation and operation of a consultative committee. Information is provided on the formation of the committee and its terms of reference.

Each of the three studies in this project sought to provide a different insight into the research question: “Does the construct gender congruence, conceptualised as self-discrepancy and measured by the Self-lines measure (SL), play a mediating role in the achievement of mental health well-being in transsexuals who are living in their preferred gender?”

The project used the independent variables that have previously been found to be correlated with satisfaction with SRS: birth gender, age of treatment onset, sexual orientation and social supports. This study used previous findings from these variables and integrated these findings with major identity theories to develop a theoretical framework to explain the achievement of gender identity congruence. Depression and anxiety were chosen as the main mental health outcome variables because they are the
central features of the dysphoric condition and are often co-morbid (Cole, O'Boyle, Emory, & Meyer, 1997). The model is represented in Figure 2.

Figure 2 Model of independent variables, proposed mediator variable and dependent variables.

Age Commenced Living in Preferred Gender and Length of Time in Preferred Gender

There appears to be very little research that has examined the developmental nature of mental health status across a number of time periods for transsexuals. The literature suggests that individuals who commence treatment in their early years, i.e., Pre puberty, appear to experience less mental health distress than those transsexuals who commence treatment later in life (Zucker, Wood, Singh, & Bradley, 2012). It is not clear whether this is related to the length of time spent living in their gender of choice or if it is related to the actual age at which the treatment commenced. An individual who at the time of the study is for example 27 years and transitioned at 25 years but commenced treatment at 15 years would have lived in their preferred gender for only 2
years but would have commenced treatment at a relatively young age. According to the literature, this individual ought to have better mental health outcomes compared to an individual who is 60 years at the time of the study but commenced treatment at the age of 35 and transitioned at the age of 40. This individual would have lived in his or her preferred gender for 20 years but would have commenced treatment at a relatively later stage. It is therefore important to focus on these issues.

It may well be that, irrespective of age of commencement of treatment, the length of time in the gender of choice is a significant predictor of mental health outcomes. It may be the case that there are differences with regard to mental health both in relation to duration of the length of time in transition as well as the actual age at which an individual enters the stage of transition. Therefore, in this project the variable age was divided into two variables to test these two concepts.

The Hypotheses to be Tested

From previous research, it was hypothesised that mental health outcomes would be more positive for (a) FM than MF, (b) transsexuals who had a homosexual orientation prior to living in their preferred gender, compared with transsexuals with a heterosexual or bisexual orientation, (c) transsexuals with a greater number of social supports, and (d) transsexuals with higher satisfaction with social supports. It was further hypothesised that mental health outcomes would vary in relation to (a) the age at which the individual commenced living in their preferred gender and (b) length of time living in their preferred gender. However, there was insufficient evidence to support a hypothesis regarding the direction of effect for the latter two variables.

A further contribution of Study 2 was to examine gender congruence and its potential relationships with mental health outcomes. The study aimed to investigate the
extent to which transsexuals who were living in their preferred gender had achieved gender congruence, as well as the extent to which participants perceived significant others were confirming of their preferred gender. It was hypothesised that transsexuals who were living in their preferred gender would have more positive mental health outcomes if they had (a) a higher perceived level of congruence with their preferred gender, or (b) stronger perceptions that significant others were positively appraising of their preferred gender. It was hypothesised that gender congruence (measured as per Self-discrepancy Theory) would be a mediating factor in predicting mental health. This model is presented above in Figure 2. Specifically, it was hypothesised that preferred gender, sexual orientation, length of time in preferred gender and age at commencement of living in the preferred gender, would not have a direct influence on mental health outcomes but would be mediated through gender congruence and that gender congruence would have a direct relationship to mental health outcomes.

To accomplish this, each study explored a particular aspect of transsexual phenomena from the perspective of transsexuals who had transitioned from their birth gender to living in their preferred gender. The three studies used different methods and methodological perspectives. It was hoped that this triangulation would provide a richer understanding of the lives of transsexuals than a unitary research method.

Study 1 engaged transsexuals in developing a questionnaire titled the “Living in your Preferred Gender Inventory” (LPGI). Through the use of open-ended interviews, a qualitative analysis identified common markers that constituted living in the preferred gender. These markers were then matched against questionnaire items that were developed by the researcher for the LPG Inventory. Once the inventory was validated for content, cultural sensitivity and ease of administration as documented in Chapter 4, it was used as a measure in Study 2.
Study 2 utilised the LPGI, together with other psychometric scales, to investigate the research question using a quantitative approach. This component sought to address some of the gaps from previous quantitative research as highlighted in Chapter 1. The study utilised the typology and empirical generalisations found in other research on transsexuals to explore mental health well-being. The conceptual framework used was based on self-discrepancy theory.

Study 3 used qualitative methods to focus in greater depth on a select group of transsexuals who had participated in Study 2. The study explored the themes, the narratives and the benchmarks on a transsexual’s journey to living in their preferred gender. It further explored the variables examined in Study 2. The semi-structured interviews used in this part of the project allowed the voices of the transsexuals to be heard and were intended to assist with developing a deeper understanding of salient issues.

In carrying out these three studies, one of the challenges for the researcher was establishing a credible research profile, and building trust with the communities being researched (Mosavel, Simon, van Stade, & Buchbinder, 2007). To accomplish this, the transsexual community was engaged to seek its approval, guidance and feedback on many aspects of the research. The framework for this collaboration was a participatory research approach which in this thesis is termed the Research Participant Partnership Model (RPPM).

The Research Participant Partnership Model

Internationally, there is an increasing voice calling for responsible representative research that is responsive to the needs and values of the populations studied (Esperat, Feng., Owen, & Green, 2005; Nilsen, Myrhaug, Johansen, Oliver, & Oxman, 2007;
O’Donnell & Entwistle, 2004; Paterson, 2005; Shea et al., 2005; Telford, Boote, & Cooper, 2004). One way of accomplishing this is by incorporating participants from within the community being researched into the research process (Pinto, et al., 2008). For example, one of the three principles of the strategic mission statement of the WHO “Health for All” project (Whitehead, 1993) stated the need for community participation in the planning and implementation of health care. In the United Kingdom, the USA, Canada, and in Australia, consumer participation is required as part of the National Mental Health Strategies.

Community based participatory research offers a challenging alternative concept to the traditional research design. This inclusive participatory process, it is argued, guides a clearer understanding of the population of interest. In addition, collaborating with other professionals and most importantly with the community of interest enriches the research team and the research process (Esperat, et al., 2005).

Participatory partnerships makes the research more meaningful (Esperat, et al., 2005). Participants, having experienced particular health or mental health concerns, can improve the quality of research by providing insights relevant to their condition (Boote, Barber, & Cooper, 2005; O’Donnell & Entwistle, 2003).

Research in transsexualism is an area that highlights some of the issues raised by advocates of participatory research. For example, psychologists and psychiatrists classify transsexualism as a mental disorder. This immediately places a stigma of being classified with a mental health diagnosis. Additionally, some transsexuals during the consultation process for the present project expressed concern to the researcher that academic research is far removed from “real life” with a polarised view of the transsexual experience and shows a lack of understanding of the needs and issues,
including the appropriate use of terminology to describe transsexuals. There was also concern that academics may guard their own academic needs and careers through the investigation of other people’s distress, rather than serve the needs of the community being researched. The use of “within” community participants in the research process is viewed as a means of addressing these issues (Mosavel, et al., 2007; Paterson, 2005; Powell & Gilliss, 2005).

One of the first objectives of this study was to engage with the transsexual community. Initially this was done through the development of a consultative committee. During the course of the research, other means of engaging government, non-government and community based organisations were undertaken to ensure the research addressed cultural sensitivity through the appropriate use of terminology and also assisted to promote the research in preparation for participant recruitment. When participant recruitment had commenced, the LGBT media and the general media were utilised to further contact the transsexual populations of Australia and New Zealand (see Figure 3). This process of engagement and promotion continued until participant recruitment was completed and then commenced again with the dissemination of the results to the community.
Early in the project the researcher identified the need for the development of a consultative committee comprised of transsexuals. The consultative committee initially comprised three members. In the first instance the researcher approached a high profile transitioned male-to-female (MF) from New Zealand who agreed to sit on the committee. The other two committee members volunteered their services after hearing about the research at a conference presentation by the researcher. One of these was a transitioned female-to-male (FM), who had involvement in the transsexual community in Western Australia and the other was a pre-transition FM third year international university student from Queensland. Participants who agreed to serve on the committee
were given the Terms of Reference which outlined the expectations for the group (refer Appendix A).

**Objectives of the Consultative Committee**

The first objective of the consultative group was to help the researcher to achieve cultural sensitivity, particularly in the area of terminology. Transsexuals are very sensitive to how they are identified in terms of the descriptive labels often used to refer to the transsexual population such as “transgender” and “transsexual”; however, there is no consensus among transsexuals on which terms are most appropriate. In addition, there are inconsistencies regarding the use of the terms “transgender”, “transsexual” and “gender identity disorder”. In the scientific literature, the term “transgender” is often used as an umbrella term to describe individuals who do not fit the binary gender categories of male and female (Lurie, 2003; Maguen, et al., 2005). This word is used to describe a group of individuals who demonstrate gender variance and gender incongruence (Maguen, et al., 2005). Transsexualism is the term used specifically for individuals who meet diagnostic criteria for GID (Zucker, et al., 2012). Transsexuals are the group of specific interest for this project. Within the transsexual community, the terms “transgender” and “transsexual” are not necessarily used interchangeably and there can be strongly held divisions of opinion about which term is the most appropriate (Pinto, et al., 2008). This issue was discussed with the consultative committee and it was agreed that the term “transsexual” was the most appropriate as it was consistent with the scientific literature.

The second objective of the consultative group was to assist the researcher to develop partnerships and networks with organisations that provide services to transsexuals throughout Australia and New Zealand. The specific aim was to assess
availability of participants and discuss logistical issues such as how and where participants may be accessed for the purpose of the research. How this was accomplished is noted in the methodology described in the following chapters.
Chapter 4

Development of Living in Your Preferred Gender Inventory

Study 1

This chapter outlines the method and results for Study 1 which investigated what constituted living in your preferred gender. The aim was to seek information and develop an inventory that identified key behaviours which were present when transsexuals were living in their preferred gender. The chapter describes participant recruitment, inventory development, tests for reliability and validity, the results of Study 1 and the implications of the inventory.

Study Objective

The aim of this study was to establish the meanings that transsexuals place on the concept of transition which for the purposes of this study was operationalised as a belief that they are living in their preferred gender (LPG), irrespective of whether they have had gender confirmation surgery (SRS) or not. The study sought to investigate whether there were common characteristics that transsexuals share when they believe they are LPG and to compare these to items of an inventory that was developed for this research. Specifically, this study’s objective was to develop and assess the face validity of an inventory of public and social behaviours that characterise the concept of living in the preferred gender. This was important to investigate as the majority of previous research defined living in the preferred gender as the point when the person undertook SRS (Bradley & Zucker, 1997; Carroll, et al., 2002; Cohen-Kettenis & Gooren, 1999; Jacques, 2007; Olsson & Möller, 2006; Rehman, Lazer, Benet, Schaefer, & Melman, 1999). While the process of a transsexual moving towards SRS has not been clearly understood, it has often been referred to as a transition process (Goldberg, 2003). The
term “transition” does not seem to have been clearly defined, but is assumed to take place when a person undertakes hormone therapy, undergoes the real life experience (RLE) and finally completes SRS.

What has been noted, including in Australia and New Zealand, is that not all and possibly very few transsexuals have undertaken SRS (Couch, et al., 2007). Therefore when investigating all transsexuals who believe they are LPG, a broader perspective needs to be applied - one that does not rely solely on SRS as a marker but endeavours to include all transsexuals who are LPG. It was hoped that the development of an inventory might assist in capturing the process or steps that transsexuals may take on their journey to achieving gender congruence, i.e. LPG irrespective of whether they have undergone hormone therapy and/or SRS.

Method

Study 1 employed a qualitative research method using semi-structured interviews. The researcher transcribed and reviewed the interviews to identify concepts and categories from the data. These concepts and categories were based on the behaviours transsexuals reported as they experienced the process of LPG. These categories were then linked to each other as well as to the core concepts that were developed prior to the study.

Development of Inventory

As the first step in Study 1, the researcher developed an inventory of public and social behaviours that might characterise the concept of living in their preferred gender as seen by transsexuals. The items for the inventory were developed from the parameters established for the RLE guidelines for clinicians which are contained in the Standards of Care of WPATH (Meyer et al., 2001). Under these guidelines, transsexual
clients are expected to experience living in their preferred gender in five areas of “real
life”: (a) family, (b) friends, (c) legal, (d) employment, and (e) education. Clinicians are
asked to assess how the transsexual maintains living in his/her preferred gender as a
way of identifying whether the transsexual is a candidate for SRS. Although this project
does not assume that a transsexual plans or even wants SRS, WPATH has provided
some established behavioural indicators in regards to what a transsexual might say they
did in achieving their goal of living in their preferred gender. The proposed inventory
focused on overt behaviours rather than cognitive and affective characteristics. This was
consistent with the Standards of Care of WPATH which focus on overt behaviours
within social settings such as spending time with family and friends. Additionally, in the
subsequent interviews, transsexuals primarily spoke in terms of the steps they actually
took in transitioning to live in their preferred gender; for example, changing their name,
and dressing in the preferred gender with family and friends and in work settings.

The researcher then developed questions asking about the extent to which
transsexuals engaged in behaviour relating to each of the five parameters, for example
“… in employment in your preferred gender” with a range of options from *never* to
*always* as well as a *not applicable* option. In addition, questions were developed for
other behavioural areas such as “change of name” (Appendix B).

**Development of the Interview Schedule**

There were two stages in the interview process. For the first stage, interview
development, four non transsexuals were recruited from people known to the researcher
who were willing to volunteer their time. They were asked to role play being a
transsexual. Some read material to familiarise themselves with the transsexual
experience and others made up answers as they went along. These four participants
were interviewed using the draft semi structured interview format which was to be used in the subsequent interviews with transsexuals. The interview was based on a time line structure (Dervin, 1992; Maas, 1996) in which participants were asked “the first thing I want to ask you is to think back to the time when you commenced living in your preferred gender. You know, living as a man/woman. What was the first thing that you did in terms of living as a man/woman?” They were then asked to identify and elaborate on each of the steps that followed up until the time they began living in their preferred gender.

From these pilot interviews the researcher found that the interviews took approximately 90 minutes, rather than 60 minutes as originally estimated. The time line approach was found to work well because it provided a structure for participants to recall what had happened, including events which in some cases had occurred many years ago. This approach also allowed the researcher to maintain focus on the objectives and to go back and clarify with participants what they had reported.

Based on these findings the time line was found to be a useful measure and was maintained in stage two. Finally, the researcher decreased the time taken for administrative tasks during the interview by completing some of them prior to the interview e.g. coding the documents with the participant’s code.

**Recruitment of Participants**

For stage two, five transsexuals were recruited on a voluntary basis through word of mouth. Eligible participants were transsexual Australian or New Zealand residents who considered themselves to be living in their preferred gender. Living in their preferred gender could include but did not have to include gender confirmation surgery.
Socio-demographic Profile of the Participants

One participant was an overseas student from Singapore, of Indian background and currently a resident of Australia and one was from New Zealand, of Maori background. The other three participants were from the Gold Coast. Two participants were from the metropolitan area of the Gold Coast, Queensland, Australia, one having moved to the area recently from a remote rural area. The other participant was from a semi-rural area of New South Wales, Australia. Participants all currently resided in Australia (3 from Australia, 1 from New Zealand, and 1 from Singapore). All the participants had completed some secondary education, and two had completed tertiary education, one at TAFE and the other at postgraduate university level. The participants were aged between mid-20s to mid-60s.

Procedures for Conducting the Interviews

Three of the interviews were conducted face-to-face and two by telephone. The participants were asked at the beginning if they minded if the interviews were recorded digitally for transcribing purposes. All participants agreed to have the interviews recorded. The names of all participants have been changed in the write-up of the study to protect their confidentiality.

After a brief welcome, the context of the interview was established. The researcher explained the study procedures, answered any questions and obtained written informed consent.

Interview process. The interviews consisted of a semi structured open ended question format. Participants were asked to think back to the time when they commenced living in their preferred gender and they were asked, “What was the first thing you did when you commenced living in your preferred gender? The answer was
written on a card. Participants were allowed to freely discuss what they wished with the researcher only prompting by asking them “and what was the next thing you did”? Once the participant had reached the present moment, the researcher then arranged all the cards in sequence of occurrence to form a time line. Participants were asked if the time line represented what they had said and what had occurred in their life. Participants were free to change the sequencing of the cards and add or remove cards if they felt this was necessary.

Once participants had verified that the sequencing and content of the cards were correct, the researcher asked the participants to indicate which behaviour for them represented the point at which they believed “now I am living as a man/woman”. This was recorded on the card.

At the next stage of the interview participants were asked to complete the LPGI. In addition, they were requested to provide feedback on instruction clarity, cultural sensitivity of terminology, and relevance of items. All suggestions were recorded as part of the interview audio recordings as well as on the inventory of each participant.

Finally, participants were asked to complete a demographic questionnaire. At the conclusion of the interview participants were thanked for their time and effort and they were given a contact list to take should they know of any transsexuals who may be interested in partaking in Study 2 and 3.

The recorded interviews were transcribed into Microsoft Word documents saved only with a participant code. These documents formed the raw data set and were then used to interpret the interviews further and to identify categories.
Results

The results are presented in two parts. First, the results related to the development and validation of the inventory will be given and second, the results that relate more broadly to the process of living in the preferred gender are provided.

Inventory

The researcher assigned each public step mentioned in the time line to a category. The six categories identified during analysis were “coming out” with two sub categories “friends and acquaintances” and “family”; “wore gender appropriate clothing in public”; “gender confirmation medical treatment” with two sub categories of “hormone treatment” and “gender confirmation surgery” (SRS); “employment”; “intimate relationships” and “name change”.

All the respondents reported behaviours in the categories “coming out”, “wore gender appropriate clothing in public” and “name change”. At least three respondents reported behaviours in each of the other three categories. For this very small sample several trends were found within the categories and sub categories: “coming out to friends” and “wearing gender appropriate clothing in public” came early in the process whereas “coming out to family” was a step taken later in the process. Gender confirmation medical treatments tended to come later in the process or not at all. These six categories and sub categories were then compared to the items which were developed for the Living in your Preferred Gender Inventory (LPGI) as shown in Table 1 below.
Table 1
Comparison of categories to LPGI items

<table>
<thead>
<tr>
<th>Categories and sub-categories</th>
<th>Items on LPGI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coming out</td>
<td>2, 3, 4, 5 &amp; 6</td>
</tr>
<tr>
<td>Family</td>
<td>5</td>
</tr>
<tr>
<td>Friends</td>
<td>4</td>
</tr>
<tr>
<td>Wore gender appropriate clothing</td>
<td>2-6</td>
</tr>
<tr>
<td>Employment in preferred gender</td>
<td>2</td>
</tr>
<tr>
<td>Hormone treatment</td>
<td>12, 13, 14</td>
</tr>
<tr>
<td>Gender Confirmation Surgery</td>
<td>9, 10, 11</td>
</tr>
<tr>
<td>Name change</td>
<td>8</td>
</tr>
<tr>
<td>Informally</td>
<td>8(a)</td>
</tr>
<tr>
<td>Formally</td>
<td>8(b)</td>
</tr>
</tbody>
</table>

Note: The item wording of the inventory may be found in Appendix B

Inventory validation

The inventory had good face validity. The behaviours that participants mentioned in the interviews were also the behaviours that had been included in the inventory. Also, the participants commented that the inventory reflected their experiences and they could offer no additional behaviours.

The validation of the inventory was also measured by asking the participants the question “at which point did you believe, now I am living as a man/woman”? When this answer was analysed in the context of the time line, although the behaviours that participants had reported matched the behaviours which were in the items on the LPGI, it was found that participants had responded to all the behaviours in the inventory even though some of them had come before and some of them had come after the point at which they themselves stated they had commenced LPG. If the inventory was
completed as conceptualised, the result would have been that participants would have completed only those inventory items that came before the point at which they believed “now I am living as a man/woman.

As a result, many changes were made to the wording of the inventory and the wording and typeface of the instructions. It was also decided that in Study 2, where the LPGI would be administered to participants as part of the quantitative analysis, the LPGI would be administered first so that participants could be talked through the instructions. Additionally, examples were developed to assist participants understand how to answer the LPGI.

**Test-retest reliability.** The test-retest reliability for the Living in Your Preferred Gender Inventory (LPGI) was conducted at the end of the data collection period for Study 2. Four variables were selected for the test-retest reliability test: frequency of living in your preferred gender with friends, frequency of LPG in employment, total number of social behaviours engaged in prior to LPG and number of years LPG. Only participants who agreed to be contacted if further follow up was needed were asked by email to participate in the retest. The first 40 who completed the original surveys were contacted in expectation that at least 30 would reply. This number was selected in order to achieve power for the study of .83 (Aron, Aron, & Coups, 2006). Thirty respondents could be matched to the original.

There was a significant correlation between the answers to the first administration of the survey and the second administration for the question living with friends before LPG ($\Gamma = .84, n = 30, p = < .01$). The correlation between the two administrations for LPG employment was, $\Gamma = .56, n = 30, p < .01$. A Pearson’s correlation was computed to determine the relationship between the total number of
behaviours engaged in on the first administration and the second administration. The relationship was significant, \( r = .62, n = 30, p < .01 \).

As participants completed the inventory at different times over a period of 18 months, the period of time between the original test and the retest varied from 6 months to 18 months. Therefore, the answers to the question on number of years living in their preferred gender had to be checked as they could have changed over time. For example someone who had done the original inventory 18 months ago and stated that had lived in their preferred gender for 4 years would on the retest have to state that they had lived in their preferred gender for 5.5 years. A Pearson’s \( r \) was also computed to test the reliability between the number of years LPG on the first and second administration of the LPGI, \( r = .95, n = 30, \rho < .01 \).

Assuming that a reliability coefficient of close to .90 is desirable (Aron, et al., 2006) only one of the correlations reached this level, the number of years LPG, despite all of the correlations being significant.

The reliability on the friends question was marginal and on the employment question was low. An examination of the results showed that the answers to always engaged in the activity and never engaged in the activity were extremely stable over time. The inconsistencies were primarily found in the occasionally and frequently categories. It is therefore recommended that the four point frequency scale on the social behaviour questions be changed to always (engaged in the activity), sometimes (engaged in the activity) and never (engaged in the activity). The reasons that reliability was relatively low for total number of social behaviours engaged in is unclear. However, it is expected that the changes to the frequency scale for the individual
behaviours will improve the accuracy for the total number of behaviours. A further test
retest reliability should be conducted after these changes are made.

This shows that the inventory is fairly robust over a considerable period of time
ranging from 6 months to 18 months.

**Other Results**

Other findings relevant to the broader study were found. First, participants
reported categories that did not match the behaviourally based items in the LPGI. These
categories were clustered under the headings “cognitive” and “affective” as they related
to how participants felt about themselves, content that they thought about or information
they sought. The categories were “information gathering about transsexualism”,
“acknowledgement and confirmation that I am transsexual”, “commitment”, “social
support from other transsexuals”, “becoming comfortable”, “growing into it”, “letting
go of past life”, and “appraisals by others”. All these eight cognitive and affective
categories came early in the process.

Second, as noted above participants were asked at what point they believed that
they were now LPG. Although four participants had had SRS and/or hormone treatment
none of them reported this to be the defining marker at which they believed they were
now LPG. For two, the defining point came after SRS, for example, “getting married in
their preferred gender”. When asked what was the defining moment one MF said “*when
I got married to [Jeremy]. It was something along the lines of being normal. I just
wanted to be normal*”. In a later stage of the interview, when providing feedback on the
LPGI this participant stated “*where I come from and life’s harsh treatment of it. It
wasn’t normal and it [transsexualism] wasn’t acceptable and what you had to go
through living on the planet*”. The other, a FM who had recently had breast surgery,
stated that his defining moment when he felt he was living as a man was when he took three months leave from work and returned after leave as a man: “I left work as a female and got back to work as a male”. For two participants the defining moment came before SRS and/or hormone therapy. For example, a FM in her mid-forties who commenced living in her preferred gender later in life stated that the defining moment when she felt she was living as a woman came “when I started living fulltime as a female....the female clothes, make up, being social.....that to me was my second birthday.” Another MF in her early fifties who had commenced living in her preferred gender fulltime at the age of 16 years reported that her defining moment came right from the day she commenced living full time as a female and changed her name to a feminised version of her male name.

"it was essentially that I had an epiphany that I was going to be [Stephanie]....the first sort of thing that I did to make that resolution [to live as a female] was to destroy all the physical things of male attire and accoutrements I owned at the time, to erase the superficial, the physical,...everything that was [Stephan], my previous self, I erased and burnt in a huge celebratory bonfire and from that day forth and it was like I buried or cremated [Stephan] and was re-birthed as [Stephanie]."

When asked directly if there was a particular point where she felt now I feel that I am actually living as a women she answered “....this may sound cheesy but from the day I cremated [Stephan].”

The fifth person reported the defining point as being the point at which he was able to go to a bar dressed as a male and have a conversation with another male. The
significance of this was that he believed that he was in a male dominated public venue and thus was being validated by another male:

*I always felt like a man but sometimes I would go back if I felt it was easier. In situations where I felt somebody was not going to be ok with it I would pretend to be feminine and girly, but when I went out fully dressed as a man I was a man.*

Furthermore, he believed that while he had in the beginning wished to commence hormone therapy and progress onto SRS, with the lapse in time and the social validation of living as a man he now felt that this was a more valuable first step and that SRS and hormone therapy were not as significant at this point in time.

**Discussion**

The study met its objectives of exploring the characteristics of living in your preferred gender for a small sample of transsexuals. The items on the inventory which were based on the RLE of the WPATH were found to be useful and meaningful based on the reported experiences of this sample. The behavioural categories that were developed form the data matched the items on the inventory and this was confirmed by the participants as they completed the inventory.

**Practical and Theoretical Implications**

The medical model assumes that transition is a process that leads to SRS. However, the inventory highlights that SRS is not necessarily a defining point to a transsexual living in his/her preferred gender. The results indicate that LPG is a process and in this sample participants engaged in behaviours that were common to all of them as they tried to achieve gender identity congruence. What stood out was that SRS was not chosen by itself as a defining maker of living in their preferred gender by any of the
participants. From the perspective of previous research what this study highlights is that not all transsexuals seek SRS and not all view SRS as either a necessary or sufficient step to LPG. Instead, LPG is a psychological construct marked by personally significant events and experiences that may vary between individuals.

The inventory has several useful properties. It might be useful for clinicians working in the area of gender studies in terms of monitoring individuals who say they are currently LPG. It may give clinicians a tool to assess to what extent a person who reports that they are LPG is in fact LPG in comparison with other transsexuals. Furthermore, individual items on the inventory may be utilised to highlight particular aspects of an individual’s experience. For example an individual may say they are currently LPG but they may report on the inventory that they never live in their preferred gender with their family. The clinician may use this information to further investigate and assess what is happening for this individual. This can generate useful clinical information in developing treatment strategies.

The inventory may also be used as an educational tool in developing our understanding of transsexual phenomena. The inventory highlights that LPG is a process that has some common markers of which one may be SRS. This gives us a broader understanding of all transsexuals and not only those who seek the medical pathway. Furthermore, the findings provide validation of the WPATH standards in the RLE even for those who do not seek the pathway of SRS.

**Methodological Changes**

The inventory was designed to measure the public and physical behaviours that came before and up to the point at which respondents believed *now I am living in my preferred gender*. What was found on analysing the interview transcripts and the
answers to the inventory was that participants had often included everything they had
done up until the present date of the interview in terms of LPG. This highlighted the
difficulty of the task and the need for further instruction. The instructions were changed
to emphasise this point: “the questions below do not refer to what you have done up
until now BUT rather what you did PRIOR to the point at which you believed ‘now I
am really living as a man/woman’”.

Furthermore, a vignette was developed to illustrate how a particular individual
may appropriately respond to the items on the inventory. Two examples were provided
to assist participants’ understanding of the instructions. In addition, it was decided that
the inventory would be administered first so that people could spend time on it while
they were fresh and so the researcher could guide participants through the instructions
and vignette and answer any questions participants had.

Limitations of the Study

The sample size was small, comprising a purposive and a convenience sample,
which limits the generalisability of the results. However, the age and educational
diversity within the sample increases confidence that the findings regarding inventory
validity would be applicable beyond the study sample.

Even though there were extensive changes made to the inventory which were
designed to increase the reliability and validity, these changes were not tested on a
sample of new respondents before implementation in Study 2. Although the LPGI items
have face validity, it requires further psychometric validity and reliability testing. Apart
from discussing the items with participants to gain feedback on whether the items
reflected their experience, the inventory was not formally assessed for criterion validity
or construct validity.
Finally, the questions in relation to SRS and hormone therapy were modified to clarify at what point the individual undertook this treatment in relation to the point at which they felt they were now really living as a man/woman. Four questions were added to the inventory to clarify whether individuals had undergone SRS and/or hormone therapy before they commenced living in their preferred gender, after they felt they were now living as a man/woman or if they anticipated these treatment options at some stage in the future after they had achieved living in their preferred gender as a man/woman.

Conclusion and Future Research

The interview data highlighted that participants could easily pick a defining moment where they felt, "now I am really living as a man/woman". Within the context of Study 1 it was not feasible to explore the meanings these behavioural markers represented for the particular individuals. Finding the meanings behind what people are saying enables the exploration of how people think about their experiences and this is a fundamental step in developing understanding about behaviour. However, it is evident from this small sample that there may be a concept of "gender identity confirmation" based on social appraisal and recognition, which describes and explains why an event or marking behaviour may be significant. For example validation and normality were mentioned by two of the participants. This provided information for guiding Study 3.

Study 1 also highlighted questions that arose from the interviews that may provide useful applications in formulating future research questions. These included: what is normal for transsexuals; is there any indication that a supportive environment is necessary to begin and /or continue the process of living in your preferred gender (LPG); was being alienated from family and friends for a period of time important as a
step; what other factors did transsexuals consider important at the beginning of the process of LPG; are there things that seem to facilitate the process, e.g., research about transsexualism; are there things that seem to stifle the process; how did transsexuals think about their past life; how did they feel about their past life; what meaning did SRS have for transsexuals; did the person see himself/herself as a man/woman; did they identify as a transsexual man/woman; did they identify as transsexual; how important and relevant was passing in their preferred gender; was passing in their preferred gender particularly important with some people; was passing in their preferred gender less important with some people; did they feel at any stage that they lived in their preferred gender, then reverted to their birth gender; did gender reversal occur frequently; what caused gender reversal. These questions are not within the scope of this research but they do offer points of further investigation for future research.
Chapter 5

Testing Models

Study 2

This chapter describes the quantitative study. The main aim of the study was to answer the research question “Does the construct gender congruence conceptualised by self-discrepancy theory and measured by the self-lines measure (SL) act as a mediator in the achievement of mental health in transsexuals who are living in their preferred gender?” by testing the validity of the proposed models and the hypotheses presented in chapter 3. The chapter provides details of the recruitment process, the measures used in the thesis to explore mental health, social supports, and self-discrepancies. The results for the statistical models are presented. A detailed discussion of the results concludes the chapter.

As discussed in Chapter 1, previous research in the area of transsexualism has furthered knowledge and understanding on what typology is currently reported to predict satisfaction with SRS and improved mental health. The typology identified in previous research is utilised in this study to form the independent variables of the model.

In Chapter 2, the Diagnostic and Statistical Manual’s (DSM IV) diagnosis of GID was deconstructed into the components of gender and identity that result in the disorder. Gender and identity were both discussed in the literature as social constructs and identity theory, and specifically Higgins’s SDT, was explored as a means of understanding how transsexuals may seek to validate their achievement of gender congruence (Higgins, 1987). The self-lines (SL) measure which is used to measure self-discrepancies according to Higgins’s theory was incorporated into the model of this
thesis (Figure 2) as a mediator between some of the independent variables found in previous research and the dependent variable of mental health (Francis, Boldero, & Sambell, 2006).

Chapter 4 reported the development of an inventory to explore what constitutes LPG. The LPGI was used in Study 2 to gain important information of what constituted LPG for transsexuals who were currently living in their preferred gender. This inventory provided valuable supplementary data for the independent variables such as the number of years a person had lived in their preferred gender and the social context (family, friends and employment) in which a person lived in their preferred gender.

Method

Participant Recruitment

Recruitment considerations. Random sampling was not feasible because it requires a sampling frame for the selection of participants. A sampling frame of transsexuals was not available, and other types of sampling frames, e.g., geographical were not useful for this particular small population. Also, due to a lack of information about the characteristics of the transsexual population, e.g., percentage of MF and FM and the number of transsexuals in each state, territory, and country, a quota sample was not feasible. Therefore, strategies were developed to recruit a diverse range of participants using convenience sampling and snowballing.

Recruitment process. The recruitment process was ongoing throughout the research and involved a number of strategies. The first strategy was the development of a consultative committee comprising three transsexuals who provided valuable ongoing feedback on research methods and cultural sensitivity. This was particularly important regarding the use of culturally sensitive and appropriate terminology. The consultative
committee provided valuable links to transsexual organisations by informing the researcher of relevant organisations and in some instances introducing the researcher to key individuals. This gave the researcher an opportunity to network with transsexual organisations and become familiar with the transsexual community. In the recruitment of participants, assistance from the consultative committee enabled the researcher to build partnerships with organisations which helped with participant recruitment by publicising and promoting the research to prospective volunteers. As previously discussed, the consultative committee followed a Terms of Reference document (Appendix A) to ensure that the committee had focus and direction.

A second strategy in participant recruitment was visiting the Sydney Gender Centre and meeting with the manager. This was also undertaken early in the research so as to build research partnerships with the most prominent gender organisation in Australia. There was ongoing contact with the Gender Centre throughout the research process.

A third strategy involved presenting at the National Health In Difference conference which was a biannual conference involving health care professionals who work with LGBT Communities. The conference was a good opportunity to network with organisations that may have transsexual clients and it also gave an opportunity to meet transsexuals who were presenters and attendees. From this conference a list of organisations who wanted to be involved in the research in terms of locating participants was developed.

Another strategy was to develop a web site so that the research could be conducted through an online format enabling people who felt more comfortable in the anonymity of an online format to participate in the research. It also enabled participants
to access the research from remote areas. (See Appendix C for more information on the web site). Choosing both internet and face to face recruitment allows for the participation to be broadened. This it was anticipated would allow for a greater diversity in the sample rather than restricting it to those who had access to the internet and who liked participating through the internet format.

The researcher also used the lesbian, gay, bisexual and transgender (LGBT) media in Australia and New Zealand to publicise the research and the website. A media release was issued informing LGBT publishing companies of the research and informing them of the researcher, his contacts and the address of the web site. This gave the opportunity for a wider audience to become aware of the research.

Doing presentations to health professionals on transsexualism was another strategy in informing professionals who may have a transsexual client base about the research. This gave professionals the opportunity to be informed about transsexual issues and to take back information about the study to other professionals and to their transsexual clients.

Similar to the above strategy, the researcher gave presentations to groups of transsexuals in which the researcher shared his knowledge of the literature with transsexuals. At these sessions, participants were also asked if they would complete the surveys. To avoid contamination of the research, volunteers were asked to complete the surveys before the researcher had given the formal presentation. Transsexuals who completed the surveys were given contact lists on which to put names and contact details of any other transsexuals who might wish to participate in the research. The contact list stated the eligibility criteria.
A flyer was developed to advertise the research (Appendix D). This provided some information about the research. The flyer gave contact details for the researcher and also the address of the website. The flyer was distributed to organisations and individuals to promote the research amongst the transsexual population.

The researcher issued a group email to all organisations which had a website for members of the LGBT community requesting they provide a link to the research website. The email also included a research flyer for potential use by the organisation to introduce the link to the research website.

**Inclusion criteria.** By utilising the above strategies volunteers were recruited from the transsexual communities throughout Australia and New Zealand. There were three main inclusion criteria. Firstly they had to be adult males and females over the age of 18 years, secondly participants had to be transitioned transsexuals, i.e. those who believed that they were currently living in their preferred gender and thirdly all participants had to be residents of either Australia or New Zealand.

There was no formal payment for participation in the study. However, participants were given an incentive by having a choice of entering a draw for a competition to win one of six prizes. Entry into the prize draw was optional. People did not have to provide proof of who they were to redeem the prize allowing them the option to provide a pseudonym and they could provide a P.O. Box address for the delivery of the prize. The six prizes were beauty packs worth approximately AUD$100. They were donated by a Company that was associated with a Beauty Therapy Clinic. The incentive offer had the prior approval of the relevant Human Research Ethics Committee.
**Missing data and sample size.** The study was conducted face-to-face where possible and was also available online. The surveys were presented in the same order for both the face-to-face and the online versions. Twenty seven people completed the scales face-to-face. One face to face survey was omitted from analysis because of incomplete data.

A total of 168 logged on to the first survey (Table 2). The surveys were administered in the order shown in Table 2. Noteworthy is the disparity between the number of respondents who started and the number who finished the LPGI. This could have been because the first question of the LPGI asked how long a person had been living in their preferred gender. This may have resulted in people realising that they did not fit the inclusion criteria of being a person who was currently living in their preferred gender and they may have left the website. Also noteworthy is the number of participants who finished and submitted the LPGI and the number who commenced the second survey, the WEMWBS.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Started</th>
<th>Finished</th>
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<tbody>
<tr>
<td>LPGI</td>
<td>168</td>
<td>148</td>
</tr>
<tr>
<td>WEMWBS</td>
<td>123</td>
<td>123</td>
</tr>
<tr>
<td>K10</td>
<td>124</td>
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<tr>
<td>DASS</td>
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<td>SSQ</td>
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<tr>
<td>GI</td>
<td>112</td>
<td>112</td>
</tr>
<tr>
<td>SLM</td>
<td>127</td>
<td>122</td>
</tr>
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*Table 2*

*The Number of People who Started and Finished the Online Surveys.*
Four variables: the number of years living in preferred gender, total number of social behaviours, whether or not they had undergone SRS and had begun hormone treatment were analysed in order to determine whether there were systematic differences between those that continued and those that dropped out. There were two significant differences between those who dropped out and those that continued to the second survey, using an alpha level of .10, two-tailed. Those who dropped out \( n = 9 \) were more likely to have undergone SRS than those who continued to the second survey \( n = 33 \), \( \chi^2(1) = 2.8, p = .09 \). Those who dropped out \( n = 24 \) engaged in a significantly lower number of social behaviours \( M = 5.9 \) than those who continued \( M = 6.6 \), \( t = (24.8) = 1.9 p = .07 \). There were no significant differences between the two groups for number of years living in their preferred gender and whether or not they had begun hormone therapy.

Another notable feature is that more people began the LPGI and SLM than started the other surveys. The reason for this could have been that being the first and the last surveys, respondents could have attempted them out of curiosity to gauge what the surveys were about.

The next step in treating the data was to remove the respondents who had not completed one or more surveys. As a result of this, twelve respondents were removed. There was very little missing data. If a person attempted a survey they tended to answer all the questions of the survey. Any missing data was kept as missing and no imputation techniques were applied.

The final step was to look at the assumptions to determine whether any of the other data had to be omitted (see Testing of the Assumptions above). As a result of this three additional cases were omitted from the final analysis. The final sample sizes for
the univariate and bivariate analyses were 134 to 136 depending on the variables. The sample size differs for each analysis depending on the number of respondents who completed the questions on which each analysis was based. This approach maximised the information obtained from those that participated in the project. There were 120 respondents who had complete data across all surveys. These respondents formed the sample for testing the hypotheses in the models.

**Participant Characteristics**

The demographics of the sample were obtained from the survey General Information (Appendix E). Ninety two percent of the participants were from Australia and seven percent were from New Zealand. Every state and territory was represented and both the North and South islands of New Zealand. Sixty eight per cent were born in Australia, 13.2% in the United Kingdom, 11% in New Zealand and 7.4% were born in other countries. Aboriginal and Torres Strait Islander individuals comprised 2.2% (n= 3) of the sample and Maori and Pacific Islander participants comprised 3% (n= 4) of the sample.

Males comprised 30.9% of the sample and females 69.1%. The age range was from 18 to 75 and the mean age was 40.12 years (SD = 12.99). The mean age at which they commenced living in their preferred gender was 32.30 (SD = 13.16).

Forty three per cent had a university qualification, 28.7% had TAFE or equivalent, 10.3% had year 12 (school matriculation), 8.8% had year 10 and 8.8% had less than year 10. English was the first language spoken by most of the sample (96.4%).

The most frequent employment type (37.4%) was full time work, with 10.7% in part time work, 10.7% in casual employment, 20.6% being unemployed and 20.6% being in the “other” category for current employment type.
Measures

There were a number of instruments used. Some instruments measured aspects of the dependent variable, mental health outcomes, while others measured aspects of the independent variables and the proposed mediator variable. The independent variables in this study were the birth gender, the sexual orientation prior to the transsexual living in their preferred gender, and age of onset and social supports. Age of onset for the purposes of this study was defined as the age at which the person commenced living in their preferred gender. The instruments and their properties are outlined below.

The Depression, Anxiety and Stress Scale (DASS, Appendix F). The DASS was used to measure mental health outcomes. The DASS is a test developed in Australia which measures symptoms of depression, anxiety and stress (Lovibond & Lovibond, 1995). The DASS 21 which is the shorter version was used as it has the same psychometric properties as the longer version (DASS 42) in terms of its reliability and validity. Each of the three subscales has seven items. The items for depression assess dysphoria, hopelessness, devaluation of life, lack of interest/involvement, anhedonia and inertia. The anxiety items assess autonomic arousal, skeletal muscle effects, situational anxiety and subjective experience of anxious affect. The stress items assess difficulty relaxing, nervous arousal, and being easily upset/agitated. Participants rate their responses on a four point severity scale and the scores for each scale are obtained by summing the scores from each item.

The DASS has good temporal reliability: the two week test-retest correlations range from .71 to .91. The internal consistency of each of the subscales is high with Cronbach’s alpha for the DASS depression between 0.96-0.97, for DASS anxiety 0.84 - .0.92 and DASS Stress 0.90- 0.95. Other studies such as one conducted in Australia using the DASS -21 on a normative sample of adolescents reported internal consistency
with the measure with high Cronbach alpha of 0.93, lending further support to the excellent reliability of the DASS-21 (Tully, Zajac, & Venning, 2009). The validity as measured in comparisons with the Beck Depression Inventory (BDI) and the Beck Anxiety Inventory (BAI) indicated acceptable convergent and discriminant validity of the two scales: DASS-D and BDI, .74; DASS-D and BAI, .54; DASS-A and BDI, .58; and DASS-A and BAI .81 (Lovibond & Lovibond, 1995).

The Kessler Psychological Distress Scale (K10, Appendix G). This was also used to measure the concept mental health outcomes. It is an instrument that measures mental health in terms of symptoms that are indicative of mood and/or anxiety disorders. It is a widely used instrument in Australia, being used in the 2007 National Mental Health Survey (Furukawa, Kessler, Slade, & Andrews, 2003). It has been shown to have strong concurrent and predictive validity in comparative studies when measured against the GHQ, the SF12 and DSM IV diagnoses (Andrews & Slade, 2001). The K10 was developed in the USA and validated by a two stage clinical reappraisal survey (telephone screening N= 1000 and face-to-face clinical interviews N=153). The items were selected from 612 questions that were selected from 18 existing scales including the Beck Depression Inventory (Fassaert et al., 2009; Kessler et al., 2002). The K10 was found to provide precise measurement of anxiety and depression in the 90th-99th percentile range of the population distribution. The standard errors of standardized scores were 0-20- 0-25 as well as consistent psychometric properties across major sociodemographic subsamples. The scale was found to have good psychometric properties and a strong ability to discriminate between DSM IV diagnoses with areas under the Receiver Operating Characteristic (ROC) curve of 0.87-0.88 for disorders having Global Assessment of Functioning (GAF) scores of 0-70 and 0.95-0.96 for disorders having GAF scores of 0-50 (Kessler, et al., 2002). The K10 has good
sensitivity and specificity in relation to establishing a true positive and a true negative DSM IV diagnosis, i.e., it has good predictive validity. The K10 had a high Cronbach alpha of 0.93, well above the accepted 0.70. There was also a high inter-correlation (0.43 – 0.74) of the items (Fassaert, et al., 2009; Kessler, et al., 2002).

The K10 also showed good inter-ethnic non-western validity and reliability in a comparative study with Dutch, Turkish and Moroccan samples (Fassaert, et al., 2009). In the comparative study, item bias in relation to ethnicity was found to be minimal, making the K10 a useful scale to use with the Australian culturally and linguistically diverse community.

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS). This was the third instrument that was used to measure the concept mental health outcomes. It was used as a positive measure of well-being. It is a 14 item scale which covers the majority of the range of concepts associated with positive mental health, including both hedonic and eudemonic aspects, positive affect, satisfying interpersonal relationships and positive functioning (Tennant et al., 2007).

The WEMWBS was validated on a student and representative population sample. It showed good content validity with high response rates in both samples. Confirmatory factor analysis supported a single factor hypothesis, suggesting that the WEMMS measures a single underlying concept. A Cronbach alpha score of 0.89 from the student sample and 0.90 from the general population sample was found. Test-retest reliability at one week was 0.83 (p<0.01) indicating a high reliability (Tennant, et al., 2007).

The Short Form Social Support Questionnaire (SSQ6). The SSQ6 is a self-report, 6-item scale which gives two scores: number of supports (N) and satisfaction
with support (S). In addition, a third score, number of unique supports, was constructed for this study from the data provided by the respondents. The questionnaire takes about 5 minutes to complete (Sarason, Sarason, Shearin, & Pierce, 1987). The SSQ6 is derived from the SSQ 27 which has satisfactory psychometric properties with high Cronbach alphas for both the subscales (alpha = 0.97 for SSQ 27N and 0.94 for SSQ 27S, Sarason, Levine, Basham, & Sarason, 1983). Reliability testing for the SSQ 27 reported high test-retest reliability. The test retest reliability after a 4 week interval for the SSQ 27 N was .90 and for the SSQ 27 S was .83. A factor analysis for the two scales found a single factor explaining 82% of the variance for the SSQN and 72% for the SSQS.

There is a modest correlation between the two subscales SSQ6-N and SSQ6-S (r=0.37 to 0.58). It is suggested that the two scales be treated separately. The validity of the scales has not been specifically tested on the short version of the scale. As such, the validity has to be viewed within the broader context of the original SSQ 27. There have been a number of criterion and construct validity tests performed. For example there were positive correlations between SSQN scores and the numbers of positive life events that were experienced, locus of control, internality and self-esteem. SSQ S scores were negatively related to reported number of negative life events and positively related to self-esteem and several other social support scales e.g. Perceived Social Support (Friends and Family) and the Interpersonal Support Evaluation List. In the studies that have compared the SSQ to other social support measures the SSQ has displayed superior sensitivity to other scales (Sarason, et al., 1987).

The Self Lines Measure (SL, Appendix H). The Self Lines Measure was developed from the Selves Questionnaire as a measure of Identity Discrepancy Theory (Francis, et al., 2006). It is an idiographic ratio scale instrument which generates
discrepancy scores based on the transsexual’s perceptions of their actual and ideal and actual ought physical characteristics. In the SL participants are asked to list up to five physical characteristics to describe how they would ideally like to be in their preferred gender. They are then asked to compare by placing a mark on a seven centimeter line what they actually are like now with what they would ideally like to be. This process is repeated for how participants perceive significant others would rate them. The second step involves comparing what the participant thinks the physical characteristics they ought to have for their preferred gender are compared to what they are like right now. This again is repeated for significant others. Discrepancy is measured by the difference in centimeters between the actual and ideal/ought. For this study an aggregate score was calculated. It was composed of up to eight individual scores depending on the number of significant others given. It comprised several different components: the difference between the ideal and actual self, the ought and actual self, the significant others actual versus ideal and actual versus ought were summed. A mean score for each individual was then computed because some people may have given only one significant other while others may have given two or three significant others. In order to determine if it was appropriate to aggregate the four scales, the scales were correlated against each other. All six of the resulting correlations were significant at the p. = 01 level. In addition all the correlations were positive and strong and ranged between .50 and .78 (Cohen, 1988 as cited in Aron and Aron).

Inter-rater reliability has been shown to be .99. Although a test retest reliability is not available for the SL, the Selves Questionnaire test retest reliability scores range from .39 to .65. Construct validity has been demonstrated in a series of studies (Francis, et al., 2006).
The Living in your Preferred Gender Inventory (LPGI, Appendix B). This was used to identify the characteristics of what constituted living in your preferred gender for this sample as it was the main eligibility criteria for the study. It was a measure that was developed for this study and the development of it was discussed in Study 1. The test retest reliability of the LPG was completed after all data gathering was completed (see Study 1, chapter 4).

Procedure

Data were collected from each state and territory and from New Zealand through formal meetings with transsexuals. There were three methods of data collection. Two, involved face-to-face meetings, in groups and individually. First, participants were given an opportunity to meet in a place of their choice. Some met in a café and others asked me to come to their homes. Second, some transsexuals organised groups and I met them in a venue organised by the group. In group situations after they had completed the survey I presented current research findings on transsexualism. Third, a web site which allowed participants to complete the surveys online was developed. This made the process easier, especially for transsexuals in isolated communities.

Face-to-face data collection. When seeing people face-to-face in groups the researcher provided information to participants about the nature of the study, consent procedures and confidentiality (Appendix I). Participants were given a package which contained a cover sheet, an information sheet/consent form, all the scales and a pencil and eraser for self-completion of the scales. Each participant was given a number to put on the top right hand side of each survey which would be the only identifying mechanism for the interviewer to ensure all their surveys stayed together. All the surveys had written instructions and examples and participants were invited to ask
further questions about the instructions if they were unsure what was required of them by any survey.

Where possible, the researcher gave the participants the information and consent form for the research several days prior to administering the tests so that participants could have sufficient time to read about the research and read the consent form. By doing this participants were better able to give informed consent, and the time of administering the surveys was reduced. The consent and information was sent via email, fax or mail. Group assessments took between 30 minutes and an hour to administer.

When participants were seen individually, they were given the package containing all the forms and a pencil and eraser. The participants who had received the information and consent forms prior to the day were asked if they had read and understood them, if they had any questions and if they consented to participate. If they had not received the information and consent form they were asked to read that first and they were then asked if they had understood what they had read and if they had any questions and if they gave their consent. Participants were then asked to commence completing the surveys and to let the researcher know if at any time they were unsure of what was required or if they had any concerns and or questions. Participants were also requested to complete a form if they were willing to take part in the interviews for Study 3.

All of the instruments were self-administered and, where possible, they were administered in the presence of the researcher to facilitate clarification and thereby improve completeness of data. The instruments were administered in accordance with the ethics submission, which had gained full approval. All collected data was stored in locked files in a secure location.
At the end of completing the surveys participants were asked how they felt and if they had any problems with completing the surveys. They were reminded that the interviewer and independent university ethics contacts were available should they need to talk about any matter that may have caused them any concern. All the surveys were checked to ensure that all surveys were attempted and if any questions were not answered, participants were asked if they had missed the question or whether they did not wish to answer the question. The participants were thanked for their participation and if they said they had other transsexual friends they were given a contact list and a business card so that their friends could participate in the research if they wished to.

**Web based online data collection.** The website available at www.gendereyedentity.net (see also Appendix C) was developed with all the information of the face-to-face version in a user friendly version. The surveys for the web site were adapted from the paper survey for delivery through a commercial provider named Qualtrics. The company was based in the United States of America and provided support, and secure storage and downloading of data to SPSS directly.

The web site format presented many challenges that needed to be addressed. One challenge was the possibility of participants taking the survey more than once. To minimise this each participant could only participate from a single Internet Protocol (IP) address only once, limiting duplicating by the same person doing the survey multiple times from the same IP address.

The web survey was pilot tested by several non-transsexuals to ensure that it worked well and was easy to understand. Once the web site was established it was promoted through a media release in LGBT publications in Australia and New Zealand.
The web site’s home page gave information about the research and included the eligibility criteria. If a participant was ineligible they were directed to an exit page which thanked them for their interest and requested that they inform eligible transsexuals about the research. The second page of the web site About Us contained biographical information on the research team and the members of the consultative committee. The third page was the consent form which prospective participants had to read and click on agree before they went to the survey page.

The Survey page firstly informed participants that if they required a break that they would need to have a break now as once they started the surveys they would have to complete all of them in the one time. The surveys were presented in the same order as they were administered in the face-to-face version. Participants had to complete them in that order and could not skip a survey and go to the next. If a participant did not answer a question on a survey they were prompted to do so or given the choice to leave it unanswered.

The instructions on the web site were the same as those on the face-to-face version for all the surveys. The only addition was that on each survey the participant was asked to enter a username and keep the same user name for all the surveys. On each online survey, the researcher’s mobile number appeared with the instructions informing participants to contact the researcher if they had any problems and the researcher would call them back (so they did not have to pay for the call) and the researcher would guide them through any difficulties. One potential participant contacted the researcher about a technical difficulty.

Once participants finished all the surveys they were given the option of entering a draw to be eligible to win one of the six prizes. They were also given the opportunity
to submit their contact details if they wished to participate in the in-depth interviews of Study 3 at some later stage.

Results

The first section of the results reports on the testing of assumptions. The subsequent sections report descriptive and selected inferential findings for the living in the preferred gender inventory and the model variables. The final section presents the results for the original models and two trimmed models.

Testing the Assumptions

The variables were tested for linearity, normality of error distribution, homoscedasticity, outliers, influential scores, independence of the errors and multicollinearity. Box plots, histograms, normal quartile plots (Q-Q plots), residual plots, the Kolmogorov test, Mahalanobis’s and Cook’s distances and leverage scores were among the procedures used in the analyses. Several violations of assumptions were found and the following actions were taken.

Firstly, each of the three variables which measured social support: mean number of supports, total number of unique supports and mean satisfaction with supports had problems which violated assumptions. Mean satisfaction with supports was negatively skewed and had a restricted range which influenced results (refer Figure 4). Total number of unique supports also had a restricted range and the plots for both this variable and mean number of supports showed multicollinearity \( r = .76 \) and heteroskedasticity. Therefore, the variable mean number of supports was chosen for the model and coded into seven categories and treated as an interval variable.

Secondly, the variable number of years living in your preferred gender (LPG) was found to have a skewed distribution. Several transformations were performed, but
the skewness remained. Therefore, the variable was transformed into an ordinal variable with 3 levels; two values were dummy coded (11 – 20, 21- 50 years) with 0-10 being the reference code.

Thirdly, three cases were removed from the analyses due to unusual and influential values across several variables. One of these cases had extreme high scores on age commenced LPG and on mean discrepancy, actual/ought discrepancy and actual ideal discrepancy. The second case removed had high scores on mean discrepancy, mean supports, and extremely low scores on the DASS. The third case also had extremely low DASS scores, high WEMWBS scores, total supports and number of years LPG. Thus, there was no consistent pattern to these discrepant cases, but they were sufficiently different to the rest of the sample to have undue influence in multivariate analyses and therefore they were excluded from these analyses.

Lastly, the variables self-discrepancy and age commenced LPG each had one remaining extremely high and influential score. As there was no evidence that the scores came from participants from a different population, deleting the cases did not seem appropriate. Therefore each score was winsorised to the next highest observation.

**Univariate and Bivariate Results**

The inferential tests conducted were two tailed unless otherwise specified with the significance level set at p ≤ .10. Since research that explores mental health of all transsexuals irrespective of whether they have had SRS or not is a new area of study, setting a more lenient significance level was considered appropriate. Unless otherwise stated, male and female refer to the participants’ current gender which by definition is the preferred gender.
**Living in your Preferred Gender Inventory (LPGI).** The purpose of the LPGI was to identify some of the behaviours which transsexuals undertook in their preferred gender prior to commencing to live full time in their preferred gender. It also measured the frequency with which they engaged in these behaviours on a four point scale from *never* to *always* (See Study 1).

The mean number of social behaviours that participants engaged in prior to living in their preferred gender was 5.74 ($SD = 2.15$). Scores ranged from 0-9. The mean number of behaviours engaged in were similar for males ($M = 3.79, SD = 1.65$) and females ($M = 3.88, SD = 1.18$). An independent samples t test for gender ($n = 135$) was not significant $t (133) = .24, p = .81$.

Acquiring a gender appropriate name prior to living in the preferred gender was the most frequently engaged in activity (86%). Of those who did acquire a gender appropriate name, 70% had done so legally. Engaging in social activities in the preferred gender which included such things as going shopping, going to the movies and going to night clubs was the second most frequently engaged in activity (40%), and engaging in sexual activities in their preferred gender was the third most frequent behaviour (39%). These were followed by living with friends in their preferred gender (38%), and living in their preferred gender with family (36%). The least frequently engaged in behaviours were being employed and going to work in their preferred gender (29%) and studying in their preferred gender (16%).

In addition to being asked whether they engaged in a particular behaviour they were also asked how often they engaged in the behaviour. Using their gender appropriate name frequently or always was reported by 84% of the sample with 68% using their name always. Seventy nine percent of those who engaged in social activities
in their preferred gender did so frequently or always and 78% engaged in sexual activities in the preferred gender frequently or always. In contrast the least often engaged in behaviours were studying in preferred gender where 60% reported “never” and employment (45%). Although 40% reported that they never engaged in their preferred gender with family only 14% reported never engaging with friends in their preferred gender.

Respondents were also asked whether they had undergone SRS prior to living in their preferred gender. Ninety eight (73%) had reported that they had not; 9% had undergone SRS since they had begun living in their preferred gender. Of those who had not yet undergone SRS 76% said they planned to do so and 21 people (24%) had no plans to undergo SRS.

A higher percentage (78%) had begun hormone therapy prior to commencing living in their preferred gender, a further 8% had done so since and only 3 participants (2.2%) never planned on having hormone therapy.

An independent samples t-test compared the mean number of social behaviours with those who had had SRS prior to LPG and those who had not undergone SRS. Those who had SRS had a higher mean number of behaviours ($M = 6.26, SD = 2.41$) than those who did not undergo SRS ($M = 5.48, SD = 1.97$). The results were significant, $t (133) = 1.91 (n = 135), p = .06, d = 0.93$.

A further independent samples t test was conducted to explore the mean number of behaviours by gender. The mean for males was $5.62, (SD = 2.14)$ and for females the mean was $5.78 (SD = 2.17)$. There was no significant difference between males and females $t (133) = -.41 (n = 135), p = .68$. 
Social Support Questionnaire (SSQ6). Social supports were measured by the SSQ6. The mean number of unique supports reported was 5.55 ($SD = 3.36$); the mean number of all supports reported by the respondents for the 6 areas of the questionnaire was 3.30 ($SD = 2.27$) and the mean satisfaction with supports was 4.91 ($SD = 1.20$). The median of the skewed satisfaction distribution was 5.3 ($IQR = 1.3$) (Figure 4).

![Mean satisfaction with social supports](image)

**Figure 4 Mean satisfaction with social supports**

An independent t test compared those who had had SRS ($M = 3.04$, $SD = 2.19$, $n = 46$) with those who had not had SRS ($M = 3.79$, $SD = 2.37$, $n = 89$) in the mean number of supports. There was a significant difference. Specifically those who had had
SRS had a significantly greater mean number of supports, \( t(132) = -1.78, p = .08, d = -0.33 \).

Using an independent t test the study also compared the total number of unique supports for those who had SRS (\( M = 6.12, SD = 3.25, n = 42 \)) and those who had not had SRS (\( M = 5.28, SD = 3.39, n = 88 \)), \( p = .19 \). There was no significant difference between the total number of unique supports between those who had SRS and those who had not had SRS.

**Age and years living in preferred gender.** For this study the number of years the person had lived in their preferred gender was measured in two ways. One was the age at which the participants had commenced living in their preferred gender which showed a mean of (\( M = 31.67, SD = 12.51 \)). This was then subtracted from their current age. The other measure was a direct question about the number of years that participants had lived in their preferred gender (\( M = 8.63, SD = 13.10 \)). In the model the direct question about the number of years LPG was used as an independent variable.

An independent samples t test was computed to compare the years lived in preferred gender between those who had SRS and those who did not have SRS. The result showed no significant differences between the two groups, \( t(134) = .42, p = .68 \).

**Sexual orientation.** The sexual orientation of the sample prior to living in their preferred gender is summarised in Table 3. A chi square analysis was performed to determine whether there was an association between birth gender and sexual orientation. A Chi square test is valid if less than 20% of the cells have an expected value of less than five or if the minimum frequency is one or more (Bryman & Cramer, 2004; Delucchi, 1983). There was a significant association between birth gender and sexual orientation. Attraction to both men and women (34.1%) was the most common
response. Heterosexual attraction was reported by 31.9% of participants, and approximately 28% of the sample was attracted to the same sex. Those born female were considerably more likely to be attracted to their own sex than those born male (40.5% and 26.1% respectively). Those born women were also more likely to report being bisexual than men (40.5% and 31.2% respectively). In contrast those born male were more likely to be attracted to the opposite sex (females) than were those born female.

Table 3
Sexual Orientation Prior to Commencing Living in Preferred Gender

<table>
<thead>
<tr>
<th>Sexual attraction prior to LPG</th>
<th>Birth gender</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Same sex</td>
<td>17</td>
<td>21</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td></td>
<td>40.5%</td>
<td>26.13%</td>
<td>28.1%</td>
<td></td>
</tr>
<tr>
<td>Opposite sex</td>
<td>6</td>
<td>37</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13.4%</td>
<td>39.8%</td>
<td>31.9%</td>
<td></td>
</tr>
<tr>
<td>Men &amp; Women</td>
<td>17</td>
<td>29</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td></td>
<td>40.5%</td>
<td>31.2%</td>
<td>34.1%</td>
<td></td>
</tr>
<tr>
<td>Neither Men nor Women</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.8%</td>
<td>6.5%</td>
<td>5.9%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
<td>93</td>
<td>135</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

*Note. \( X^2 (3, N = 135) = 10.51, p = .01. \)*

**Self-discrepancy.** The Self Lines test measured the hypothesised mediator variable gender congruence (refer Method section). Higher scores indicate a higher self-
discrepancy. The Actual vs. Ideal mean discrepancy was 3.59 ($SD = 1.55$). The Actual v’s Ought mean discrepancy was 3.52, $SD = 1.78$. The total mean discrepancy was 3.54, ($SD = 1.47, n = 126$). The total mean discrepancy “self-discrepancy” was the variable used as the measure of gender congruence in the models.

A Pearson product-moment correlation coefficient was computed to assess the relationship between the Actual Ideal (AI) and Actual Ought (AO) discrepancies reported by participants. There was a strong positive correlation between the two variables ($r = .61, n = 130, p < .00$).

In order to determine whether there was a difference in self-discrepancy between those who had undergone SRS ($M = 3.06, SD = 1.57$) and those who had not ($M = 3.78, SD = 1.36$), an independent samples t test was conducted. There was a significant effect showing less discrepancy among those who had SRS, $t (124) = 2.61, (n=126), p = .01. d = -.05$.

**Mental health measures.** There were three scales that measure mental health: the DASS ($n = 135$), the K10 ($n = 136$), and the WEMWBS ($n = 136$). The DASS showed a mean of 32.90 ($SD = 24.80$). The K10 mean was 21.69 ($SD = 7.52$). The WEMWBS showed a mean of 48.39 ($SD = 10.88$).

A one way MANOVA was conducted to compare those who had undergone SRS and those who had not using the mental health variables. The Box M test was not significant showing that the assumption on equality of co-variances was met. The effect of SRS on mental health was not significant, Wilks’ $\lambda = .99, F (3, 116) = .36, (n = 120) p = .78$. 
The Models

In the first instance a path analysis using three multiple regressions was conducted to test three models (Models 1-3). The variables were entered simultaneously. The independent and mediating variables and the paths for the three models were identical. The models differed only in the outcome measure used to assess mental health. A generalised model showing the paths is presented in Figure 5. In order to enhance legibility, the inter-correlations between the exogenous variables are given in Table 4 rather than on Figure 5.

Figure 5 Generalised model.
As Figure 5 shows, the independent variables were age commenced LPG; number of supports; the dummy variables 11-20 years LPG, 21-50 years LPG, homosexual prior to LPG, bi-sexual/asexual prior to LPG (sexual orientation); and being male post LPG. The hypothesised mediator was self-discrepancy. The outcome variables which measured mental health were the WEMWBS (Model 1), the DASS (Model 2) and the K10 (Model 3).

Table 4
Correlations among Exogenous (Independent) Variables: Models 1-4

<table>
<thead>
<tr>
<th>Exogenous Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 11-20 years LPG</td>
<td></td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. 21-50 years LPG</td>
<td>-.13</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Homosexual prior LPG</td>
<td>-.18</td>
<td>.43**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Bisexual or asexual prior LPG</td>
<td>.07</td>
<td>-.18*</td>
<td>-.53**</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Number of supports</td>
<td>-.20*</td>
<td>.05</td>
<td>.05</td>
<td>-.10</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>6. Age commenced LPG</td>
<td>.02</td>
<td>-.32**</td>
<td>-.30**</td>
<td>-.02</td>
<td>-.15</td>
<td>-</td>
</tr>
<tr>
<td>7. Being male</td>
<td>-.03</td>
<td>-.13</td>
<td>.14</td>
<td>.11</td>
<td>-.18**</td>
<td>-.25***</td>
</tr>
</tbody>
</table>

*p < .10  **p < .05, ***p < .01

Model 1: WEMWBS

The Hypotheses for model 1 were as follows:

1. The following variables would directly and positively affect mental well-being, that is, the variables would be positively correlated with the WEMWBS:

   a) being homosexual prior to LPG

   b) having a greater number of supports

   c) being bi-sexual or asexual prior to LPG
d) having LPG for a longer number of years

2. The following variables would also directly affect mental well-being but the variables would be **negatively** correlated with the WEMWBS

   e) being younger when commencing LPG

   f) having a lower self-discrepancy

The correlations among the variables are shown in Table 5. There were two significant but low correlations (Aron, Aron, & Coups, 2006). Both were in the anticipated direction.

Table 5  
Correlations among Independent and Dependent Variables: Models 1-3

<table>
<thead>
<tr>
<th>Variables</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 DASS</td>
<td>120</td>
<td>31.7</td>
<td>23.23</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2 WEMWBS</td>
<td>120</td>
<td>49.04</td>
<td>10.53</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3 K10</td>
<td>120</td>
<td>21.69</td>
<td>7.66</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4 Self discrepancy</td>
<td>120</td>
<td>3.56</td>
<td>1.42</td>
<td>.18**</td>
<td>-</td>
<td>.18**</td>
<td>.05</td>
</tr>
<tr>
<td>5 11-20 years LPG</td>
<td>120</td>
<td>.12</td>
<td>.32</td>
<td>-.07</td>
<td>.05</td>
<td>.14</td>
<td>.02</td>
</tr>
<tr>
<td>6 21-50 years LPG</td>
<td>120</td>
<td>.11</td>
<td>.31</td>
<td>-.09</td>
<td>.06</td>
<td>-.01</td>
<td>-.16</td>
</tr>
<tr>
<td>7 Homosexual prior to LPG</td>
<td>120</td>
<td>.29</td>
<td>.46</td>
<td>-.02</td>
<td>.14</td>
<td>-.06</td>
<td>-.02</td>
</tr>
<tr>
<td>8 Bisexual or asexual prior to LPG</td>
<td>120</td>
<td>.41</td>
<td>.49</td>
<td>.19*</td>
<td>-.13</td>
<td>.15</td>
<td>-.01</td>
</tr>
<tr>
<td>9 Number of supports</td>
<td>120</td>
<td>3.95</td>
<td>1.96</td>
<td>-</td>
<td>.31**</td>
<td>.26**</td>
<td>-.07</td>
</tr>
<tr>
<td>10 Age commenced LPG</td>
<td>120</td>
<td>31.87</td>
<td>12.49</td>
<td>-.10</td>
<td>.10</td>
<td>-.17</td>
<td>.14</td>
</tr>
<tr>
<td>11 Being male</td>
<td>120</td>
<td>.32</td>
<td>.47</td>
<td>.02</td>
<td>-.09</td>
<td>-.01</td>
<td>-.04</td>
</tr>
</tbody>
</table>

*p < .10 **p < .05, ***p < .01
The multiple regression resulted in a significant result $F(7, 112) = 3.21, p = .00$. The model showed that 16.7% of the variance was accounted for by the predictor variables ($R^2 = .17$). Taking into account shrinkage, adjusted $R^2 = .12$. Significant standardised betas (refer Table 6 and Figure 6) were found for number of supports, $\beta = .29, p = .00$, Self-discrepancy, $\beta = -.185, p = .04$ and being homosexual prior to LPG, $\beta = .20, p = .10$. Age commenced LPG was also significant but contrary to the hypothesis was correlated positively with mental well-being, $\beta = .23, p = .02$ with older participants showing greater well-being.
Figure 6  Standardised betas for paths in models 1-4

*p<.10, **p<.05, ***p<.01
Table 6
Summary of Regression Analysis Models 1 to 4

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>Semi partial r</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model 1: WEMWBS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age commenced LPG</td>
<td>.19**</td>
<td>.08</td>
<td>.23**</td>
<td>.22</td>
</tr>
<tr>
<td>11 – 20 years: LPG</td>
<td>4.62</td>
<td>2.93</td>
<td>.14</td>
<td>.15</td>
</tr>
<tr>
<td>21- 50 years LPG</td>
<td>.45</td>
<td>3.34</td>
<td>.01</td>
<td>.01</td>
</tr>
<tr>
<td>Homosexual prior to LPG</td>
<td>4.55*</td>
<td>2.70</td>
<td>.20*</td>
<td>.16</td>
</tr>
<tr>
<td>Bisexual or asexual prior LPG</td>
<td>-.44</td>
<td>2.23</td>
<td>-.02</td>
<td>-.03</td>
</tr>
<tr>
<td>Number of supports</td>
<td>1.55**</td>
<td>.48</td>
<td>.29**</td>
<td>.29</td>
</tr>
<tr>
<td>Self-discrepancy</td>
<td>-1.36**</td>
<td>.65</td>
<td>-.18**</td>
<td>-.19</td>
</tr>
<tr>
<td><strong>Model 2: DASS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age commenced LPG</td>
<td>-.25</td>
<td>.18</td>
<td>-.14</td>
<td>-.13</td>
</tr>
<tr>
<td>11 – 20 years LPG</td>
<td>-9.74</td>
<td>6.32</td>
<td>-.14</td>
<td>-.14</td>
</tr>
<tr>
<td>21- 50 years LPG</td>
<td>8.102</td>
<td>7.179</td>
<td>.109</td>
<td>.11</td>
</tr>
<tr>
<td>Homosexual prior to LPG</td>
<td>.34</td>
<td>5.80</td>
<td>.01</td>
<td>.01</td>
</tr>
<tr>
<td>Bisexual or asexual prior LPG</td>
<td>9.90**</td>
<td>4.80</td>
<td>.21**</td>
<td>.19</td>
</tr>
<tr>
<td>Number of supports</td>
<td>-4.01***</td>
<td>1.03</td>
<td>-.34***</td>
<td>-.35</td>
</tr>
</tbody>
</table>
### Model 3: K10

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>Semi partial r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-discrepancy</td>
<td>3.00**</td>
<td>1.41</td>
<td>.18**</td>
<td>.20</td>
</tr>
<tr>
<td><strong>Age commenced LPG</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 – 20 years LPG</td>
<td>-.12*</td>
<td>.06</td>
<td>-.20*</td>
<td>-.18</td>
</tr>
<tr>
<td>21- 50 years LPG</td>
<td>2.73</td>
<td>2.25</td>
<td>.12</td>
<td>.11</td>
</tr>
<tr>
<td><strong>Homosexual orientation prior LPG</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-.39</td>
<td>2.07</td>
<td>-.02</td>
<td>-.02</td>
</tr>
<tr>
<td><strong>Bisexual or asexual prior LPG</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.81</td>
<td>1.71</td>
<td>.12</td>
<td>.10</td>
</tr>
<tr>
<td><strong>Number of supports</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-.27</td>
<td>.37</td>
<td>-.07</td>
<td>-.07</td>
</tr>
<tr>
<td><strong>Self-discrepancy</strong></td>
<td>.35</td>
<td>.50</td>
<td>.07</td>
<td>.07</td>
</tr>
</tbody>
</table>

### Model 4: Mediation

| **Age commenced LPG**                 | .01  | .01  | .09   | .08            |
| 11 – 20 years LPG                     | .02  | .05  | .00   | .00            |
| 21- 50 years LPG                      | -.63 | .46  | -.14  | -.13           |
| **Being male post LPG**               | -.10 | .29  | -.03  | -.03           |

*p < .10, **p< .05, ***p< .01

Number of supports and age commenced LPG had the largest standardised betas and zero-order and semi-partial correlations. This suggests that these two variables
were the most important, and that the greater the number of supports a person had the
greater their well-being and as stated above the older participants were when they began
LPG the higher their well-being. The results support hypotheses 1a and 1b and 2f
above. The other hypotheses were not supported.

Model 2: DASS

The Hypotheses for Model 2 were as follows:

3. The following variables would directly and positively affect mental health, that is, the variables would be **negatively** correlated with the DASS
   a) being homosexual prior to LPG
   b) being bi-sexual or asexual prior to LPG
   c) having LPG for a longer number of years
   d) having a greater number of supports

4. The following would directly and positively affect mental health, that is the variables would be **positively** correlated with the DASS
   d) being younger when commencing LPG
   e) having a lower self-discrepancy

Again the correlations were generally low with only number of supports
reaching the moderate level (Table 5). Self-discrepancy was again significant. The
direction of both these correlations supported the hypotheses, However, being asexual or bi-sexual was positively associated with the DASS.

The model was significant $F(7, 112) = 4.19 \, p = .00$. The independent variables
accounted for 21% of the variance in mental health ($R^2 = .21$). Adjusting for shrinkage,
the $R^2$ was .16. There were three significant predictors, two of which were in the
expected direction. As hypothesised a significant negative standardised beta (refer Table 6) was found between person’s number of social supports and the DASS, $\beta = - .34$, $t (7, 112) = -3.88$, $p = .01$. As expected gender congruence measured by self-discrepancy was positively and significantly related to the DASS, $\beta = .18$, $t (7, 112) = 2.13$, $p = .04$. Being bi-sexual or asexual prior to LPG, $\beta = .21$, $t (7, 112) = 2.06$, $p = .04$, was significant but not in the direction hypothesised. In summary, people who had a greater number of total social supports and lower self-discrepancy and were not bi-sexual or asexual prior to LPG but were heterosexual prior to LPG experienced less depression and anxiety as measured by the DASS.

As with the WEMWBS the most important variable (using size of the beta and correlations) was the number of supports. Also, self-discrepancy was found to be a significant predictor for both the DASS and the WEMWBS. Sexual orientation emerged as a significant variable for both measures but the effect of the variable differed. Homosexuality prior to LPG had a positive effect on mental health, but being bi-sexual or asexual prior to LPG had a negative effect. In summary, hypotheses 3d and 4e were the only hypotheses confirmed for the DASS.

Model 3: K10

The hypotheses for Model 3 were as follows:

5. The following variables would directly and positively affect mental health, that is, the variables would be **negatively** correlated with the K10

   a) being homosexual prior to LPG

   b) being bi-sexual or asexual prior to LPG

   c) having LPG for a longer number of years

   d) having a greater number of supports
6. The following would directly and positively affect mental health, that is, the variables would be **positively** correlated with the K10

   e) being younger when commencing LPG

   f) having a lower self-discrepancy

Table 4 shows that all the coefficients were low and that there were no significant correlation coefficients. The K10 model was not significant $F(7, 112) = 1.32, p = .25$. The predictor variables accounted for 7.6% of the variance in well-being ($R^2 = .08$) and adjusted $R^2 = .02$. Although the seven independent variables as a group were not significant predictors, age commenced LPG was significant on its own, $\beta = -.20, t(7, 112) = -1.97, p = .05$. However the result was not in the direction hypothesised and none of the hypotheses above was confirmed.

**Model 4: Self-discrepancy as a Mediating Variable**

As stated above, two of the three models were significant. In these models self-discrepancy was hypothesised to be a mediating variable between four independent variables: being born male, years LPG (11-20 and 21-50), age commenced LPG and the three mental health measures (Figure 7). In order to determine whether there was mediation, additional procedures were undertaken to test the hypotheses that:

7a. Effects of gender, whether a person is FM or MF, would be partially mediated by self-discrepancy, and those that are male after LPG would have lower mean self-discrepancies than those who are female.
b. The age at which a person commenced living in their preferred gender would be partially mediated by self-discrepancy, and people who commenced living in their preferred gender younger would have lower self-discrepancies than people who commenced living in their preferred gender when they were older.

c. The length of time that people had lived in their preferred gender would be partially mediated by self-discrepancy. People who had lived in their preferred gender longer would have lower self-discrepancy than people who had lived in their preferred gender for a shorter time.

None of the hypothesised independent variables were significantly correlated with self-discrepancy (Table 5). The first step undertaken to determine whether or not mediation was present was to regress self-discrepancy against the four independent variables. The result was not significant, $F (4, 115) = 1.06, p = .38$. The independent variables accounted for 3.5% of the variance in self-discrepancy ($R^2 = .04$). When adjusted for shrinkage the amount of variance estimated for the population was equal to
approximately .2% (adjusted $R^2 = .00$). There were no significant betas (Figure 6, Table 5). This suggests that self-discrepancy was not a mediator.

Table 7
*Descriptive Statistics and Correlation: Self-discrepancy as a Mediator*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self-discrepancy</td>
<td>120</td>
<td>3.56</td>
<td>1.42</td>
<td>-</td>
</tr>
<tr>
<td>2 11-20 years LPG</td>
<td>120</td>
<td>.12</td>
<td>.32</td>
<td>.02</td>
</tr>
<tr>
<td>3. 21-50 years LPG</td>
<td>120</td>
<td>.11</td>
<td>.31</td>
<td>-.16*</td>
</tr>
<tr>
<td>4. Being male</td>
<td>120</td>
<td>.33</td>
<td>.47</td>
<td>-.04</td>
</tr>
<tr>
<td>5. Age Commenced LPG</td>
<td>120</td>
<td>31.87</td>
<td>12.49</td>
<td>.14</td>
</tr>
</tbody>
</table>

*$p<.10$ ***$p<.01$***

However, according to Kenny and Baron (as cited in Kenny, 2011) three additional steps are required to test mediation: 1. each independent variable must be correlated with the outcome variable; 2. each independent variable must be correlated with the mediator; 3. the mediator (self-discrepancy) should be correlated with the outcomes when controlling for each independent variable.

These steps were tested by conducting a series of simple regression analyses. The conditions of step 1 were fulfilled for age commenced LPG and the K10, $F (1, 118) = 3.40; p = .07$. None of the other independent variables were significantly correlated with the outcome variables. The conditions of step 2 were met for 21-50 years LPG which was significantly correlated with self-discrepancy, $F (1,118) =2.16; p = .08$. The Step 3 conditions which required mean discrepancy to be correlated with the measures of mental health when the independent variable was held constant were met by several
variables: self-discrepancy was significantly correlated to the DASS and WEMWBS and the K10 and self-discrepancy were correlated when age commenced LPG was held constant. None of the hypothesized independent variables met all three conditions.

Lastly, in order to provide further evidence on mediation or the absence of it, eight Sobel procedures were conducted to test the null hypotheses that there was no mediation between WEMBS and the DASS and each of the independent variables (age commenced LPG, 21-50 years LPG and 10-20 years LPG and being male). Although some writers have stated that the use of the Sobel test is problematic, it was thought to be useful as another source of evidence (Baron & Kenny, 1986). None of the eight tests was significant ($p>.12$)

In summary, gender congruence did not meet the requirements for mediation for any of the independent variables. Hypotheses 7a-c were not confirmed.

Baron & Kenny (1986) suggests that one reason a variable might fail the mediation tests is that the outcome variable might be the mediator and the hypothesized mediator the outcome variable. As it was not unreasonable to think that a person’s mental health might affect the way they think about their physical selves, two additional models were tested with DASS and WEMWBS as the mediators. The results for the DASS showed that the model was not significant, $F(4,115) = .70, p = .60$. The result of the WEMWBS model was significant, $F(4, 115) = 3.76, p = .01$, and number of supports and age commenced LPG were significant predictors. The three steps described above were carried out for this latter model; however the three conditions for mediation were not met and there was no evidence that either the DASS or the WEMWBS was a mediator in the model.
Trimmed Models

In order to try to find a model which more adequately represents the data, three \textit{a posteriori} trimmed models were constructed from the full models by selecting all the significant paths (refer Figure 8). In the trimmed models, self-discrepancy was no longer a mediator variable but rather it was an independent variable with a direct path to the DASS and the WEMWBS. Two other independent variables—asexual or bisexual prior to LPG and number of supports—were also included in the DASS model.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{trimmed_models.png}
\caption{A posteriori trimmed model based on significant paths for Models 1-3.}
\end{figure}
The application of self-discrepancy theory

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DASS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bi or asexual prior LPG</td>
<td>8.52**</td>
<td>4.03</td>
<td>.18**</td>
</tr>
<tr>
<td>Number of Supports</td>
<td>-3.42***</td>
<td>1.02</td>
<td>-.29***</td>
</tr>
<tr>
<td>Self discrepancy</td>
<td>.15*</td>
<td>1.74</td>
<td>.15*</td>
</tr>
<tr>
<td><strong>WEMWBS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age commenced LPG</td>
<td>.19**</td>
<td>4.14</td>
<td>.22**</td>
</tr>
<tr>
<td>Homosexual prior to LPG</td>
<td>4.33**</td>
<td>2.08</td>
<td>.19**</td>
</tr>
<tr>
<td>Number of supports</td>
<td>1.39***</td>
<td>.47</td>
<td>.26***</td>
</tr>
<tr>
<td>Self-discrepancy</td>
<td>-1.36**</td>
<td>.47</td>
<td>-.18**</td>
</tr>
</tbody>
</table>

*p < .10  **p<.05  ***p<.01

The DASS model was significant, $F (3, 116) = 5.08, p < .00$. The independent variables accounted for 14.9% of the variance ($R^2 = .15$). The adjusted $R^2$ was 12.9%. The three independent variables’ standardized betas were significant: number of supports ($p = .00$), bisexual or asexual prior to LPG ($p = .04$), self-discrepancy ($p = .09$) (refer to Table 8). Again bisexual or asexual prior to LPG was not in the direction hypothesized and being bisexual or asexual predicted higher DASS scores. Overall this model did not account for as much variance as the full model. Part of the reason may be because of the smaller number of predictors.

The WEMWBS model contained 4 independent variables: self-discrepancy, homosexual prior to LPG, age commenced LPG, total number of supports This model
was also significant, $F (4, 115) = 4.99, p = .00$. All four standardized betas were significant (refer Table 8). Again age commenced LPG was positively related to WEMWBS which was contrary to the hypothesis. Total number of supports appeared to be the most important of these variables with a standardized Beta of .26. The total variance accounted for by the model was approximately 15\% ($R^2 = .15$) and adjusted $R^2 = .12$). Again the amount of variance explained by this model is less than the full model.

The K10 model contained only one independent variable-age commenced LPG. The result was significant ($p=.07$) but age commenced LPG was negatively related to K10 which was contrary to the hypothesis. The model explained 2\% of the variance.

**Adequacy of the Models**

One of the disadvantages of multiple regression analysis rather than Structural Equation Modelling is the lack of an overall goodness of fit statistic. However, one can measure fit by decomposing the effects of individual variables, that is by summing the standardised betas for all the valid hypothesised direct and indirect paths for each pair of variables. The sum of this procedure produces the implied correlations. Ideally, the correlations implied by the causal model will be close to the actual correlation between the variables.

Table 9 shows the implied correlations and the differences (residuals) between the implied and the actual correlations for the original models. Although these models did not adequately reflect the data because of the mediation problems, the results are interesting relative to the trimmed models. The mean absolute residuals for the three original models were DASS .020, K10 .018; and WEMWBS .073.

Although there is no procedure that directly tests the fit between the implied and actual correlations, several authors have suggested that there should be no absolute
residual above .05 if the model is an adequate reflection of the original correlations (Kenny and Baron, 1986 as cited in Kenny, 2011; Billings and Wroten, 1978 as cited in Baroudi, Olsen and Ives, 1986). The mean residual is below .05 for both the K10 and the DASS, but the K10 is the only one for which all of the individual residuals are below the recommended discrepancy. Using the .05 discrepancy guideline, K10 is the best fitted model although the model was not significant and explained only a small amount of the variance and hypothesised a mediator that was not confirmed. This illustrates that many models can be fitted to a set of data and by itself, fit is not an adequate measure of the goodness of a model.

Table 9
Implied Correlations and Absolute Values of Residuals for the Original Models

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Age began LPG</td>
<td>--</td>
<td>.09</td>
<td>-.11</td>
<td>-.19</td>
<td>.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Male</td>
<td>--</td>
<td>.03</td>
<td>-.01</td>
<td>.00</td>
<td>.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. 11-20 yrs LPG</td>
<td>--</td>
<td>.00</td>
<td>-.14</td>
<td>.12</td>
<td>-.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. 21-50 yrs LPG</td>
<td>--</td>
<td>-.14</td>
<td>.08</td>
<td>.03</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. Bi or asexual/ prior LPG</td>
<td>--</td>
<td>-.21</td>
<td>.12</td>
<td>-.20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Homosexual prior to LPG</td>
<td>--</td>
<td>.01</td>
<td>-.02</td>
<td>.20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Total number of supports</td>
<td>--</td>
<td>.19</td>
<td>-.07</td>
<td>.29</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Self-discrepancy</td>
<td>.05</td>
<td>.00</td>
<td>.02</td>
<td>.02</td>
<td>- .19</td>
<td>.07</td>
<td>-.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. DASS</td>
<td>.01</td>
<td>.01</td>
<td>.07</td>
<td>.01</td>
<td>.02</td>
<td>.01</td>
<td>.03</td>
<td>.00</td>
<td>--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. K10</td>
<td>.02</td>
<td>.01</td>
<td>.00</td>
<td>.00</td>
<td>.04</td>
<td>.05</td>
<td>.00</td>
<td>.02</td>
<td>--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. WEMWBS</td>
<td>.11</td>
<td>.08</td>
<td>.19</td>
<td>.04</td>
<td>.07</td>
<td>.06</td>
<td>.03</td>
<td>.00</td>
<td>--</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Implied correlations are above the diagonal and values of residuals below the diagonal. Empty cells represent correlations between independent variables.
The same analysis was performed for the trimmed models (Table 10). As the K10 has only one predictor, beta is identical to the correlation between the independent and dependent variable and the residual is .00. The mean residual for the DASS is .02 and for WEMWBS .05. Again the DASS appears to be a more appropriate fit than the WEMWBS and fits the requirement that no residual be above .05.

_Table 10_  
_Implied Correlations and Absolute Values of Residuals for the Trimmed Models_

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Age began LPG</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>.17</td>
<td>.10</td>
<td></td>
</tr>
<tr>
<td>2. Bi or asexual/ prior LPG</td>
<td>--</td>
<td>--</td>
<td>.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Homosexual prior to LPG</td>
<td>--</td>
<td>-</td>
<td>.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Total number of supports</td>
<td>--</td>
<td>--</td>
<td>.26</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Self-discrepancy</td>
<td>--</td>
<td>.15</td>
<td>-</td>
<td>.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. DASS</td>
<td>.01</td>
<td>.02</td>
<td>.03</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. K10</td>
<td>.00</td>
<td>.02</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. WEMWBS</td>
<td>.12</td>
<td>.05</td>
<td>.00</td>
<td>.02</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Implied correlations are above the diagonal and values of residuals below the diagonal. Empty cells represent correlations between variables connected by a curved arrow or variables not in the model.

**Summary**

This study tested 7 models – 4 hypothesised models, and 3 a posteriori trimmed models. The hypothesised models were rejected as tests showed there was no evidence
of mediation. In addition the K10 model was insignificant. There also was no evidence that the DASS or WEMWBS were important or significant mediators. When the trimmed models were tested, one of the residuals for the WEMWBS trimmed model was above what is usually considered adequate. Based on standard statistical tests and guidelines, none of the models except the DASS trimmed model adequately fitted the data.

**Discussion**

**Overview of Research**

There has been considerable and comprehensive research in the area of transsexualism. Much of the research as discussed in chapter 1 focuses on the treatment of transsexualism through Sex reassignment Surgery (SRS Brownstein, 2009; Cohen-Kettenis, et al., 2008; Goldberg, 2006; Rachlin, 1999). The aim of treatment is to ameliorate the depression and anxiety often associated with the disorder (Edwards-Leeper & Spack, 2012; Megeri & Khoosal, 2007). Certain predictors such as age, sexual orientation, gender and social supports all discussed in Chapter 1 have frequently been found to be predictors of satisfaction with SRS and therefore good mental health. Evidence suggests that people are highly satisfied with SRS (Bowman & Goldberg, 2006; Cohen-Kettenis & Gooren, 1999; Lawrence, 2003; Michel, et al., 2002).

However, some evidence that indicates that mental health did not improve after SRS (Megeri & Khoosal, 2007; Newfield, et al., 2006). Further evidence indicates that there are other factors at play in treatment such as “passing” (Carroll, et al., 2002; Couch, et al., 2007; Edwards-Leeper & Spack, 2012; Nuttbrook, et al., 2002; Rakic, Starcevic, Maric, & Kelin, 1996; Ross & Need, 1989) and identity validation (Nuttbrook, et al., 2002) that are not addressed through SRS.
From a theoretical and conceptual framework, little is understood about why the frequently found predictors are significant and what characteristics are important in achieving gender congruence. Using Higgins’ theory of self-discrepancy (Higgins, 1987), this study attempted to build a conceptual framework and construct a model that might explain the relationship between previous predictors, self-discrepancies and their impact on mental health. A better theoretical understanding of the characteristics of gender congruence and identity formation would be useful for developing a broad range of treatment protocols.

Newfield et al. (2006) made the observation that research into transsexuals often restricts participation to those who seek treatment through medical interventions and thereby excludes those who identify as transsexuals but who do not seek medical treatment. This was another aspect that was addressed by the current research by including all transsexuals who self-identified as transsexuals who were currently living in their preferred gender irrespective of whether they sought SRS or not.

**The Three Models**

The predictor variables accounted for a noteworthy percentage of the mental health variables (WEMWBS 16.7%, DASS 21%) Although not large in an absolute sense it is still an important finding. Most particularly, the results show that that some of the variables that are used to predict satisfaction with SRS are also useful when attempting to predict mental health. One reason why the models were relatively weak may have been due to the fact that the variables that were used in these models were ones that only related or were specific to the transsexual population. There are other multiple and interacting psycho-social and biological factors that are predictors of mental health which the model did not test (World Health Organisation, 2000). The
Australian National Mental Health Survey showed that genetic factors, personality, age, unemployment, an unsupportive and demanding work environment, and lack of control in work are all variables that show significant relationships to mental health (Australian Bureau of Statistics, 2007). For the transsexual population job satisfaction and being gainfully employed may be an important factor in their mental health. Studies have found that due to transphobia many transsexuals are often not protected by the law, are often disadvantaged by employment prospects, face discrimination within the workplace and have to work in occupations that do not meet their skills or career aspirations (Couch, et al., 2007; Egan, 2007; Richard Green, 2010; Preston, 2010; Schlatterer, Yassouridis, von Werder, Poland, & et al., 1998; Schwin, 2009). Also being able to live day-to-day lives and function satisfactorily in society, as noted in Couch et al. (2007), may be salient issues that would have improved the fit of the model testing mental health outcomes. In this sample, as noted, the level of education was quite high but many participants were either on a pension or on an unemployment or sickness benefit. The reasons for this are not fully understood but studies have shown a causal relationship between the social gradient (employment, socio economic status and job satisfaction) and health. For example The Whitehall studies into social inequalities reported that the social gradient in health involves a number of factors including the ability for people to feel that they can participate in their health outcomes. This was reported as beneficial and causally related to health (Artacoz, Banach, Borrell, & Cortes, 2005; Blas et al., 2008; Culley, 2010; Marmott et al., 1997; Marmott & Wilkinson, 2006). There is good reason to accept that these variables would also be relevant to the transsexual population.

The K10 was associated with a weak model ($R^2 = .08$). The model was insignificant but it did have one significant predictor which was age commenced LPG.
The reasons for the K10 being a weak model may be due to the use of it as a means of indicating psychological distress rather than differentiating between depression and anxiety, even though the distress it reports on is based on anxiety and depression symptoms. Therefore it may be testing something like general distress which is more diffuse than the DASS which very specifically gives scores for depression and anxiety.

Three of the seven independent variables in the models were not significant predictors for the three mental health measures: gender; 11-20 LPG and 21-50 LPG, nor were there significant correlations either directly with mental health or indirectly through self-discrepancy.

The reasons why the three did not have significant associations with mental health may be related to a number of factors. Even though research shows high satisfaction with SRS, SRS may not be directly correlated with mental health. While SRS provides satisfaction in reassigning the birth sex genitalia, other factors that are important to passing that were not addressed through SRS may be salient; therefore, the assumption that SRS ameliorates mental health may be an incorrect assumption.

Hormone therapy, for example, may be just as important in achieving “passing” in the street on a daily basis as SRS. Previous research has shown that FM do better and are more satisfied with SRS (Smith, et al., 2005) and this may be due to testosterone having a better effect or altering the physique of FM more than does oestrogen in MF (see also Delemarre-van de Waal & Cohen-Kettenis, 2006). Couch et al. (2007) found that participants in their survey reported feeling a sense of well-being at the bodily changes that occurred after hormone therapy and the satisfaction at having their body correspond to how they always felt (Couch, et al., 2007). Furthermore, the fact that these variables are related to satisfaction with SRS may be unique to the SRS treatment process and
have no bearing on mental health. Also, mental health may be influenced by factors unrelated to being transsexual.

There were two variables that were related to two of the mental health measures: number of supports and age commenced LPG. Number of supports was a significant predictor for the DASS and the WEMWBS. Age commenced was a significant predictor for the WEMWBS and the K10. The findings for the number of supports confirmed what had been found in the literature (Gagne, et al., 1997; Nuttbrook, et al., 2002; Ross & Need, 1989). In contrast the results for age commenced LPG was contrary to the hypotheses and the findings of previous research (Cohen-Kettenis & Gooren, 1999). However, it was similar to a finding made by another Australian study conducted by Collyer and Heal (2002).

Most previous research on age has found that the younger a person is when they commence treatment via the triadic treatment model, the more likely they are to experience higher satisfaction with SRS and therefore have better mental health (Cohen-Kettenis & Gooren, 1999). The inference from this was that the number of years a person lives in their preferred gender may also result in increased mental health well-being. This was not the case in this study. Therefore, it may be that early transition is important because it halts the development of the secondary sexual characteristics of the birth gender which may improve mental health. If this is the case then it is not surprising that age commenced is a significant predictor and number of years living in their preferred gender is not significant.
Self-discrepancy as a Mediator

One of the major findings was that self-discrepancy was not a mediator between any of the hypothesised independent variables and the mental health measures. A number of factors may account for why self-discrepancy was not a mediator.

Firstly, the self-lines measure may not have been a reliable measure for this study. While it has been used before and its reliability has been tested, the length of the questionnaire and the detailed instructions needed may have led to confusion for the participants. Secondly, it may not have been a good measure of gender congruence. It may be that choosing the physical characteristics as a measure of gender congruence was not a valid way to examine self-discrepancies, even though passing was considered important in other studies (Couch, et al., 2007; Nutbrook, et al., 2002; Ross & Need, 1989). Perhaps there are other variables or factors that are more relevant to the concept of self-discrepancy for transsexuals.

Identity theory based on how transsexuals view themselves and how transsexuals perceive others view them may not provide an adequate conceptualisation of self-discrepancy. The constructs of self-discrepancy and identity validation may be external to the transsexual. For example the issue may be social rather than psychological, a social injustice issue rather than individual pathology where the problem is causally related to the transsexual socially actualising the preferred gender (Lev, 2005; Winters, 2005). Perhaps social distance theory and social categorisation theory which change the frame of reference for identity validation from the transsexual’s perspective to a general social perspective may be a more appropriate measure of the concept of “passing”. Here it is not the transsexual’s self-discrepancy of being appraised by others that is important. It is not the transsexual’s view that is the
reference point for validating appraisals but rather it is the view of others within society who appraise the transsexual based on what the person believes is acceptable in terms of appearance. Therefore, while the transsexual may feel gender congruent, the actualising of their preferred gender within social contexts may be distressing and contribute to pathology and this may be more appropriately measured through social distance and social categorisation (Evans & Giles, 1986; Georges-Aebyie, 2006; Gerhardstein & Anderson, 2010).

**Model Fit**

Despite the significance of two of the models neither the DASS nor the WEMWBS was found to fit the data when standard analyses were undertaken. The WEMWBS in particular was a poor fit. The implied correlations suggest that there was a problem with model specification in both cases but particularly with the WEMWBS. Perhaps the model developed for the WEMWBS which is a measure of positive well-being, may be different for that which was created for the DASS and the K10. Depression, anxiety and well-being are not bipolar (diametrically) opposed. For example people who commenced living in their preferred gender when they were older were shown to have lower DASS scores indicating better mental health but this does not necessarily mean they would have better well-being. The model for the WEMWBS may require some other variables and these variables may need to be different for each mental health measure.

In conclusion none of the original models fit the criteria required for a satisfactory model. Self-discrepancy was not a mediator for any of the three models and the K10 was an insignificant model. The WEMWBS was not well fitted to the data and the DASS model came closest to being an acceptable model. It explained an important
part of the variance however one of the variables showed an implied correlation
different to what is acceptable.

The Trimmed Model

*Two a posteriori* trimmed models- one for the DASS, the other for WEMWBS-were
constructed from the full model by selecting all the significant paths (refer Figure 7). In
contrast to the original models the independent variables were different for each of the
two models. All three of the independent variables in the DASS model were significant;
two, self-discrepancy and number of supports, were in the direction hypothesised and
the number of supports is consistent with previous research (Gagne, et al., 1997;
Nuttbrook, et al., 2002; Ross & Need, 1989). Bi or asexual prior to LPG was in the
opposite direction to what was predicted; Bi or asexual participants had higher DASS
scores when compared to heterosexuals. This agrees with the Australian study, Private
Lives 2, which found poorer mental health for bisexuals than for homosexuals (Leonard
et al., 2012). Why this might be the case is not clear. However, it may be that being
bisexual or asexual creates its own difficulties prior to living in their preferred gender.
Having to negotiate two genders in sexual orientation may be very difficult for the
transsexual. The most important of the three variables judging by the betas and
correlations was number of supports. Surprisingly, perhaps, self-discrepancy was the
least important (Refer Table 6). Again this provides evidence that other variables related
to identity need to be explored. In summary, this model explained a significant
proportion of the variance, the implied correlation residuals were all under .05 and the
findings are broadly consistent with other research.

The four independent variables in the WEMWBS were significant and three
were in the hypothesised direction. One, age commenced LPG, was positively related to
WEMWBS and thus did not confirm the hypotheses. This was consistent with the findings for the K10 where the variable was negatively related to the K10. However, one of the residuals of the implied correlations was above .05. Based on the guidelines used for this study this model must be rejected and the DASS trimmed model remains as the only model that met all the guidelines.

There were three variables that showed significance across several of the models; age commenced LPG, sexual orientation and self-discrepancy. These therefore are worthy of further investigation especially since age commenced LPG and sexual orientation were not consistent with the empirical generalisations.

**Mental Health**

The current study found that the transsexuals did not, as a whole, experience an affective disorder such as major depression. The participants’ mean DASS and WEMWBS were in the normal range (Lovibond and Lovibond, 1985). Only 15% scored above the moderate range on the DASS.

The absence of a high rate of mental health diagnoses in the sample in this study may be accounted for by a number of factors. Firstly, the sample was restricted to those who identified as transsexual whereas the Couch et al., (2007) study included all people who identified as transgender so the samples of the two studies were different in how they identified and at what stage they were in their identity. Secondly, the sampling method, which used a web based structure and snowballing and included advertising with transgender groups and agencies, may have attracted people who were more engaged with the community and were proactive in seeking services and supports. Being engaged within a supportive environment has been shown to be a protective factor in mental health in other studies, in the Australian general population and also in
the present study (Australian Bureau of Statistics, 2007). Also the surveys required time and persistence in reading instructions which may have been more acceptable to those who had a higher level of education which was found to be the case with this sample. Another factor is that the DASS is susceptible to manipulation where participants could feign being well. However, from feedback from participants they appeared very motivated to participate in the research and did not seem to have anything to gain from misrepresenting themselves through feigning their responses. However, it is possible that participants may be biased in the direction of reporting better mental health after transition, both for their own self-image as well as to improve social acceptance of transition. Also it is unknown if participants were on prescribed medication for anxiety and depression which may have masked their symptoms at the time of completing the surveys. Another factor that may have masked depressive symptomatology is the treatment of transsexuals with hormone therapy which has been shown to lower stress, anxiety and depression and increase quality of life compared to those who do not take hormone therapy (Gomez-Gil et al., 2012; Gorin-Lazard et al., 2012).

**Self-discrepancy**

Mean scores on the Self-lines measure could range from 0 (no discrepancy) to 7. Transsexuals in this study had a mean of 3.54. This mean discrepancy score was similar to the samples studied by Francis et al. (2006). They found that the aged and several student samples had self-discrepancy scores in the range of 2-4. This similarity was unexpected, as transsexuals have reported feelings of gender incongruence and also have talked about the importance of “passing” (Carroll, et al., 2002; Couch, et al., 2007; Rakic, et al., 1996; Ross & Need, 1989). Rakic et al (1996) found that although transsexuals were satisfied with SRS they still expressed unhappiness with the physical characteristics SRS surgery could not change; beards, large feet and hands, voice timbre
and Adam’s apples are examples of these characteristics, all of which affect the transsexual’s ability to pass in society. Therefore, transsexuals in their preferred gender would have been expected to show fairly high self-discrepancies between the actual/ought and the ideal irrespective of SRS. The discrepancies found in this study show that transsexuals’ perceptions of their physical characteristics and their perceptions of how significant others assessed these physical characteristics reflect a relatively normal response.

Those who had undergone SRS had lower self-discrepancies than those who had not had SRS. The difference between the groups while significant was not large and the effect size was small. Changing their genitalia may have given transsexuals who had undergone SRS a greater sense of gender congruence and thus a lower self-discrepancy. The evidence, however, shows that transsexuals believe that they are not passing because of the physical characteristics they are unable to change through SRS (Carroll, et al., 2002; Couch, et al., 2007; Rakic, et al., 1996). This and the effectiveness of hormone therapy (see below) may explain why the difference between those who had SRS and those who had not was small and relatively unimportant.

Living in your Preferred Gender

Most of the sample had not undergone SRS and approximately one-quarter of the sample never intended to do so. This finding illustrates the imbalance in the research into transsexualism. The medical model with its focus on SRS and satisfaction with surgery does not reflect the life experiences of many transsexuals.

In contrast a large percentage of the transsexuals in this sample had undergone hormone therapy. This may be a reflection of the fact that hormone therapy is easier to
access, less costly and may allow them to pass sufficiently enough to relieve their sense of gender incongruence.

Participants who had SRS engaged in more behaviours prior to LPG than those who had not had SRS. These behaviours may have been a prelude to SRS and related to the RLE and the need to fulfil this obligation which requires transsexuals to engage in all of the social behaviours listed in the LPGI. This finding again provides evidence that the LPGI is a valid and useful tool as it was modelled on the Standards of Care of WPATH and the RLE (Myer, et al., 2001).

The high percentage adopting a gender appropriate name and always using it prior to living in their preferred gender suggests that this was something that was important. This is perhaps an indication of the significance of identity in the preferred gender and the importance of appropriate ways of reinforcing identity through names and appropriate pronouns (Couch, et al., 2007; Van Houten, 2011; Zamboni, 2006). The importance of names has been significant throughout all cultures and it is often marked by elaborate rituals such as the baptismal ceremony (Deluzain, 2012). Bestowing a name is a symbolic act which personifies and identifies an individual placing the person in a historical context within society. The name separates the person from others in society and when introduced into interactions the name informs others and validates to ourselves a sense of who we are and who we wish to be (Charon, 1995; Deluzain, 2012; Drury & McCarthy, 1980; Weigert, 1986). Therefore a name has implications for how people interact with others and how they feel about themselves. Dissatisfaction with one’s name has been associated with emotional disturbance and poor academic performance and attempts to change one’s name are marked by both loss and gain (Drury & McCarthy, 1980). Transsexuals could seek to change their name to reflect how they feel internally. Their birth name would be seen as invalidating how they feel
and reinforcing their sense of distress when they interact with others. Therefore, the transsexual changes their name to reflect a change in their social status and communicate their new identity. The transsexual may feel that it divorces them from their birth gender and presents them in their preferred gender and creates another person. It therefore would be an important and significant ritual and one the transsexual would seek to have performed.

Transsexuals more often lived in their preferred gender in social settings with friends and when engaging in sexual activities and less often when working in their preferred gender and being in their preferred gender with family. This is not surprising as transsexuals in the interviews discussed the support they derived from social settings and friends (refer to qualitative study chapter 6) and the stress involved when confronting their issues with family and within a work setting. Family and work are often where transphobia is highest, resulting in ostracising and alienation (Couch, et al., 2007).

Social Supports

The fact that number of social supports was an important and significant variable in the models highlights the importance for transsexuals to have a supportive environment. At a time where many decisions have to be made and life changing events are taking place a good social support structure would be vital. The importance of social supports has been well established in previous studies conducted with transsexuals (Gagne, et al., 1997; Nuttbrook, et al., 2002; Yuksel, et al., 2000). Social supports have been found to be protective with regards to health and mental health with the National Mental Health Survey in Australia finding a higher prevalence of mental disorders in those who did not have close family supports (Slade et al., 2009).
Furthermore, Nuttbrook et al. (2002) reported that social supports from significant others, family and friends were most important to transsexuals. Overall people were very satisfied with their supports. The importance of social supports is discussed in more detail in the qualitative study (Chapter 6) where the transsexuals’ own discourses are presented.

**Sexual Orientation**

Bisexuality before LPG was the most common sexual orientation for this sample. A high prevalence of bisexuality has also been found in other research (Lawrence, 2005). Those born female were more likely to be bisexual or homosexual prior to living in their preferred gender. Other research has also found that females are overwhelmingly homosexual prior to living in their preferred gender. Research evidence on the homosexual FM subtype has found that as children they were conspicuously masculine, demonstrated masculine play, and had hobbies and career patterns which were close to that of non-transsexual men and dissimilar to non-transsexual women (Lawrence & Zucker, 2012; Lippa, 2001). Homosexual FM transsexuals have been described as being more like typical males exhibiting more sexual jealousy than emotional jealousy, having more sexual partners, were more sexually aroused by visual sexual stimuli and sought phalloplasty more often than the non-homosexual sub type. They were more masculine than lesbian women with regards to self-ascribed masculinity (Lawrence & Zucker, 2012; Lippa, 2001). Because those born female have been primarily homosexual, there has been relatively little attention paid to those females with a bisexual or heterosexual orientation. According to Dickery and Stephens (1995),
In fact, the sexual orientation of genetic female transsexuals has been so overwhelmingly homosexual….that the recognition of other sub types may well have been delayed or compromised. It is only recently that a sub group of genetic female transsexuals who are attracted to phenotypic males has begun to be recognised and described (p. 439).

As stated above a considerable number of participants who were born female reported a bisexual orientation. In addition, six of those born female reported that they were heterosexual providing further evidence that such a subtype exists.

As the results showed, males were predominantly heterosexual prior to LPG. Again this conforms with previous research. In the Lawrence (2005) study 11% of genetic males identified as homosexual prior to SRS, a further 17% identified as bisexual and 59% identified exclusively as heterosexual.

Why MFs identify primarily as heterosexual raises an interesting point with several possible reasons. An analysis by Lawrence (2010) which looked at studies conducted in 22 countries hypothesised that non-homosexual transsexualism would be higher in individualistic cultures such as Australia; the findings of this present study support Lawrence’s findings. Additionally, engaging in heterosexual behaviours prior to LPG may be a form of reparative therapy and a means by which the person can try to live a “normal” heterosexual life. It may also be a “smoke screen” and a means to go undetected. Conversely, it may also be a way that they can have access to female clothing from a female partner. For some birth males having access to female clothing could be a way to experiment. For birth females wearing male clothing is easier as it is more acceptable for women to wear clothes such as suits, trousers, and jeans without having negative consequences (Edwards-Leeper & Spack, 2012).
Sexual orientation, like social support, was an important and significant variable in the WEMWBS and DASS models, although not necessarily in the direction hypothesised. Being homosexual prior to LPG is associated in the literature as a predictor of satisfaction with SRS and therefore being protective of mental health (Lawrence & Zucker, 2012; Smith, et al., 2005). In this study, those who were homosexual prior to living in their preferred gender showed increased well-being, thus confirming the previous findings; however, those who were bisexual showed higher DASS scores than heterosexuals. Little research has been done on bisexuality in transsexual individuals and its effect on mental health. Future research would benefit from exploring bisexuality as a separate subtype.
Chapter 6

The Personal Stories of Transsexuals.

Grownups like numbers. When you tell them about a new friend, they never ask questions about what really matters. They never ask: “What does his voice sound like? What games does he like best? Does he collect butterflies?”. They ask: “how old is he? How many brothers does he have? How much does he weigh? How much money does his father make?” Only then do they think they know him (Saint-Exupery, 2000 p. 10).

This chapter reports on the method, results and discussion of Study 3 which was a qualitative study. As part of discussing the methods the methodological considerations are described to explain the influences that shaped this study. The methodological perspectives that were considered and ruled out are also discussed. The chapter describes the steps taken to maximise reliability and validity.

The results section is intended to stay true to listening to the voices of the transsexual participants and telling their story using their words and expressions. Apart from providing a structure of brief linking between what was said and the concepts being explored, the results section keeps other commentary from the researcher’s perspective to a minimum. The overall aim in analysing the results was to remain close to the transsexuals’ experiences and to allow the data to speak for themselves rather than to seek to attain generalisability (Wren, 2002). Key concepts that arose out of the results are explored such as the transsexual moment, passing, who was in the picture and being happy after.
Study 3

Methodological Choices

This section of the study is written in the first person. This approach adopts what Cresswell (2007) referred to as the rhetoric of qualitative discourse. The rhetoric of qualitative discourse is inductive; personal; less formal than quantitative, positivist approaches; and emerges from the data rather than being imposed by the researcher (Cresswell, 2007). This I felt was the best way to convey reflexivity and transparency. The subject-object, researcher-researched, third person formal usage in quantitative methodology would have been cumbersome and awkward in this context (Swanson-Kauffman, 1986). The format I used for presenting this section came from my readings and loosely followed some of the discussion presented by Denzin and Lincoln (2005).

Identifying the Need for a Qualitative Study

Study 3 involved qualitative analyses that aimed to complement and triangulate the quantitative analyses in further exploring the core concepts of the process of “transition” to living in the preferred gender and the mental health outcomes that transsexuals may experience. By including a qualitative inquiry, the research aimed to achieve corroboration through triangulation (Kinn & Curzio, 2005; Miles & Huberman, 1994; Seale, Gobo, Gubrium, & Silverman, 2004); to elaborate and expand on Study 2; and to explore new avenues of thinking (Miles & Huberman, 1994) in order to build a comprehensive understanding of the transsexual phenomenon of living in your preferred gender. At this time according to Couch et al. (2007) “… many aspects of the transgender experience have not been adequately described” (p. 12).

Living in your preferred gender as noted in previous studies is usually based on the medical model of transition. The information is primarily quantitative, e.g. age,
mental health, SRS status. Couch et al. (2007) provided some opportunity for participants to comment in writing on their experiences and therefore allow their voices to be heard. However, because of their written method they could not request participants to elaborate further about the experiences as could be achieved in an interview. In addition, the authors reported that some participants thought that the survey was too focused on the medical model rather than the framework of the transsexuals (Couch, et al., 2007). Finding out more what constitutes the process of living in their preferred gender may help with the development of theory that would explain the process. In order to achieve this, the variables that were examined in Study 2 such as social supports, sexual orientation and self-discrepancy were explored further through a semi structured interview format.

The main aim of Study 3 was to describe and understand the process of living in their preferred gender of transsexuals living in Australia and New Zealand, by using a phenomenological and grounded theory approach within a constructivist paradigm (Denzin & Lincoln, 2005). The core concept of “living in their preferred gender” has been defined and operationalised previously. Under this main aim there were several other aims:

1. To understand the process of living in your preferred gender.
2. To explore the importance of passing in their preferred gender.
3. To explore what transsexuals believed were good helpful supports and also what was unhelpful.
4. To explore whether transsexuals felt that they were happier after/since they commenced living in their preferred gender and to what they attributed this happiness.
5. To explore the roles that participants played in early and subsequent sexual experiences and how they perceived these experiences in terms of sexual orientation.

The study sought to find answers to the following questions:

1. What happens when a transsexual decides to commence living in their preferred gender?
   a. What precipitants lead to the person taking the step to living in their preferred gender?
   b. How did they feel about the decision?
   c. Are they happier now than before they commenced living in their preferred gender?
   d. What social supports did they have?
   e. What was helpful and what was not helpful?
   f. What role did they see themselves playing in their sexual relationships prior to living in their preferred gender and how has that now changed since they commenced living in their preferred gender?
   g. How do they see themselves as being accepted by others in their preferred gender?
   h. What if anything has changed for the better or worse since living in their preferred gender?
   i. If they have not had gender confirmation surgery what are the reasons for this?
Reflexive Analysis: Axiological and Epistemological Perspectives

Qualitative research design requires awareness of the need to achieve objectivity in data analysis within its subjective format. One way some have endeavoured to achieve objectivity is through the concept of bracketing where the researcher, to the extent possible, tries to eliminate pre-existing assumptions about the object, event or experience. (Cresswell, Hanson, Plano Clark, & Morales, 2007; Jootun & McGhee, 2009). Others claim that being reflexive and reporting researcher assumptions and how the researcher came to conduct the research, i.e., noting the researcher’s “axiology” (value system; Meyrick, 2006; Ponterotto & Grieger, 2007) and in whose interests the research was carried out is the most appropriate way of being truthful to the analysis, providing valuable insights and researcher transparency (Donalek, 2004; Hale, Treharne, & Kitas, 2007; Jootun & McGhee, 2009; Parker, 2004). In qualitative research the researcher is the instrument and, like in positivist research, reflexivity in qualitative research enables validation of the research and understanding of how the research itself could influence the data. The researcher’s axiology is therefore described below.

As the researcher, I became interested in conducting this study after a long and varied engagement with the transsexual community over 29 years. Initially, this was through professional interactions, through university study, and then through personal experiences with friends and colleagues who lived as transsexual. Some friends who were transsexual experienced discrimination in the work place and had to leave their chosen occupation and career. Other transsexual friends experienced domestic violence and transphobia due to being transsexual. I experienced the death of a transsexual friend through HIV/AIDS. Most often I witnessed the alienation of transsexuals from their family, friends and community. Through these experiences, I became aware that the
transsexual experience was quite complex and with my clinical training and experience as a clinical psychologist I believed that what transsexuals had to endure might impact on their mental health. I subsequently discussed this with a colleague who also was a clinical psychologist and who had the lived experience of being transsexual. We both agreed that there were mental health concerns that would be worthy of a PhD inquiry.

Therefore I brought to the research my own beliefs that transsexuals who were currently living in their preferred gender that I had met and observed continued to experience problems that impacted on their daily lives which could, I believed, result in poor mental health. This to me was concerning as you might expect that once a transsexual had commenced living in their preferred gender they would, after a period, feel ameliorated of their gender dysphoria, having achieved gender congruence. To me there appeared to be something other than “living in their preferred gender” that possibly contributed to their achievement of gender congruence and the subsequent amelioration of their gender dysphoria that was causing the perceived poor mental health outcomes. Based on what I observed, my hypothesis was that social perspectives on transsexuals, specifically how transsexuals perceived their gender congruence through their own lens and also through their perception of how they thought others may perceive them, may be a mediating factor in mental health outcomes. In Study 2 I utilised a conceptual framework based on self-discrepancy theory (Higgins, 1987) to explore the research question and aims. Therefore, this conceptual framework formed and influenced my own thinking on this issue.

Conducting research in a sensitive area with a marginalised and minority population meant that the researcher had to be sensitive to the needs and vulnerabilities of the transsexual population. Being a clinical psychologist assisted in my understanding what transsexuals had to go through and permitted me to anticipate
potential risks and minimise them. This according to Haverkamp (2005), illustrates good use of professional reflexivity. I was able to resolve any potential risks as they arose in the interviews.

To adequately capture the complex and dynamic changes that transsexuals often have to experience I believed an in depth qualitative inquiry was needed that would build on and compliment the quantitative analysis and provide a more robust inquiry. The quantitative analysis would show the extent of the problems and highlight possible relationships in numerical terms. A qualitative analysis would, I envisaged, show a deeper human impact based on the views and beliefs of the participants, in an emotionally powerful way. Through a qualitative inquiry which focuses on change and which traces the process of change, with a focus that accepts multiple realities and interpretations, I sought to gain a greater understanding of the transsexual experience of living in their preferred gender (Parker, 2004; Ponterotto & Grieger, 2007). I believed this process of inquiry would result in a great depth of description of experiences and deep analysis of data and “thick” interpretation (Ponterotto & Grieger, 2007). This, I hoped, would as its end point provide a possible explanation, a theory, of the process of living in their preferred gender (Cresswell, 2007).

I commenced by immersing myself in the literature and meeting with transsexual groups and organisations and individuals. I then organised a consultative committee of three transsexuals (discussed in methods of Study 2). At first, I was focussed on a quantitative analysis as this seemed what was the usual methodology utilised in the literature with respect to the transsexual population. Furthermore, a quantitative study gave a quantifiable result which appeared to meet scientific criteria of an established mandate of objectivity, verifiability, generalizability and repeatability.
(Parker, 2004; Swanson-Kaufman, 1986). However, as the research took shape it became apparent that several factors called for a qualitative analysis.

First, as noted in the chapter of previous research, most studies conducted into transsexualism were based on those individuals who sought treatment through the triadic treatment model of the real life experience, hormone therapy and reconstructive surgery. Very little was therefore known and understood of transsexuals who did not seek this treatment process and yet lived in their preferred gender i.e. the gender opposite to their birth sex. Since there was a paucity of knowledge in this particular area of transsexual research, there was little that could be drawn on to investigate the phenomenon quantitatively to explain why and how it occurs (Donalek & Soldwisch, 2004). Second, the transsexual experience spans the life of an individual. The quantitative analyses used in Study 2 investigated the potential for linear relationships among pre-specified variables (such as social supports, living in their preferred gender, and sexual orientation). While these quantitative analyses provided valuable information, they can also be viewed as giving a specific “snapshot” perspective, which is one perspective on reality, being imposed on the population (Alston & Bowles, 2003; Meyrick, 2006). Using qualitative analyses allows exploration of the possibility of multiple realities, freely generated from the transsexual population. Third, there was concern that the transsexual population in Australia and New Zealand may be difficult to access in gaining a large sample and therefore, a purely quantitative analysis may have had limited capacity to explain transsexual phenomena. In circumstances such as these, qualitative methodologies are useful in providing an understanding of what is happening (Hale, et al., 2007; Weingand, 1993). It was believed that qualitative investigation would allow me to seek answers as to how and why transsexuals experience living in their preferred gender and give me useful perspectives to assist
understanding of living in their preferred gender. Finally, this exploration, corroborated by the quantitative analyses of Study 2, gave a more robust, triangulated insight into transsexual experiences (Brannen, 2004).

As mentioned earlier, I brought to the study certain beliefs and biases which were based on my experiences with transsexuals. This was then further reinforced through my reading of the research literature which contained assumptions and expectations that people with low social supports would have poorer mental health and that people who believed that they did not “pass” well in their preferred gender would also show poor mental health. My biases and beliefs together with what was highlighted in the literature guided the aims of the study and the research questions.

**Which Methodological Approach would suit this Study**

In choosing which methodological approach would best suit as a lens for viewing and understanding transsexuals who were living in their preferred gender, the five methodological approaches based on parsimonious practices described by Creswell (2007) were examined in relation to the aims and the research questions. Narrative analysis was considered inappropriate as the study, while interested in the stories people were telling, was not solely focused on detailed accounts of a single life. Ethnography was considered inappropriate as the study was not seeking to describe and interpret the behaviours and beliefs of a culture-sharing group (Cresswell, 2007). The case study was considered inappropriate as the aim was not to study one or a few cases using multiple strategies such as observation, diaries, interviews etc. What resonated well with the research question and aims of this study in terms of the epistemological lens for developing, conducting and analysing the study was Phenomenology (Cresswell, 2007)
and in particular Interpretative Phenomenological Analysis (IPA, Hale, et al., 2007) and Grounded Theory (Cresswell, 2007).

**Phenomenological perspective: The exploration of phenomena and themes.**

Interpretative Phenomenological Analysis (IPA) has risen from the school of phenomenology. It is reported to have gained success in health care research, becoming popular as a conceptual methodology in the 1990’s (Aisbett, 2006; Hale, et al., 2007; Wojnar & Swanson, 2007). IPA is concerned with not only people’s experiences but also how they interpret and interact with the world and how they make sense of their experiences. The principles of IPA combine descriptions of people’s experiences with their personal interpretation of their experiences within the context of their life and with their surroundings. In the IPA perspective the meanings people give are of most importance rather than the frequency of a topic (Aisbett, 2006). Therefore IPA principles suggests that there is a link between what people think and what people say (Hale, et al., 2007). The IPA analysis allows the researcher to investigate the data and make interpretation within existing literature and theoretical perspectives. It also acknowledges that the researcher will bring his/her own biases to the investigation and will be confronted with discrepancies between the data and the researcher’s expectations and assumptions (Wojnar & Swanson, 2007).

Therefore in developing this study, IPA was used as a lens to view the phenomena within the context of the conceptual theoretical framework utilised in Study 2. IPA is conducive to conveying the fact that it was the transsexual’s experiences of living in their preferred gender that was being explored. This enabled the information and theoretical aspects of Study 2 to be utilised as a framework for developing some of the semi structured interview questions. Given that I wanted to develop an understanding of what characterised living in your preferred gender, a
phenomenological perspective offered an approach for also developing the research questions, aims and objectives and in this case it also permitted the individual’s beliefs and interpretations to be considered. Additionally, IPA allows for the researcher’s values and views to be honoured in the research process.

**Grounded theory: A means to analyse and describe the phenomena**

Grounded Theory (Strauss & Corbin, 1991) was used for data gathering and analysis. This involved “constant comparison” where data were coded and grouped into categories and categories were compared with subsequent data to achieve saturation. Use of Grounded Theory enabled what Creswell (1998) and (2007) has called a “zigzag” pattern of data collection and analysis which involved analysing and coding data and returning back to participants to seek clarification and further information where appropriate. Also, grounded theory is based on the notion that the views and experiences of people can be developed into a theory. Therefore the theory is based or “grounded” in the data and emerges from within (Cresswell, et al., 2007; Creswell, 1998; Krysik & Finn, 2010). It was felt that this could be useful with this population as little was understood in terms of conceptualising the problem.

In summary, the study utilised a inductive grounded theory approach as well as a phenomenological qualitative inquiry method using as its basis of inquiry a semi structured interview format (Dew, 2007). The grounded theory approach meant that there was no specific theoretical expectation. The phenomenological approach enabled transsexuals to tell their story from which phenomena and themes could be studied (Creswell, 1998; Strauss & Corbin, 1991). These two approaches together with Study 2 provided the framework for developing strategies to permit participants to respond in an introspective manner in which participants elucidate experiences along a cognitive
temporal continuum (both past and present). The two approaches offered a useful medium of understanding a lifespan perspective which is pertinent with the transsexual population. This meant that interview participants were able to revisit, review and decipher their retrospective experiences through open-ended discussion and insightful inquiry with me as the researcher/interviewer using probes that were relevant to the inquiry and that could further elucidate valuable information at a deeper level. Other studies (such as Swanson-Kauffman, 1986) have utilised combined methodological analysis for a similar objective.

It was believed that these approaches were the appropriate platform for the present study in regard to the procedures for participant recruitment, data collection and analysis, and for its relevance to the study aims and research questions. These procedures are addressed in detail accordingly.

**Method**

**Participants**

**Participant recruitment and sampling.** Since this study complemented and built on the inquiry of Study 2, recruitment was based on participants from Study 2. Study 2 therefore, was used as a sampling strategy for this study with sub samples of particular individuals selected on specified criteria (Brannen, 2004). During the process of conducting Study 2, participants were given the option of filling out a form which provided the researcher with their contact details, if they wished to participate in the interviews of Study 3. The same form was utilised for participants who participated in Study 2 online.

In choosing a sampling frame for including participants in Study 3, several factors were taken into consideration. It was noted early in the research process that
most participants who participated in Study 2 were willing to also participate in the interviews of Study 3. It was impractical to attempt to interview all participants who said they would participate in the study. Therefore the sampling method was purposive which is the basic sampling method of qualitative research (Carter & Little, 2007; Fossey. Ellie, Harvey. Carol, McDermott, & Larry., 2002). Within the purposive sampling framework, several strategies were employed. In keeping with some of the variables investigated in Study 2 and the conceptual framework of study 2, theoretical sampling was used to examine common themes (Fossey. Ellie, et al., 2002; Meyrick, 2006). This strategy also supported the epistemological approach of the study which used both a phenomenological and grounded theory approach. (Carter & Little, 2007). I also wanted to have sufficient variability in spread so participants were chosen to maximise variability where possible to ensure maximum possible differences and opposing viewpoints could be explored. Additionally, extreme case sampling or deviant case sampling (Krysik & Finn, 2010) was employed where possible to compare individuals with, for example, extreme opposites on mental health well-being. Quota sampling was used to ensure the sub groups of MF and FM were studied (Krysik & Finn, 2010). Snowballing was also employed as a sampling strategy where appropriate to meet the research objectives (Carter & Little, 2007; Fossey. Ellie, et al., 2002; Krysik & Finn, 2010).

**Socio-demographic Profile of the Participants.** Participants were transsexuals who stated they were currently living in their preferred gender. Participants were recruited voluntarily. Of the 13 people interviewed, 4 were male and 9 were female. As for Study 2, gender was defined as the current, preferred gender. The age range was between 19 to 76 with a mean of 47. Table 1 gives information on participants’ scores on the Warwick- Edinburgh Mental Well-being Scale (WEMWBS), The Depression,
Anxiety and Stress scale (DASS) and the Self-lines Measure (SL). The Kessler Scale (K10) scores were not given as the K10 was found not to fit any of the models in the quantitative study. Table 1 also gives information whether participants have had sex reassignment surgery (SRS) or not. All participants’ names are pseudonyms to protect their confidentiality.

Table 1
Characteristics of the participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>SRS</th>
<th>WEMWBS</th>
<th>DASS Depression</th>
<th>DASS Anxiety</th>
<th>SL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bella</td>
<td>Female</td>
<td>37</td>
<td>No</td>
<td>High</td>
<td>Normal</td>
<td>Normal</td>
<td>Low</td>
</tr>
<tr>
<td>Enrique</td>
<td>Male</td>
<td>48</td>
<td>No</td>
<td>Low</td>
<td>Normal</td>
<td>Normal</td>
<td>High</td>
</tr>
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Ethical Considerations

Study 3 gained ethical approval from the Griffith University Human Research Ethics Committee. The study also gained ethical approval from the AIDS Council of New South Wales (ACON) Research Ethics Review Committee and was endorsed by ACON. The AIDS Council of NSW is the largest organisation offering education, support and health services to the Lesbian, Gay, Bisexual and Transgender (LGBT) communities in Australia. Examples of the types of questions asked in the semi-structured interview format were submitted for approval prior to ethical clearance being granted (see Appendix J).
The standard ethical approvals were gained through the university’s ethical committee which covered informed consent, full and open information on the research, confidentiality and volunteer participation (Christians, 2005). Additionally, qualitative research requires other ethical considerations in light of the methodological perspectives and methods used which I had to consider and implement. Being so different in methodological stance from the positivist approach, qualitative research engages participants in discourse about actions, reactions, recollections and reflections of their life’s journey. The relationship of the researcher-participant is one that can leave both parties vulnerable to ethical conflicts. Talking about such personal and intimate concerns of an individual requires a relationship built on trust and respect and this within itself calls for constant ethical evaluation (Eide & Kahn, 2008; Haverkamp, 2005). Consequently, the principles of beneficence (doing good) and nonmaleficence (the avoidance of doing harm) are important cornerstones of qualitative research (Haverkamp, 2005). There are considerations to be made regarding the researcher and the research audience who may read and make use of the research. There are considerations regarding the relationship of the researcher and participants where there is an asymmetrical power differential. Participants are vulnerable during the research process and it is important that the information they give is treated by the researcher in a manner that would do no harm (Eide & Kahn, 2008; Haverkamp, 2005).

Therefore it was important to appreciate what ethical practice meant in the context of this research. The implementation of a sound ethical framework had to be reflected in the decisions I made, the actions I took and the relationships and commitments in which the research occurred (Haverkamp, 2005).

The grounded theory approach of data and analysis meant that the focus of the study may change as the initial data were analysed and further information was required
from participants. This meant that ongoing and careful attention was required as to whether planned inquiries for second and third interviews met ethical standards. Haverkamp (2005) discusses the importance of ethical considerations in qualitative research and guides the researcher to both the American Psychological Association’s *Ethical Principles of Psychologists* and the *Code of Conduct*. Similar documents are available in other countries, including the Australian Psychological Society’s Code of Ethics, which is the standard adopted by the Psychology Board of Australia for use by registered psychologists in Australia.

**Procedure**

**Data collection.** Data were collected from each state and territory and from New Zealand through formal meetings with transsexuals. There were two methods of data collection. The first involved face-to-face individual meetings (n = 11). The other involved telephone interviews (n = 2). Telephone based data collection was used to make the process easier for transsexuals who lived interstate and in isolated communities.

Once participants had stated that they were willing to participate in Study 3 they were contacted and a suitable time was made to interview them either in person when it was possible or by telephone when distance called for this. Participants were able to choose where they would like to be interviewed. This included their homes, a room at the university, a café, or my residence. I was also sensitive to the time of the interview and where it coincided with a meal such as lunch or morning tea I provided gestures of hospitality by sharing light refreshments. This strategy was considered important in developing rapport, establishing trust and communicating that the participant’s needs were being cared for.
Prior to conducting the interviews and initiating the process I provided the participants with a comprehensive consent form which provided them with an explanation of the study with particular emphasis on maintaining strict confidentiality and emphasising that participation was voluntary (Appendix 1). Participants were informed that they could withdraw from the interview at any stage without obligation. This was important so that participants felt comfortable that they were in control and they could participate with as much depth as they wished. This it was hoped would encourage them to speak openly and candidly in a manner that suited them. Participants were asked if they understood what they had read and if they were in agreement with it. They were then given a copy of the consent form to take with them.

Permission was sought to audio tape the interviews. I explained that I would not refer to the participant by his/her name during the interview to maintain anonymity for the audio tape. Furthermore I explained that I would be the one transcribing the interviews and that when I transcribed the interviews I would code the transcript with an identifying number. Once again it was deemed important to take these measures in explaining anonymity and confidentiality with this population due to their negative community experiences and previous experiences of transphobia.

**The Interview Process.** After a brief warm up discussion where the participant and I could get acquainted and relaxed (Aisbett, 2006) with any queries being answered I commenced with an introductory marker. I asked participants to go back to the time when they first could recall feeling different and maybe not feeling that they were the standard female/male? Later they were also asked at what time they commenced living in their preferred gender and to recall what was it about that particular time that made them take that step? I was exploring precipitating factors that led the person to decide as of “now” I am going to live my life as a man/woman. This was used as a starting point.
The interviews progressed in a generally conversational mode with few or no interruptions. Where appropriate, probes were used to elicit specific subject areas based on the framework guide previously mentioned. When participants described a particular event the interviewer using probes encouraged the participant to also discuss how this event affected them emotionally as well to gain an understanding of their mental health at the time and also coping strategies to mental health well-being. For example if participants stated that they were disowned and thrown out by family I inquired “Why were you thrown out of the family home?”; “How did this make you feel?” or “How did you deal with this?” The participant’s response would initiate a discussion where distress and coping strategies were engendered. If the situation was particularly distressing or traumatic the participant was asked if they would like to have a break and a pause would be held before the interview could continue when the participant indicated that they were ready to continue.

As noted the nature of qualitative research and the semi structured open ended interview format can leave the participants vulnerable. Participants may find themselves at times discussing topics associated with their life that they did not anticipate talking about and that may be distressing (Haverkamp, 2005). I was cognisant, respectful and receptive towards participants’ non-verbal nuances that might indicate if a particular inquiry or subject matter was associated with hesitancy, trepidation or feeling distress. In such circumstances, I either checked that the participant was feeling comfortable with continuing, emphasised that he/she did not have to talk about the matter if it was upsetting or I tangentially shifted the topic by asking a few innocuous and indirect questions, before attempting to return to the original issue with an oblique, and slower approach. This allowed the participant to overcome any momentary reluctance and unease, as well as for me to emphasise that the interview and questions were not
intended to be intimidating in any manner. This process in some way made the notion of informed consent more active and dynamic, rather than viewing consent as a static event. This according to Haverkamp (2005) is more in keeping with sound and ethical qualitative research practice.

On occasion, I drew parallels from participant stories that resonated with my own experiences of being a member of the lesbian, gay, bisexual and transgender (LGBT) community by way of making comment or reference to them in the context of the interview. This contiguity or what Rapley (2004) terms “intimate reciprocity” was utilised to provide a sense of familiarity with certain subject matters such as transphobia/homophobia, while remaining objective, impartial and non-judgemental (Eide & Kahn, 2008).

I remained attuned to the course and content of the interviews and proposed concluding the session when the participant’s responses appeared to reflect redundancy. In such situations, it was felt that prolonging the interview would not yield further information. The participant was always asked if they had anything more they wished to discuss, before I thanked them for their co-operation and valuable time.

The interviews were concluded by gradually disengaging from discussions about serious issues and talking about relatively trivial topics. This was ensured in order to allow participants to reconnect with the present and re-establish their sense of temporal reality. Participants were also offered the opportunity to ask me any relevant questions relating to the interview and the study. Unlike other studies (Eide & Kahn, 2008) which have found that people engaged in the interview process more once the tape recording had stopped, this was not found to be the case in this study. In fact, participants wanted
to make sure that the tape recorder was working properly and were quite happy when I
conducted a recording check.

In total, the interviews varied from approximately 50 minutes to 80 minutes in
duration and they were audio taped. Interviews were conducted over a 12 month period
from August 2010 to August 2011.

**Data Editing, Checking and Transcribing**

**Qualitative data analysis.** The interviews were coded for common themes and
sub themes using the software package NVivo 9.2 (NVivo, 2010). The use of NVivo
version 9.2 facilitated the development of an audit trail particularly enabling the
iterative process of developing concepts (Bringer, Johnston, & Brackenridge, 2006).

The interview audio files were stored into NVivo and the transcription was done
directly into NVivo. Open coding was done on the initial interviews and then after all
interviews were transcribed, axial coding (linking codes) and coding trees were
developed enabling further data analysis and interpretation. Each code (known as nodes
in NVivo) was given a name and where necessary a description. In total 48 nodes were
developed from the 13 transcripts (Appendix K).

The approach to the initial coding was based on an interpretative
phenomenological approach. In the first instance concepts were developed from the
literature, my understanding of transsexual phenomena and the research questions that
guided the study as a whole. Therefore, some of the initial codes looked at positive and
negative social supports, the who what when and where of the support structure, the
transition process, the physical strategies of transition such as SRS and hormone therapy
and the social and psychological strategies such as appeasing, being true to self,
defying, negating, and reparativing (a term I developed to describe strategies that
appeared to be reparative). Often the names used for the coding e.g. “being true to self” were derived from the language used by the participant (referred to as “in vivo” coding), which is an acknowledged process for staying true to the data. In other instances the coding aimed at exploring process such as “external” versus “internal” when a process appeared to be initiated by an external factor such as the death of a spouse or an internal factor such as a feeling of desperation. This meant going beyond describing what was happening to also look at issues of process (Strauss & Corbin, 1991).

As the interviews progressed and the interview format was refined to obtain more in-depth and focused information, the coding structure was developed from the data itself when I found particular themes that seemed salient to multiple participants. This was in keeping with a qualitative approach where the data spoke for themselves (Strauss & Corbin, 1991). I was able to move from the open coding to developing axial coding that made greater distinctions within a category or theme. As coding developed, themes were noted and discussed. After a coding some of the interview’s specific themes emerged that were discussed with others in my research team. These themes were salient to answering the questions of this study and contributing overall to the research questions of this thesis and to our understanding of transsexuals once they have commenced living in their preferred gender. Sub categories were added to explain in greater detail differences that were experienced. These codes also had the advantage of being able to collapse and to incorporate many other aspects of the coding framework that were initially developed. So codes such as “transition, being a man or a woman” etc. could be integrated within the theme and code, “the transition moment”. This enabled codes to be reduced and developed according to saliency. Strauss and Corbin (1991) state that it is important to understand that there are many themes that may appear important and it is essential to make a choice of saliency.
Coding reliability. Initial coding was conducted on the first three interviews to analyse the data for relevance and depth. This initial coding allowed for the development and refinement of the questions in the semi structured interview format. These codes were inputted as nodes into NVivo version 9. The coding was performed by the principal researcher and reviewed by another person who had expertise in qualitative research. Once agreement was reached on the naming of codes, transcripts were analysed and ascribed to the relevant codes. Memos were developed regarding thoughts or problems and either attached to the nodes or to the interview transcripts as was deemed relevant. Additionally, a model was created and constantly revisited and revised according to the analysis. Therefore the whole process involved a reiteration between interviews, coding of nodes, memo writing, and discussion, changing nodes, renaming nodes, axial coding and model development. This process is deemed essential in a qualitative analysis especially one that incorporates grounded theory methods as a way of analysing the data (Strauss & Corbin, 1991).

Development of Semi-structured Interview Format

The study attempted to create a thematic image of meaningful stories. Participants were asked questions pertaining to their experiences of living in their preferred gender. The semi structured interview process provided a means by which triangulation of the core concepts of the research could be achieved by in-depth exploration of the variables explored in Study 2. Since the qualitative analysis was building on and complementary to the quantitative analysis of Study 2 a loose flexible framework of questions that could guide the open ended questions for Study 3 was constructed based on some of the variables explored in Study 2 (see Appendix J). These questions were only used as a guide to ensure the interviews stayed on track and covered a sufficient amount of “required” subject matter to complement the data from
Study 2 (Aisbett, 2006; Minichiello, Raroni, Timewell, & Alexander, 1995). Therefore, the variables of social support, sexual orientation and the importance or not of passing in their preferred gender were explored in the qualitative analysis as well. The questions captured a very broad sense of the meanings of these variables.

Participants were asked for example about the things they found helpful or not helpful in others who offered them support. They were asked to elaborate on the reasons they believed the support was helpful or not. They were asked their feelings about the support they received.

Participants were asked about their sexual experiences both before and after they commenced living in their preferred gender. Since sex is viewed as an intimate topic, participants were first asked if they felt comfortable discussing their sexual experiences with me. I informed them that I was not seeking to know the details of each experience but rather how the participant identified their role in the experience in relation to sexual orientation. For example, did a MF see herself as a female having sex with a male even though it was before the time she commenced living as a female?

Participants were also asked questions about their early experiences of their sense of being different as this provided a unique opportunity to complete the lifespan perspective. I wanted to know if early gender identity was something that was kept secret or if it was discussed with anyone at that stage and what the outcomes were for the transsexual of this early knowledge. Additionally, if it did not evolve in the interviews participants were asked if they felt they gained or lost or felt any change in their status since living in their preferred gender.

Initially, the first eight participants who completed Study 2 and who volunteered for the interviews for Study 3 were interviewed. After these interviews were transcribed
and analysed by the researcher a coding framework was developed using NVivo version 9. As themes emerged in the first eight transcripts of eight interviews the question guide was revised and updated to ensure it captured what was being sought (Aisbett, 2006). For example participants often talked about an epiphany and a feeling of liberation and feeling normal when they commenced living in their preferred gender. This was then explored in subsequent interviews. I found it useful to keep returning to these first eight transcripts and analyse what information was given and what information was sought and to alert myself to possible themes that were emerging from the narratives that required further probing.

Initially it was found that transsexuals were very happy to relate their story. It appeared that the “telling of their stories” was most important. In the initial eight interviews I found it useful to permit this unstructured approach to occur. However when the interviews were transcribed and analysed they were found to be in need of further depth and clarity (J. Mason, 1996) based on what emerged from the unstructured interviews. The initial analysis of the data from the transcripts together with the semi structured interview format enabled refinement of the interview format to elucidate particular information that was relevant to the study. For example it was believed that the interviews should look at precipitating factors that led the transsexual to commence living in their preferred gender at that point in their journey. Did factors such as relationships, finances, knowledge, or supports play any part in this decision? Essentially at every step in the interview where the transsexual mentioned something about their journey I believed it was important for me to take a step back and probe deeper. Examples of such probes were: “That’s interesting; tell me more about that”; “What was it about that which made you do that”?; “Why did you find that helpful/unhelpful?”; and “When you said she/he was supportive what do you mean?”
Can you tell me a bit more about what she/he said or did that was supportive/not supportive”? Participants were asked how they described themselves now. Did they see themselves as a transsexual women/man, a transsexual, a transwoman/transman or a woman/man or some other identification label?

Demonstrating a Research Trail through Research Transparency

Transparency in qualitative research is regarded as good practice and a way of demonstrating rigour which acts as a trail to confirm what was done (Meyrick, 2006). Through transparency and reflexivity, qualitative research endeavours to describe the factors that may affect the data. It is through such rigour that the researcher obtains the effect of “controlling” the variables achieved in quantitative research (Weingand, 1993).

In achieving transparency I employed the following strategies. I always had a note book handy to record any information that was relevant from the interviews. While in most instances note taking was not required due to the fact that the interviews were audio taped, it was still deemed important in case relevant observations needed to be recorded.

The interviews were recorded on a portable audio recorder and these were then listened to and transcribed by myself. I felt it was important to immerse myself in the data by listening and transcribing the interviews without using any transcribing computer software (see also Seale, et al., 2004). In 11 interviews the entire interviews were transcribed. In two interviews only selected sections of the interviews were transcribed. All audio recordings were stored on a computer for future reference during data coding and analysis.

Results

This section describes the results of the qualitative analysis. The characteristics of the 13 participants are provided in Table 10. These may be used together with the
concepts and themes that were developed from both the literature and the interviews for comparison. The process of constant comparison enabled the themes to be examined in relation to age, gender, and the scales completed by participants from the quantitative analysis (Bazeley, 2009).

**Concepts and Themes**

Many issues and topics arose from the interviews, however only those themes directly related to the research questions of this study are presented in these results. Forty eight codes were developed from the interviews. However, once the interviews were coded key themes were identified that supported the aims of this study and the overall project. Firstly, since the interviews commenced with asking the question about the time the person commenced living in their preferred gender this was defined as the Transition Moment. From this theme several other themes were identified such as the nature of the transition moment being either externally driven or a result of an internal realisation or need. The second theme that was salient to this study and the project was the outcomes of the transition moment. Once they had commenced living in their preferred gender what were their experiences. Of these, how they felt they were received within their social setting in their preferred gender was termed “passing” and who were the people that were involved in the transsexual’s journey before, during and after they had commenced living in their preferred gender was termed “who was in the picture” How transsexuals felt once they had commenced living in their preferred gender, termed “Being Happy After” formed the final main theme for in-depth investigation for this study and this overall project.
Overview of the Transition Moment

This was defined as the moment at which the person believed they commenced living as a man/woman. This could have been a gradual process or one that occurred fairly rapidly within a fixed time period. The transition moment had two sub categories (internal and external) which in turn had sub-categories. This is represented in Figure 9.

![Figure 9 Model depicting the factors that influenced the transition moment.](image)

- **Internal**: The transition moment resulted from an introspective emotional response, for example a feeling of “desperation”, a sense of there was “nothing to lose”, or “a do or die” moment. Alternatively, the transition moment could have been positive in that it was the “right time” for making the change.
- **External**: The transition moment was preceded by an event that was outside the individual. There were two sub categories:
  - **Discontinuity** was defined as a time when the trajectory of the person’s life changed quite dramatically because of an event that prevented the person continuing on their previous trajectory e.g. death of spouse, children leaving home, commencing hormone treatment.
• *Disclosure* describes an incident in which the participant had endeavoured to discuss their gender dysphoria with a significant other.

The interviews showed that all of the participants went through many aspects of change over many years before they made the decision to live in their preferred gender. Some had many years of wanting to live in their preferred gender but did not make the move due to circumstance. Others lived on and off in their preferred gender incorporating social experimenting like at times going out socially to bars, shopping, movies etc. dressed in their preferred gender.

Other strategies leading to the transition moment included doing research on the internet, experimenting in buying clothes or in dressing up occasionally in public. In many cases there was also a fracture in family relationships with the transsexual either being ostracised from the family or moving away to create some distance.

What was common however to all the participants in this study was the presence of a definite moment when the person had what I termed the *transition moment*. This concept was developed from the responses given to the question: “Can you tell me about the time when you said ‘I am now living as a man/woman’?” Participants were then asked to elaborate on their decision.

**Internal Transition Moment**

Participants experienced the transition moment in several different ways (refer to category definitions above). Some participants’ transition moment was internal; they had an emotional experience, which for some was a negative one. These transsexuals had experienced life primarily by living in their birth gender, although they may have experimented with some transsexual behaviour such as dressing up. Some got married,
had children, travelled overseas but this all occurred in their birth gender. There then came a moment when the person reached breaking point and where something had to change. At this point these participants felt a sense of desperation, of having nothing to lose. There were eight people who experienced desperation.

**Desperation.** Helen was 48 years at the time of the interview. Helen had known all her life that she was transsexual but she got married as her girlfriend at the time had become pregnant. Helen stated that she got married because they were Catholic and therefore it was the right thing to do. Helen had discussed with her girlfriend the fact that she felt that she was transsexual prior to them getting married but they still got married to bring up the children. Later Helen and her wife split up and then reunited. Helen also mentioned that she had problems with alcohol and marijuana use during her marriage. In her LPGI Helen indicated that prior to commencing to live as a woman four years ago she had experimented very little with being a woman:

*I'm not quite sure. It was a thing that I had wanted to do for a long, long time. When I was 28 I had delved into it for some reason maybe it was a maternal thing with my children and I had got back with my family. Then there came a time when something just snapped inside of me. It was either this or suicide. I could not stand living as a man any longer.*

Gail, a 55 year old female, also experienced desperation because of her belief that nothing was working. Gail, who was of a similar age group to Helen and Enrique (see below), described a life that had reached a stalemate and her feeling that there was nothing to lose. Gail also had very little social experience in living as a woman, similar to Helen and Enrique (who is discussed on page 171). In fact Gail’s LPGI profile was almost identical to Helen’s. Gail also had only lived in her preferred gender with friends
and in going out socially. However, Gail’s experience of living in her preferred gender was experienced more erratically rather than on a regular basis. Also, like Helen, Gail had been living in her preferred gender for 4 years at the time of the interview:

*I had been to the Gender Centre. I didn’t feel my career was going anywhere. Um I didn’t have a girlfriend. I didn’t have a boyfriend. There was no one stopping me and I was kind of....and I ended up in this office by myself (sighs).*

Nerida, a 47 year old female, had her transition moment when she was 21. Nerida had been doing shows at a bar dressed as a female and working during the daytime as a male. After several months of this she had reached a serious breaking point. Nerida had a lot of experience living in her preferred gender going out socially with friends, engaging in sexual activities, working as a female, dressing up when she was with family and also commencing hormone therapy. This is in sharp contrast to Helen and Enrique and Gail who had very little experience of living in their preferred gender. Nerida attributed her feelings of desperation to having to work as a male during the day which caused her internal confusion. The constant separation of gender roles each day at a time when she was feeling comfortable being a female was causing her too much anguish. She talked about a constant build-up of living as a woman more and more as time went on and enjoying it:

*I took a whole year off just doing the shows first and just enjoying that for what it was then it started to get more serious you know and I couldn’t take it and I actually started to have a nervous breakdown. Because you know I was really caught between the devil and the deep blue sea where my brain was ticking so much. Towards 1984, that’s the beginning of starting to take*
hormones in 84, but in 83 I was starting to get very...... I almost had a nervous breakdown because I was caught where I was getting more popular now dressing up and the more I dressed the more I was starting to get comfortable with that persona and because I had to stop it and then go to work as a boy it played with my head and then the late nights from work and stuff I couldn’t take it anymore you know and it came to a head where one night my mother came to pick me up from work and I finished and when I got home I was really starting to sob and cry because I had to tell her how I was really feeling that I can’t go on like this anymore I you know I’m living a lie where I work as a boy but my inner self is yearning to be more like a girl now.

The right time. There were two participants who had positive experience of an internal transition moment. For them, their transition moment came from an internal sense that it was the right time.

Bella was a 37 year old female. In Bella’s case her transition moment was a gradual process. Bella had a great deal of experience living in her preferred gender prior to her transition moment which included using her gender appropriate name and living as a woman in employment settings. Most of the other participants lived in their birth gender in employment settings.

Bella found herself in a situation where she no longer could live as a man. Bella stated that she had been living as a female at home and with her mother and friends. She also went out socially as a female. Her circumstances over the years had changed to such an extent that all her friends knew and accepted her transsexualism and her
wardrobe had become largely female with very few male clothing. Trying to live as a man had become too difficult:

*I think it was more a fact I came to the realisation that well that the only time I wear anything that is more androgynous was work clothes which was unisex anyway and every other time I was living full time female anyway. So it was more so the fact that I wear these clothes for safety, not that I have to for my job, not for any other reason. They are unisex they are not a man’s thing. So that was sorta the realisation ”hey you are living full time” You are who you are. So that was more the turning point for me.

yeah I think it was also the fact that I had too many female clothes and I had to make room for more and I had to clean out my closet. The female clothes were going right up and the male clothes were going right down and it just got to the point that it was too hard.

Bella also recounted how even when she occasionally went out dressed more as a man her friends all addressed her as female:

*I was living in both lives I suppose. ...I was still I think fearful, everybody knew anyway. It was not a secret. Everybody would be going “hey Bella how is it going” even though I was dressed as a boy and they were... So I was gradually going more feminine, permanent, permanent, permanent until I went why am I doing this? Why am I going outside dressed as a boy when everybody knows any way and they all know what I look like? I never have any problems so why I am doing it. So that’s when I basically stopped doing it.*
External Transition Moment

**Disclosure.** Two participants experienced disclosure. One additional participant (see Natasha below) experienced both disclosure and discontinuity in her transition moment.

Nigel was younger than the other participants at 19 years of age. His transition moment involved a disclosing to his family his transsexualism. Nigel had reached a point that he no longer could deny his feelings and could not live with his parents with them also in denial of his transsexualism. Nigel felt that he was finally living as a man when he disclosed to his parents and told them that he was transsexual and that he wanted to live as a man. This was at the age of 16 when he was still in high school:

*I probably consider myself living full time as a guy when I came out to my parents because with everyone else with all my friends was and even though the people didn’t acknowledge me and accept me I still considered myself to be living as a guy because I knew who I was.*

Nigel had considerable experience in his preferred gender before his transition moment living as a man with friends, family and in social settings such as going shopping, when engaging in employment and studying in his preferred gender.

**Discontinuity.** Fatima was a 55 year old female. Fatima’s transition moment came at a time when she experienced a discontinuity in her life’s trajectory. This was the moment her two sons left the family home to start their own lives as adults:

*my last boy, my son left home. I told them I wouldn’t do it until they left home, because I was a single parent for 8 years. So I couldn’t. I said I wouldn’t do it to you boys. They had enough on their plate, without having to deal with all my stuff.*
Fatima had been living in her preferred gender for 2 years at the time of the interview even though prior to this point she had lived *occasionally* as a woman in employment and student contexts and frequently within the contexts of friends, engaging in social activities such as going to bars, shopping etc. and engaged *frequently* in sexual activities in her preferred gender. In her interview Fatima discussed a life with her wife where she went to social gatherings dressed as a woman for many years during her marriage and acquired a gender appropriate name which she changed legally and used *frequently* on a daily basis prior to her transition moment.

Nicole was a female aged 38. Nicole had very little exposure or experimentation with living as a woman prior to her transition moment, and she responded *never* to seven of the questions on the LPGI answering *occasionally* to using her gender appropriate name. Nicole described how she gradually came to dress more and more in public in her preferred gender. Indeed she described it as a process of continuous confidence building and one which continues: “...it’s very much true that process of building confidence continues and it still continues.”

Nicole’s transition moment was influenced by an external event which changed her life trajectory. She had just had some surgical procedures:

*when I came from facial surgery. after I had some facial surgery done I had rhinoplasty done  um and for me um it was like...because it was a permanent thing and it was a definitive step I felt more and more, more feminine because the one thing that was really bugging me was the shape of my nose and my face. All my friends said “oh no it looks fine and stuff”... but for me that was and I went and did that and it gave me, I felt*
so much more confident even though I didn't have any problems in public
nobody ever picked my past and after that I felt so much more confident.

Kobe is a 22 year old male and came from a small country town. Kobe had been living in his preferred gender for one year. He had engaged in only two social behaviours in his preferred gender prior to transitioning. This was frequently living as a man with his family and frequently going out socially to the shops movies etc. In all other categories in the LPGI he indicated never. Kobe had told his parents about his transsexualism and had started seeing a psychiatrist and an endocrinologist. He had done considerable research on the internet. What made the difference to Kobe was when he moved interstate and changed his name:

The biggest goal was to change to make it different. So the first time that I actually acknowledged the fact that I was really was a man sort of thing would have been really recently because that was when the changes actually started occurring to make everything better........living as a 100% male in the eyes of everyone would be when I came to [city name] and changed my name from that point onwards.

Tanya’s transition moment occurred at a similar age to Kobe’s but about 30 years before Kobe and therefore of a different generation. Tanya had been living as a woman for 40 years at the time of the interview. Prior to her transition moment she had engaged in a number of social behaviours as a woman and had acquired a gender appropriate name which she “always” used and had changed it legally. When asked about the moment she believed she commenced living in her preferred gender, Tanya aged 65, talked about how her family broke down when she was 22. Her father confronted her with her transsexual behaviour and she was thrown out of the family
“...my family unit had fallen apart. My father had thrown me out because he had noticed differences and being very religious... no child of mine will be like that...Yeah, started doing it all...taking hormones”.

**Mixed Categories**

Although most participants’ transition moments could be placed into a single category, some had transition moments that fell into several categories.

Lyn, the oldest person interviewed, was 75 years old. Lyn had very limited experience in living in her preferred gender prior to her transition moment. She stated that she lived “occasionally” with family and in social setting in her preferred gender. Lyn had changed her name legally but did not use her gender appropriate name until she had her transition moment. Lyn experienced both internal-desperation and external-discontinuity in her transition moment when she was in her late sixties. She talks about dealing with her internal transition moment when she states “…It was the mere fact that I could not outrun my demons any longer.” Lyn’s internal reaction of “out running her demons” suggests that this had been going on for some time.

Lyn’s transition moment also came about from an external influence. Lyn, had experienced the death of her wife:

*Sounds terrible but because she died that freed me up. So I just went for it. I looked at it from the point of view that I was 65 years then coming up to 66 years and if I didn’t do anything now I never would. So that was it.*

Natasha was a 62 year old female and married. She had been living as a woman for 15 years even though prior to living in her preferred gender, she had had very little experience living as a woman in social contexts answering *never* to most questions.
Natasha experienced both a disclosure and a discontinuity. Natasha told her wife about her transsexualism and following a breakdown in communication Natasha separated from her wife and moved away to live in a different geographical area:

*Well the issue was brought up by my wife and I knew then...because every time she would go out I would be dressed.... and she couldn’t accept it. We tried to solve the issue a number of times. It didn’t work..... It was about 6 years ago and that was when I moved to [city name].*

In Natasha’s case her disclosure resulted in a change in her life’s trajectory as a result of the separation. This appeared to give her the opportunity to live and dress as a woman in private and public without the stress and friction of her wife’s disapproval.

Raj was a 35 year old male who had transitioned in the last 3 years. Up to this point Raj had led a life that was socially acceptable as a male without the actual label of transsexual. Raj had also lived a life as a State ward and therefore did not have parents to discuss these issues with. Therefore, in his LPGI Raj had responded never to engaging in employment, studies or with family in his preferred gender prior to his transition moment. He had, however, experienced living as a man with friends and going out socially to the movies etc. He also had experienced sexual activities in his preferred gender. He had not acquired his gender appropriate name until after his transition moment. Raj’s transition moment came from external health issues that were not directly related to his transsexualism.

The treatment of the health issues required testosterone treatment which then made him realise that he felt good about himself for the first time. It was a realisation that the testosterone was the answer to something he had always felt but not had an explanation or name for:
I made the decision after I...a....I started developing health issues with my immune system. I stopped producing testosterone and started taking testosterone to bring my levels up. I then started developing antibodies to the testosterone and my specialist tripled my testosterone to try and saturate my body to take it up and I started to physically transition. And that was when I realised that um that there was actually something that physiologically that could occur that would make me feel better in my body.

Raj also had an emotional response that “it was the right thing for me”:

and as I was changing the more comfortable I was becoming and the more I was able to relate to myself and to understand myself and I felt more comfortable and happier...so I started to explore it from that point.... I didn’t want to rush I wanted to spend time doing therapy on it and making sure that was what I wanted to do and started cross dressing and binding to pass and it just felt really right, It was the right thing for me.

Enrique a 48 year old male provides another example of a person who experienced two types of circumstances in his transition moment. The first was a discontinuity which occurred when he moved to Australia from the USA. The second was one of desperation that had reached a point where suicide was the only other option.

Enrique had known something was different about him since he was 5 or 6. He had always played as a boy doing boy things and engaging in play that involved him playing the male role. Despite a long successful career and much research and soul searching Enrique finally reached a breaking point.
However, as an adult Enrique had not engaged in social settings in his preferred gender. He had lived as a female until the point where he felt he could not do so any longer. His transition moment suggests a dramatic change which is similar to Helen’s as noted above where she could not live as a man any longer.

It appears that moving away from family and friends to a new country far away from home may have brought Enrique to a safe place where he felt he could transition. After much research to validate that what he was doing was not something he would regret he reached a breaking point where his life had hit a low:

_If it’s about addressing an issue that has been constantly presenting itself over a lifetime, maybe that is why I am here in Australia. to come to a safe place where I can do it. Australia is fairly supportive in transgender stuff. So it was real._

Because my life [had] pretty much hit [rock bottom]… nothing was working again. It did not seem to be flowing and I just had an inner knowingness going I guess…..you know what if I don’t deal with this now, then I will die. This is it. It’s gotten worse. I’m now at a breaking point where I need to address it. It is literally live or die.

**Summary of Transition Moment**

The transition moments of all the participants were a point of no return in their life. This was regardless of whether it was through internal desperation or external through a confrontation or a discontinuity. It was a point of no return; a point where change felt inevitable. It was the catalyst that set in motion either carefully researched plans or enabled the person to commence the process of planning and execution of the path to living in their preferred gender.
Outcomes of the Transition Moment

The transition moment was a profound moment in the lives of all the transsexuals that were interviewed irrespective of whether they had had SRS and went through the triadic treatment model or not. There were many things that transsexuals experienced in the process preceding and following the transsexual moment. Of interest to the research question of this study were the categories noted in Figure 10.

Figure 10 Model of the Outcomes of the Transition Moment.

Once the participants had taken the step to commence living in their preferred gender there were specific outcomes. These outcomes were analysed in the three categories of **passing** and also a sense of **happy after**. These three categories were important firstly because they lent support to the constructs that were being studied in study 2 namely that achieving gender congruence in the preferred gender and therefore being able to pass was important to transsexuals. Furthermore, once a transsexual commenced living in their preferred gender, passing and gaining social validation and acceptance in their preferred gender would impact on their mental health. Gender congruence was conceptualised by the use of self-discrepancy theory in study 2 to explore whether transsexuals believed they had the physical attributes for their preferred gender. This was measured using the Self-lines measure in study 2. For the third study, in order to explore if people felt that they had the attributes of their preferred gender,
congruence was conceptualised as passing. Therefore, in this study the concept of achieving gender congruence was based on whether transsexuals reported being accepted within the general community in their preferred gender. Secondly, the medical model assumes that once a person has commenced living in their preferred gender, achieved through SRS, the distress associated with being transsexual will be ameliorated and it would be expected that the participants who had SRS would be happy after. Based on the medical model participants in the study who had not undergone SRS would be expected not to be happy after even though they were living in their preferred gender.

The people and organisations important in the transition process were also analysed because social support is a predictor that past research has frequently found to have a positive effect on satisfaction with SRS and thus on mental health. Social support was also a significant predictor of mental health in the quantitative analysis (refer Chapter 5). However, in this qualitative study social supports were analysed differently. The phrase “social supports” suggests at face value that all support is positive and therefore good. Firstly, perceived support is not identical to externally rated support. Secondly, social influences can be mixed or detrimental, not universally positive e.g. constructs like “negative support” and “social constraints”. Taking these factors into consideration I wanted to leave open the exploration of social supports to include both the positive and negative aspects of the contributions of the people who were in the lives of these transsexuals. Therefore, in this study I asked the question “what did people do that you found was helpful or unhelpful?” Therefore the category was defined as who was in the picture to allow for both positive and negative help. It was also understood for this study that who was in the picture could have come before, during, or after the person commenced living in their preferred gender.
Passing

Passing was conceptualised for this study as the transsexual’s perception that they could live within the broader community once they had commenced living in their preferred gender and be accepted as a person of that gender. Of the 13 participants, there were two who did not talk about passing during their interviews, even though there were many opportunities for them to discuss it. Based on their interviews it was deemed that passing was not a salient issue for them and they are omitted from this analysis.

Eleven participants believed they did not pass. Nine felt that passing was important and two felt that it was not important. The model for passing is shown in Figure 11.

![Figure 11: Sub categories of the Concept of Passing.]

**Important.** For the seven who reported that passing in the general community was very important to them, not passing had a severe psychological impact. These participants when they went out in the general public got the impression or received feedback that they did not pass in their preferred gender. For example Kobe who felt he looked like a boy all his life and had played boy games as a child suffered much anguish when he was in public for fear that he would get caught [as a transsexual]:

*the voice was the only thing that was giving me away to other people.*

*……things that would make things more depressing for me like um ....it’s again was like little things. Like when I would go to the shop...um*
everyone would think that I was a guy but then I would talk and my voice
was very very high pitched and they would immediately, you could see
their in their eyes.....or this is the girl.

For Kobe not passing in the eyes of others was devastating. “…… it’s like
um…it’s like….it’s just like being stabbed in the heart kind of thing. It’s the worst
feeling. You think everything is going fine and then one little set back and everything is
going backwards.”

Raj also had a similar experience to Kobe. Raj had for many years lived as a
male in aspects such as play and dress. However, once he realised that he was
transsexual and had breast surgery, Raj became very self-conscious of passing in the
eyes of others. For Raj passing took on a whole new meaning. He wanted to know that
he had the ability to pass as a man in the eyes of the general public without being caught
out as an “imposter”:

it actually took me a while to get comfortable with it. And even now I still
have body consciousness issues and the distribution of fat on my hips and
that kind of stuff. I think I had an assumption that once I had my breast
surgery that I would be totally comfortable getting around without my shirt
on but I was very uncomfortable with it. It took me months to gradually
doing it out in public. I remember the first time I did it I was down on the
beach and I thought I would take my shirt off and have a swim and walk
down to my car with my shirt off and I was half expecting someone to go
“You imposter” or something. It was weird. Like the first time going into a
male toilet and that fear of getting caught doing something you weren’t
supposed to do or something.
Tanya also found that she did not pass in the general community. Tanya approached passing as a learning experience and took feedback from others about her ability to pass. Tanya did not want to be seen as a “freak” which is a similar sentiment echoed by Raj who did not want to be seen as an “imposter”:

*It took me a while to get it together. …the transition period is like ugly duckling into swan it’s a bit rough in the beginning…. and I was in my 20’s when…so I had certainly developed as a male and so I had a lot of changing to do… a lot of adapting. I got a job as a stripper actually. I thought that was very good. If I could fool all that crowd I was going very well… That I could prove to the general public that I was a woman not that heads were going to spin and they are going to say “look at that freak” and I did do it.*

In contrast, Nicole believed that she did not pass even though she received feedback that she passed in the eyes of other people. Nicole stated that in the eyes of her family and friends she believed that they accepted her in her preferred gender and therefore she passed “…*all my friends said “oh no it [her nose] looks fine and stuff”*, but Nicole had a sense that she did not pass. This was despite the fact that she had had hormone therapy for many years and also had completed SRS. To assist with her high self-discrepancy Nicole had some facial surgery and had her nose reshaped “…*after I had some facial surgery done I had rhinoplasty done “…..I felt I felt more and more, more feminine because the one thing that was really bugging me was the shape of my nose and my face.”* This appeared to have lowered Nicole’s self-discrepancy “…. *I felt so much more confident even though I didn’t have any problems in public nobody ever picked my past and after that I felt so much more confident.”*
Bella had strong negative feelings about the concept *passing*. She felt that she had no reason to try and pass. For her it was the ability “to be you” and be accepted as a woman that was important rather than trying to pass as a woman. However, her following statement about passing suggests that being invited to play a public role as the maid of honour at a friend’s wedding in her preferred gender was important for her and signified an acceptance for who she was:

*If you’re transsexual, one thing I absolutely detest, is that people have an ambition to be passable. What’s passable? I have an ambition to live. Not just to walk down the street and hope that people think that I am a female. A lot of people get sucked into that. They want to be passable. What’s passable? I walk into a pub in [city name] and my friend who works there said I knew that was you. You walk in like you own the place. I walk with my head held high not with tucked in-between my legs. I was maid of honour at a friend’s wedding.*

**Unimportant.** Two of the participants believed that they did not pass in the eyes of others. However for these three participants passing was not important.

Nerida talked about enjoying wearing make-up and had studied the role of being ultra-feminine “...*love it! It’s just make-up to me. Whether I deal with it or not. You don’t want to wear make-up that’s your business. I love wearing it. I ache for it. I love painting myself up. You know it’s fun...”* However, Nerida found that in the eyes of some people she did not pass:

*The highest compliment that a straight man could give was ...you were so ultra-feminine that I sprung you for that... sprung you because women now-a-days are not like that. You know your hand deportment, the way you...you know,
every move you did was of the utmost femininity…women are not like that anymore.

For Nerida, being herself and looking after herself and how she presented herself was more important than the concept of passing:

Now for me, if I went out into the straight scene, I don’t care if I wear a face full of make-up that springs my act. The quicker I spring my act, the better I’m happy that I don’t have to tell anyone who I am….You know what if I look beautiful, they still going to come.

When Helen first transitioned she experienced anguish when she went out in public. However as time passed Helen found that she learnt to deal with people who looked at her strangely:

I used to walk down the street in my early days of transitioning scared to look sideways at somebody because they would start to pick on me…never ever got picked on and um now like these days I would be walking down the street, someone will look, it’s mainly women who would pick me out and they will look sideways and then stare. My reaction is to stare them back out…”what’s the matter darl…do I look gorgeous?” I’ve never ever really confronted anybody about it ……. I live my life these days as a woman. I want to be recognised as a woman. I have always felt that I was a woman. This is the path that I want to travel on. I couldn’t look in the rear vision mirror anymore. I don’t want to go back in reverse.

Helen had come to a point in her life where she felt that it was her perceptions of herself that mattered to her the most. “… I look at myself and I see a woman in the mirror that is all I need to know.”
Summary of Passing

Passing was generally a means by which a person could live a relatively normal life in their preferred gender without being considered and accepted as a male or a female rather than as a freak or an imposter. Why passing is important for some and why it is unimportant for others is not clear from these findings. There was some ambivalence with regards to the concept of passing. There was a sense that there was an expectation to fulfill a social expectation of what was appropriate in the preferred gender. Therefore the ambivalence of whether or not transsexuals should have to feel the need to pass came back to social expectations of the expressions of gender. The idea that people should feel the need to pass was in opposition to the person’s right to self-expression. The question to be asked in these circumstances is whether the formation of a person’s gender identity constrained by social confinement to a binary expectation of gender is helpful to the transsexual who may wish to live in their preferred gender in a manner that reflects their particular life choices and that suits their lifestyle.

Who Was in the Picture

There were many people who came in and out of the transsexual’s life during the course of them living in their preferred gender. Some of these were present in early childhood and others came later in life. What I wanted to find out was who was in the picture at the time transsexuals commenced living in their preferred gender and what impact did these people have on the transsexuals if any? In some cases people who were in their lives at certain periods of time were helpful and in some cases they were unhelpful. For this reason I believed the term social supports did not adequately capture what occurred in these relationships as, at face value, the term social supports implies that these contacts were all in some way supportive and that the impact was always helpful and positive. Consequentially I used the term “who was in the picture” to
explore the concept more broadly. I commenced by asking participants what were the things that people did or didn’t do that they found were helpful to them in living in their preferred gender and what, if anything, did they find that people did or did not do that were unhelpful. From their evaluations of what was helpful and not helpful, subcategories of the types of support with regards to who was in the picture emerged. Figure 12 shows the concept of “who was in the picture”.

**Figure 12** Model of who was in the picture showing the source of the support, the type of support and the evaluation of the support.

**Helpful Emotional Support**

Emotional support was defined as anything that helped the person feel accepted, loved, cared for, and understood.

**Family and friends.** Family and friends included parents, siblings and extended family members. It also included spouses and partners. Friends included anyone the participant referred to as a friend.

> it was around that time (puberty) I told them (parents) exactly what I wanted and who I wanted to be. They took it pretty well I guess for parents, I do remember my mum saying that she didn’t really understand or accept
what was going on but it didn’t make a difference because she still loved me sorta thing (Kobe).

Other participants found similar help from family and their partner.

and after I had been full time for about a month or so I came out to the family. And the fact that my family did not cut me off. They were upset and surprised and all that stuff but they did not cut me off. So that was another help (Gail).

“….I had a partner at that stage. That gave me stability and made me feel comfortable……..my parents have been fantastic……….. All my friends said “oh no it looks fine and stuff” (Nicole).

My mother got it she was a very beautiful soul. I love her dearly. She’d just look at me and say “I love you, you’re so beautiful” and I knew she wasn’t talking about physical, she’s looking at the soul the spirit and I went…..”oh I love you, you are just an amazing human being, you really are.”…….. ......believe in yourself... And my friends instilled that in me (Tanya)

like um I remember quite distinctly the first time my mum ever introduced me to people as her son for example and that was like a big deal because these were people she had worked with and known for like years. It’s not easy to see people you have not seen in a while and be like “my kid’s transsexual”. Um I guess just stuff like that (Nigel)

I had good moral family upbringing you know what I mean…….all that I really needed was for my family to say everything is fine dear, go for it
and they did. Everything else fell in place, after that you know what I mean? (Nerida)

“... um...my younger sister has always been there for me........... a lot of friends who help me out” (Helen).

Helpful emotional support was not always based on positive actions by family and friends. For example Gail said “...It was probably a help too that my male friends cut me off .....two straight male friends ....and they cut me off and that was probably a good thing for my transition”.

Natasha also got emotional support from her neighbour “...He is heterosexual. We went away for a weekend because he is very supportive and he has helped me through some very rough times.”

There were a number of occasions where it was relayed to me afterwards where friends of mine had had conversation about my gender change and where my friends had stepped up and challenged other people about things that were said that were negative. So I felt that I had a lot of explicit support in the community. My friends made themselves available to talk to so that I had people to call if I needed support (Raj).

people who had known me cause I had been here for probably 4 years or so...when I discussed it with them they were like...yeah we knew the energy all the time .... They said you look great. You seem really cool within yourself. it’s good to see you again. ...... they were supportive even though I did not ask them for support. I asked them nothing. That was probably the most rewarding, the unexpected reward if you want to call it reward. (Enrique).
**Organisations and LGBT community.** Organisations were both government organisations and non-government organisations. Some provided general services and some specific transsexual services. The LGBT community included organisations that provided services for transsexuals and also individuals who were identified as gay, lesbian, or transsexual.

Organisations such as the Gender Centre support groups or Alcoholics Anonymous (AA) offered Gail the opportunity to meet other transsexuals where she found people who understood:

> it was in AA...I met this transsexual .... she said that...a lot of guys they never do it and they never find out what it was like...and then she said also...that if you want to try ...... she said why don’t you go to the [organisation name] ( a club for Cross Dressers and their partners) and try that for a while...see what you think (Gail).

The Gender Centre .... Well [organisation name] was helpful because it had other people. So I went there and you know I was talking to the other girls ..I came in dressed as a man terrified ...and I just told this person  this other one who was dressed half and I said to ..I said...why are you here...well I always thought I was a woman and I have been waiting for it to go away ..and she said:.... ‘it never goes away’ .and I knew I had found someone who’d understood . That they had the same feelings as me. So that’s what I connected with. That’s what I really got because they were early days ...so I found 2 people there who really understood.....well they connected with me and um ....amongst all the madness and all the rest that was going on (Gail).
Because they had the shared experience and I felt the same way. I mean…I couldn’t imagine saying that to anyone else and they would understand with that answer. It’s like they had the key.....the right answer .... like a password in the spy movies.” ...The snow is thick in Vienna this year and the other person answers “yes” but the rain in Venice is worse or something” and it.....you got the key word (Gail).

I got the fun at the [organisation name] and the [organisation name] taught me how to dress and gave me my first confidence. I got the confidence to dress in public at the [organisation name] that led me on to the [organisation name], there was dancing there was fun and after a while even though I thought I was too ugly to pick up a man I started picking them up and what I found was ..this was a revelation to me too and this was another connection so I thought ..oh sex as well ..not only getting dressed up there is sex going on here for me as well . so this is kind of looking like some sort of rounded life...is shaping up ....you know what I mean...not just dressing up and dancing. Well there are other transsexual women who could share your experiences and you could meet them and then meet them outside I particularly had one friend there called Elanore.....well you would just go to their place and have a coffee and talk about stuff...so it was kind of like a social life (Gail).

I could go there and it was safe.....a safe place for me. That was one thing.

I had that social network which isn’t available to other people and um there was so that was I could go somewhere in [city name] and calm my head down. I could still be a tranny (Gail).
Gail also found that living in a smaller city where she did not experience transphobia and being employed in an organisation that had many female employees also helpful. Additionally, having mental health professionals who were familiar with transsexualism was also helpful:

the fact that I hardly got hassled living in a place like [city name] that was a support. having a job helped. Having a job in an organisation where there was kind of a lefty organisation with lots of women in it...kind of helped (Gail).

I was on the discussion list I think it was [GLBT organisation name] and um a woman posed the question something to do with transgender stuff. Anyway I responded to her and I said....I think she was also in the process of transitioning herself. So I responded to her and explained who I was so you know,...could I have a coffee with you and so we met and we are still friends to this day and she actually introduced me to the Gender Centre (Enrique).

"I've had a lot of other friends through the fellowship of AA" (Helen).

they (gay community) showed me... they opened up doors for me and showed me where I was going.........when I got to [city name] and got caught up in this whole transsexual world...oh wow now I feel at home. .... ....... the girls totally support me, they protect me. They take me out. They say if anyone says anything to you or touches you we will go them. Because they are sort of butch dykes. I like butch dykes. I’ve got a thing for butch dykes..............yeah I went to balls....went to the [organisation name] balls in [city name] (Tanya).
I was exposed to the gay community the lesbian community .... I was more exposed more to the gay male community which that felt a lot better, I guess because they also had an understanding of transgenderism and just more accepting. One association that has had a fair amount of lesbians they said make sure you come to this group, your still part of our gang. There was no ostracisation  (Enrique).

"I rang the Gay and lesbian hotline. At that time there was no GLBT , the T part didn’t exist” (Nicole).

“um I had a gay teacher who was very good”(Nigel).

Nigel also reported an overall positive effect from being supported. While Nigel reported being happy with his supports he also reported frustration. A part of Nigel did not believe or feel that people were taking him seriously.

it certainly had a good effect. I mean it was probably a combination of happiness and frustration because I was happy that I was being supported and I was very grateful and at the same time I was frustrated because at that time I was 15. It certainly made me happy to feel that I was accepted but at the same time I felt that people were like patronising me a little bit it was like they were accepting me for the sake of like let’s just go along with it.

definitely good effects. I guess I never felt like I felt I could talk to people and ask for help with things. Like I wasn’t at risk of being kicked out by expressing feelings about my gender that kind of thing. Like there is ridiculously high rates of drug use amongst young trans people, homelessness and sex work especially transwomen but also trans people in
general because people get kicked out and they don’t really have any other way to support themselves or to pay for their transition. You know the fact that I felt so welcome at home and I felt I mean I developed alcohol use problems but that was not so much to do with me being trans. I never felt I had to resort to any of that because of being trans. In general they were quite supportive because I was very young..... it must have been really mind boggling for adults to look at me and be like happy. He doesn’t know what he is talking about. He’s a kid (Nigel).

Unhelpful Emotional Support

Some transsexuals felt that they were dissuaded from transsexual related activities and others felt ridiculed and not accepted in their preferred gender and were treated as their birth gender.

Family and friends. Kobe experienced his parents generally as helpful as time went on and he got older. However, in the beginning Kobe found that his parents were not very supportive.

“...my parents they always tried to dissuade me from doing anything masculine or anything like that.” (Kobe).

Gail found judgemental attitudes a hindrance to the acceptance she sought:

what wasn’t helpful was people some of those were judgemental and I could tell some people wouldn’t accept you as a woman even though you are presenting as a woman they try to treat you like a man. So that wasn’t helpful Gail)

Tanya met with very rigid stereotyping on what was expected of her:
dad was very black and white ...this is how it is you are going to be a farmer and stuff like that and I went No no no...Don’t get any fancy ideas (Tanya).

For Enrique having professional colleagues around the world appeared to make it stressful for him in the first few years “... Put it this way I would say in those first two years it was just like here is another coming out experience. Um as Enrique.”

**Health care professionals.** Nicole had a few unhelpful experiences with health care professionals that left her feeling “gutted”.

_I saw the first GP when I was at that stage in my final year at University so I would have been 20  um at that stage.......(I) told him I wanted to transition..... by the look of disgust on his face you could tell that he wasn’t particularly happy about the concept. ...... he just went right off basically yelled at me (Nicole)_

Not long after finding another GP who was sensitive and who referred her to a Psychiatrist, Nicole experienced further unsupportive professionals:

_his attitude was that all transsexuals were gay cross dressers and nobody could not convince him otherwise  um and because I didn’t come in wearing a dress and high heels and stockings or whatever because I was still living as a man  and I didn’t feel comfortable dressing as a women because I could not pass as one um  his attitude was that ...... whenever I went and saw him I felt totally gutted from the experience._

_I wish I could say that that was the only time I have had that happening but it it’s not...I have had other  ladies who have had the same experience um_
with other professionals whether they be GP’s, Psychologist or Psychiatrists (Nicole).

I think I’ve had one Doctor who was an elderly doctor who was late 60’s look at me with disgust when I have explained that I want these drugs for this reason (Bella).

I actually had seen a psychiatrist in [city name] and a girlfriend of mine had been through all the surgery and I walked in and he said wake-up to yourself you’re a man. I should put you in an institution and put you on testosterone you can’t do stuff like that that’s ridiculous. And I ran out of there crying (Tanya).

Some experienced violence, abuse, rape “…….in [city name] in [street name] I would get abused….or you know you are part of the show…one of the weirdos or whatever (Gail).

what happened was that at 19 I got raped by 15 men…. I was caught as Fatima….. They grabbed me and when they found out I wasn’t what they wanted they proceeded to rape me, bash me. I was in hospital for 3 months, unconscious, nearly dead. Nearly died. I recently only 5 years ago had 2 operations to fix what they did to me (Fatima).

In discussing his school experiences Nigel believed that there was little understanding: I think again most of them were confused

when I think about what I went through because I was bullied relentlessly and I was sexually harassed….. and spreading horrible rumours about me, that kind of thing.
Helpful Informational Support

There were many sources from which the transsexual gained helpful information on transsexualism. The information could have been related to support groups, medical assistance, social clubs, etc. Support was often gained through discussions with family and friends and also with organisations. Information Web sites were also an important source.

Family and friends. Kobe’s parents gave him a talk about the Birds and the Bees when he was 5 years old.

Then I realised that what I wanted (to be a man) wouldn’t happen naturally. So then I was thinking about ways that would make it happen....... So I knew that when puberty came that like my body and everything would change I thought for the worse at that time so I kind of made the most of it while I could (Kobe).

I was frightened you know because I could tell that it was a man but at the same time she was living and dressing and doing something else, you know what I mean...as a women (Watching an entertainer at a LGBT venue) and I felt her...I felt what she was doing. I understood inside deeply (Nerida).

Health care professionals. Health care professionals were people who were in primary or secondary health care such as GP’s, Psychologists and Psychiatrists.

Participants found health care professionals who knew about transsexualism helpful “.... the first Doctor I saw was himself transitioning ..... I just took a punt and went to a gay clinic” (Natasha). “My main Doctor I go to she has been treating transsexuals for years” (Bella). “My GP was great. Really understanding. Everybody
was really understanding. My homeopath” (Enrique) “…… having a Psychiatrist in [city name] who was familiar with transsexual people was helpful” (Gail).

“Once I started seeing the psychiatrist and knew I was on the right path and things were going to go well except for that instability, will they or wont they, that made it a lot easier” (Tanya).

After being yelled at by the first GP she saw about a medical transition, Nicole found a GP she could trust “…. I went to see another GP. He was really nice.”

I mean the Psychiatrist had absolutely no experience with my situation but he completely empathised and I suppose everything that a good Psychiatrist was supposed to do um…..which was just a big load off my shoulders because there have been plenty of stories where there have been bad experiences with psychiatrists…..He made an effort to understand (Kobe).

“There was also those network places where …the transsexual…what’s that..[organisation name] (Outreach Program for Sex Workers). all that kind of stuff [in city name] which were really helpful” (Nerida).

Organisations and LGBT community. Kobe who was isolated in a small country town got informational help through reading about others’ stories on the internet. It was difficult for Kobe to finds supports in his home town and there were no professionals who had the expert knowledge either “……I did not have friends or anything like that.”

I had just come to know computers and everything so the internet was helpful. I just researched about sex change procedures, pathways I could
go down that sorta thing. Other people that had gone through it. I found this website on the internet that was really helpful in basically everything..... that was exactly what I needed to know.

Kobe found himself engaged with what he calls an online community…

I was on the internet with the online community. There were personal stories and like one story that was pretty similar to my situation. I sort of clung on them and used them as inspiration and hope, that sort of thing.

**Helpful Functional Support**

Functional supports were helpful in providing hands on help on how to dress and where to shop for gender appropriate clothing, etc. These supports provided advice and feedback. Functional support was also instrumental in changing documents to show the preferred gender and also included welfare agency support.

**Family and friends.** Kobe found that he gained help form his family particularly his mother:

*I guess my mum started to accept it a little bit and then was supportive in buying me clothes that I wanted to wear and allowing me to cut my hair short. Telling my dad about it because he was not as supportive as she was so she broke it to him* (Kobe).

Nerida had commenced working in a night club within the LGBT community and derived her first supports from within that community: *so I started to become famous with doing shows you know in the gay scene which lead me to meet my*
“mummy”, my drag mummy you know what I mean that ... she took me by my hand and took me to my first .. to have my first injection (Nerida).

Organisations and LGBT community.

Centrelink [Government- Income Support] were very good.... The passport office helped me out quite a bit.... I have my driver’s licence as female, I am registered as a female voter, I work as a female and the ATO [taxation office] refers to me as a female (Bella).

Natsha also got functional help on dressing and clothing:

I was going to a dress shop.... and I got to know the girl that works for her mother there and she is very accepting of it. You know she sells me the clothes she advises me.

Gail also received functional support from places like the [organisation name - A social club for cross dressers and their partners]

.... and the [organisation name] taught me how to dress and gave me my first confidence. I got the confidence to dress in public at the [organisation name].

Summary of Who Was in the Picture

There were many people who were in the picture when a transsexual was considering living in their preferred gender. Most people were helpful and provided a caring and accepting context for the transsexual to commence living in their preferred gender. In some cases where transsexuals approached health authorities for specific services they met with unhelpful professionals which hampered the transsexual’s use of such services. Emotional support appeared to be the one type of support that was discussed the most and this came from all sources. Emotional support also provided a
safe environment where transsexual experiences may be shared and conveyed the idea of being accepted by the broader community. Being accepted and being allowed to be transsexual was reported as being very significant and the LGBT community was noted as an important provider of acceptance even if the transsexual did not identify as gay or lesbian. Overall friends tended to be more helpful than family.

**Happy After**

Happy after relates to how the participants felt about themselves after they commenced living in their preferred gender. The coding was based primarily but not solely on their answer to the question “how do you feel now since you commenced living in your preferred gender compared to before?” Likewise if a participant said that friends or family saw them as happier now than before and the participant did not refute the claim then it was inferred that they were happy after. Therefore being *happy after* relates to a very specific dimension of happiness and an emotional state that was attached to their decision to transition. It also included whether or not the transsexuals felt that they had made the right decision to LPG i.e. expressed no regret. It did not relate to mental health diagnoses such as depression and anxiety that may have existed prior or commenced after the transition moment. It did not related to an overall sense of being happy with life in general.

All of the participants reported that they were better off since they commenced living in their preferred gender. None of the participants wished that they could go back to living in their birth gender and they all stated that commencing to live in their preferred gender was a good decision. There were no expressions of regret, or wishing they had not done it. Rather they talked about being “better off”, “this is me”, or “happy after”. There was overall a sense that life had progressed and was continuing to
progress. For some participants, being happy after was unconditional and they expressed “no concerns.” These participants expressed no regret since LPG and did not state that they had any ongoing or new concerns relating to LPG. Other participants, however, talked about depression, anxiety or other issues that could impact on their mental health. There were those who had specific mental health diagnoses before they commenced living in their preferred gender that carried over once they commenced LPG (“Mental Health Concerns”). There were also those who had social issues (“Social Concerns”) which included personal relationships as well as broader concerns such as discrimination and transphobia. The model depicting the categories is shown in Figure 13.

![Figure 13: The Categories of Being Happy After the Transition Moment.](image)

**No Concerns**

Nerida was very sure of the choice she had to make and knew what she wanted:

*It made me feel good as I started to transform...I felt this is me...this is me...... like I said everything just fell into place and came to me....I was content with how I was travelling, you know what I mean? The hormones kicking in, my work was of the highest standard as far as my boss was concerned, I was making money for them, you know what I mean?.......In*
my eyes .....you know this is how you can see the seriousness in me.....in
my eye you either wanted to be a women or not right. It's one or the other.
...My decision was already made for me when I was born.

Fatima also described being “unbelievably happy…….oh unbelievably. Yeah
unbelievably happy. It’s just the top of the world.”

Lyn also found life after her transition moment to be happy and content:

from then on I am a happy little bunny…….so basically it’s been good.
People that I dealt with before hand as a male and through my change and
now no change, no problems. I go to the same hair dresser [organisation
name] where I used to go as a male as a female. I am accepted. I get
looked at because I am 6’1” built like a Barn door. Nothing is ever said.
There hasn’t been any bad comments so I take it that I am accepted……..
Mostly people that I come in contact with have been 150% marvellous.

Bella was also happier since she had transitioned and found that it gave her
freedom: ...definitely, I am the happiest that I have ever been. I am and not
feeling fear of people in general and living and being able to live my life.

Enrique believed that after commencing LPG he was now congruent “...... in
my mind .... I’m now congruent. So it’s the congruency of it.”

**Mental Health Concerns**

Nigel, like the other participants with mental health issues, thought the most
important thing was that once they commenced LPG they were happier and everything
else was more bearable:
And the whole time even though my depression got really bad and I had serious self-harm issues and a serious eating disorder, but still that whole time I would still consider myself happier and more comfortable than I was before I came out as trans. Because even when I was miserable about myself and my physicality or you know hating myself for eating or something I was still comfortable with who I was and knowing I’m a boy.

Nigel comes from a family with a history of mental health problems which he recognises as a genetic predisposition. He stated that his mental health diagnoses were inter-connected and perhaps acted as precipitants whereby they activated each other.

my dad had clinical depression. I think my mum also has it but she would not go to see anyone about it. My sister has it. And I have it so there was definitely a genetic factor so I guess everything was lying dormant for a while and then suddenly everything happened at once, wow eating disorder, wow self-harm.

Nigel believed that in some ways his eating disorder was a response to the difficulties he was experiencing in trying to express his transsexual identity:

I guess my body shape. It was probably part of a manifestation of my physical dysphoria…but also in general I guess the way eating disorders happen it’s a sub conscious coping mechanism. Your brain can’t process what’s happening and it kind of retreats to a place and basically shuts down and it tells the conscious that everything is wrong and if I get this weight right then it will all be ok. So it shuts everything out and concentrates on the one thing. That’s probably my brain’s way of coping with all the transphobia because I was so happy and comfortable with who
I was and it was so frustrating to have the rest of the world hate me for something I had no say in. I was finally happy. I was finally coming out and accepting who I was and it was awesome.

Kobe also had diagnosed anxiety and major depression and was on medication for his depression. When asked he stated that he was happy for the first time in his life after he commenced living in his preferred gender.

Well prior to that time there was just um constant, constant days of unhappiness, my well-being was pretty much non-existent, just rare moments of happiness every now and then. I’ve never truly experienced being really happy or a true sense of self till after that. My well-being is something I had never felt before but it is really good…… just pretty much ecstatic joy. Just great emotion. Very very very good.

Nicole also had a diagnosis of depression and was on prescription medication for her depression:

I get depression and anxiety. Um I get anxiety attacks for no reason ..... my Psychiatrist said that because of the number of nervous breakdowns I had she believes it has created a biological deficit, neurotransmitter deficit which has actually caused ...... as a result of that I need to have continual anti-depressant treatments probably for the rest of my life

Social Concerns

Some participants found that once they commenced LPG they faced many social issues such as discrimination, transphobia etc. Others had personal relationship problems with their spouse or partner.
Nicole experienced many relationship problems with her partner that continued after she commenced LPG. The relationship problems centred around the difficulties with her partner after she was diagnosed with schizoaffective disorder. “XXX became very ill shortly after that. She stopped taking her medication um she has schizoaffective disorder and dissociative disorder. She stopped taking her Zyprexa and her anti-depressants.”

Nigel described a complex mix of emotions since he commenced living in his preferred gender. While happy to identify as transsexual he also was aware of the problems that transsexuals faced and therefore what he would have to endure as a result of his identity and coming out. Many of the issues Nigel mentioned were concerns about social and community aspects:

_Tumultuous. Volatile. Certainly happy to be able to live the way I felt but at the same time it opened up a whole other host of issues. I realised how few rights transsexuals have and the massive social stigma we face in living everyday lives…... Then I had to face the rest of the world like well this thing that is you that you are finally coming to terms with and it means that you are worthless. You are nothing. Obviously it was hard to go well that’s great…now I’m happy because of I am accepting of myself now I have to cope with the rest of the world instead.

Some of Nigel’s concerns came from people not knowing enough about transsexualism and therefore impacting on his journey. He believed that due to his young age people thought he was too young to know what was right for him.

_Um I think there is still a lot of ignorance and a lot of....just very condescending. I think there needs to be a kind of a lot more education in terms of how people, how gender identity works because a lot of people_
said you’re too young to make this decision, you’re too young to do this.

They did not understand that you can know from 4 years old

Even with supportive parents Nigel felt that the lack of education and knowledge about transsexualism impacted upon him:

“They [parents] are supportive of who I am, of my life and my need to express myself but they are not sure that they...have a different understanding and are naïve and a little bit ignorant about it.” (Nigel).

At times, Nigel feared for his life in social settings. He was unsure what the outside world would do should people find out that he was transsexual:

It’s really hard to leave the house sometimes in the morning and know... like 1 in every 12 trans people will be murdered. Or that every time I use the guys’ toilets that someone could just come shove me against the wall and grope me and find out that I am not that gender and would I be able to fight them off? What would happen in that situation? Would I get attacked? Sexually assaulted? And also tying in with a lot of the stress I received at my school. I lost a lot of the feeling of safety and security.

Nigel identified problems with educating people about transsexual issues:

I don’t know how well you can change the older generation because you know it’s not something they were brought up with..... The problem I guess with that is that is that the older generation influences the younger generation by not letting them.

Like Nigel, Raj recognised the “complexities” and “challenges” that sometimes can cause him to lose his sense of balance:
Happier...yeah absolutely... happier and there are more complexities involved. And there are moments I feel like the experience of being so far out of the norm can be very challenging and I have to work hard to stay grounded and I it can be a bit intense at times but I would not change it.

Summary of Being Happy After

The concept of being happy after they commenced living in their preferred gender was one that was experienced by all the participants. Irrespective of whether they had lived for many years making efforts to get to the transition moment or had had their transition moment fairly quickly, the overall feeling after was that of being happy after. Being happy after did not mean that everything in their life was happy and that they had no problems, being happy after meant that they had resolved for themselves the important problem of whether or not to live in their preferred gender. This gave them the strength to deal with the other challenges of life.

Other life challenges continued or presented themselves to transsexuals once they commenced living in their preferred gender. Some, such as the social challenges of discrimination and transphobia were directly related to their living in their preferred gender. However, the individuals felt that they could meet with these challenges and were prepared to deal with these challenges with the knowledge that they were being themselves.

For those who had dual diagnoses of other mental health conditions, resolving, accepting and living as a transsexual was reported as a significant step in their life. Once they identified as transsexual and resolved that issue by living in their preferred gender, they were then able to confront their other mental health diagnoses. For example, once
they were living in their preferred gender they could deal with being a transsexual who
was living with depression or anxiety.

Discussion

Issues in Method and Interviewing when Working with a Minority Group

The particular cultural aspects of the transsexual population made a significant
difference when conducting interviews for qualitative research (Hill, 2005; Kingsley,
Philips, Townsend & Henderson-Wilson, 2010). This section explores some of the
difficulties that were highlighted while conducting the research and what strategies were
implemented to overcome the difficulties.

The Use of Culturally Appropriate Terminology

Minority groups often have specific terminology which they use when
describing themselves within the group and outside the group. In the transsexual
community there is an ongoing debate on what is the most appropriate terminology
(Hill, 2005). The identifying label “transsexual” is itself debated. Some transsexuals
refer to themselves as being “transgender” and are offended by the term transsexual
while others find the reverse to be the case. Therefore in a research interview setting it
was important to be sensitive to these differences and be able to respond appropriately.
In this case I informed participants that I acknowledged and supported the different
ways in which transsexuals identified themselves. I further explained that I was using
the terminology contained in the research literature so that it was maintaining the
continuity and relatedness to the research literature.

The use of their gender appropriate name as well as gender appropriate pro
nouns also assisted in showing respect, sensitivity and acceptance. Strategies such as
these were important to ensure that transsexuals felt that their beliefs and views were important.

**Telling the Story versus Providing Depth**

Minority groups such as the transsexual population have often not had the opportunity to tell their stories to a professional. The stories of their unique experiences are often shared within the community with other group members and usually this occurs within informal social gatherings. It was noted early into the research interviews that participants were happy to tell their stories with little or no encouragement from me. While this was useful it meant that I had to be careful in probing in order not to interrupt the telling of the story but at the same time I did not want to risk missing out on valuable information due to the under use of probes or my attempt to overlay my structure on their story.

To achieve a balance between telling the story and probing deeper I began by outlining to each participant the format for the interview. I informed them that I wanted to hear their experiences and I was very interested in their story. I further informed them that I had some specific questions to help as a guide. I read out to them some examples of the questions and told them that at times I might interrupt their telling of the story to find more information on that part of the story. I asked if they understood what I meant and if they were all right with that. I then commenced the interview.

Another strategy for achieving this balance was having genuine respect for their stories and for their sharing of these very personal and at times painful stories. Because I was engaged with the participants as an active listener, when I did want to probe deeper or when a part of the story touched on an area I was particularly interested in exploring I was able to respond by saying something like…”that is interesting; could you tell me a little more about that or can we talk about that a little more?” This served
in validating their story and also achieving my goal of seeking depth. The semi
structured interview format together with strategic probes and the interview guide
enabled me to seek sufficient depth and clarity by ensuring I had some form of check on
where I wanted to be in each interview. At the end of an interview I would inform the
participant that I would check my guide and see if there was anything else I wanted or
needed to cover. I found these strategies helped me to achieve a balance between telling
the story and gaining more depth.

Psychological Perspective versus the Research Perspective: Where is the
Boundary: The Role of the Researcher

One of the challenges in conducting this study was the role of the interviewer. I
played dual roles as the interviewer and also the researcher. I am also an experienced
Clinical Psychologist. This was initially believed to be an asset due to my experience
and ability therefore to conduct interviews and establish rapport. Certainly my
experience was beneficial in recruiting participants and in establishing rapport. It was
also beneficial in sensitively working with a disadvantaged minority group. However
one problem that had not been anticipated was that being a clinician I at times found it
difficult to conduct interviews and remain an interviewer without at times falling into
the trap of wearing the clinician’s hat. The result of this was that at times I felt I was
intruding or felt the need to normalise behaviours and validate experiences. This meant
that in the initial interviews the transcripts had to be examined for content and to ensure
that what was required for the research was being explored and I underwent further
practice in the interviewing process.
The Transition Moment

The transition moment for these participants was a very specific moment or a very short period of time in which the person felt that they made the switch from their birth gender to their preferred gender. All 13 participants could remember clearly their transition moment and distinguish it from other experiences, even though the lead up to the transition moment was in some cases a long and drawn-out process. It was something that each person was able to respond to and give an answer to spontaneously. Additionally, they had vivid recollections of the transition moment. This was the case for all transsexuals who were interviewed irrespective of whether they had SRS or not. Also of salience is the fact that no one who had undergone SRS saw this as a marker of their transition moment.

These findings have importance to how concepts are defined and used by those discussing transsexualism. In many ways the research in the area has developed and identified concepts that do not appear to reflect the meaning of the transition moment from the perspective of the transsexual. Based on the medical model with SRS as an end point, the transition moment conceptualised in this way represents a physical change to the person’s body which, while possibly salient to some, seems to be imposed upon the transsexual. Based on the evidence of this study the achievement of living in your preferred gender, conceptualised as the transition moment, is varied and therefore must be assessed and understood from the transsexual’s perspective.

The transition moment for these transsexuals was not a physical moment of change as it is assumed in the triadic medical model. The physical appearance or change may have come much earlier prior to the transition moment for some and for some it came after the transition moment. The transition moment and the concept of living in your preferred gender was not a social transition either (Coleman, et al., 2011).
Participants were at various stages of social transition but considered themselves as living in their preferred gender. In some cases the person considered themselves as living in their preferred gender, even though they did not go to work dressed in their preferred gender.

The transition moment was more a psychological process. It was a moment that may have been characterised by an intense emotional response or it may have been triggered by a moment of discontinuity. The transition moment as expressed by this sample seemed to involve a process of giving permission or waiting till the moment was right. For some participants, permission came after an intellectual reasoning process. This was the case for those transsexuals who had experienced a discontinuity, for example the death of a spouse. In others, the moment emerged from a deep sense of desperation, an intense emotionally charged response. Regardless of the varied points where participants had their transition moment, what they all seemed to have in common was that they had reached a point where they were giving themselves permission to transition.

**Who Was in the Picture**

There were many people and organisations that were in the picture over the life of the transsexuals who were interviewed for this study. Because the impact people had were discussed by transsexuals as being helpful and unhelpful the term was referred to as *who was in the picture* rather than *social supports*. The reason for this was that the term “social supports” may imply that the social contact was positive. Who was in the picture were significant in this study in having an impact of the transsexual’s process of living in their preferred gender. Social support was also a significant predictor of mental health for transsexuals in the qualitative study. They were reported as being both helpful
and unhelpful. There was also similarity between what was helpful and unhelpful across all the sources of support.

Family was an important source of support. In some cases the support was more positive, particularly in those who were younger. This is perhaps reflective of greater familiarity with transsexualism through exposure to the media in recent years (Polat, Yuksel, Discigil, & Meteris, 2005). Regardless of whether the support was helpful or unhelpful family and family acceptance was a contentious issue.

Those who had contact with the broader community and contact with the LGBT community; compared to those who came from more closed and isolated communities such as small country towns or closed ethnic communities, or fundamental religious groups; had lower self-discrepancies and perhaps less emotional trauma. Though the evidence is inconclusive, there seems to be a connection between being isolated and having higher self-discrepancies and also in experiencing more intense emotional patterns in the transition moment.

Some found supports were unhelpful because they experienced “denial” where they were denied the right to live as a transsexual or be accepted as a transsexual. Social supports that were unhelpful also conveyed the idea of “dissuasion” where the person was dissuaded or forbidden to live as a transsexual by family. There were also unhelpful supports that were betrayal of trust or confidences. The unhelpful supports were a barrier to some in living in their preferred gender but they were able to overcome these obstacles in various ways either by isolating themselves from people who were unsupportive or separating themselves from situations that tied them down.

Transsexuals seek the services of health care professionals to assist them with a range of issues. However it was found that the support structures established by
government and other organisations in some cases failed them. The reported experiences of transsexuals with health care professionals show that many were ill-informed and did not know how to respond to the transsexual’s request for assistance. These professionals appeared to have no education in the area of treatment of transsexuals and often responded from a personal judgemental standpoint, rather than a caring, “do no harm” professional standpoint. Furthermore, they did not know how to refer appropriately to specific services that could assist the transsexual. Instead, transsexuals were denied a service, often judged and ridiculed and left feeling worse. Health professionals when they were sought out sometimes had a lack of basic knowledge and had erroneous information e.g. believing all transsexuals were cross dressers. Most often the failures occurred within the medical profession with GP’s and psychiatrists. Therefore this sample experienced great difficulty when accessing health care and this appears to be similar to the experiences of other transsexuals (Maguen, et al., 2005; Sobraiske, 2005).

The Concept of Passing

Passing was reported in the literature as being important to transsexuals despite them being satisfied with SRS (Carroll, et al., 2002; Rakic, et al., 1996b). Of the 13 people interviewed, passing was important to some and how others saw them was important to some. However, passing was not a universally felt or experienced concept in this sample. Some did not discuss it even though they had the opportunity to do so in interviews that lasted over an hour. The fact that two participants did not discuss passing does not mean that they did not think it was important. It may also have been the case that they found it too challenging and emotional a topic to discuss. One person found the concept of passing detestable. Linking passing to the concept of achieving gender congruence as it was looked at through the use of self-discrepancy theory and
measured by the self-lines measure in Study 2, the finding that passing was not universal to the sample is consistent with the finding that self-discrepancy was not a mediator for the sample in Study 2.

However, the participants who discussed not passing did so with highly expressed emotions such as fear, anxiety, and depression and even with emotions that were based on feelings of being physically attacked. There was also a sense of ambivalence with regards to passing or having to pass. On the one hand, being complimented for being feminine or being accepted in feminine roles appeared to make some feel pleased. There appeared to be some pleasure and relief when they received confirmation from heterosexual males that they possessed feminine qualities that confirmed their status as a woman (Docter & Fleming, 2001). However, this was also at times juxtaposed by the resentment felt by the very expectation that passing existed as a concept and resentment and anger that having to pass was considered important by some transsexuals. Therefore, passing as a concept was important both directly and indirectly. Some wanted to fit in with social expectations of their gender, or what Devor (1997) calls the “dominant gender schema”, and conform to the stereotypes of a binary gender norm (Devor, 1997). Others resented the fact that there was an expectation to pass and experienced ambivalence with regards to passing.

**Happy After**

All the participants reported being *happy after* commencing living in their preferred gender. Now that they were living in their preferred gender, they were happy with the decision. This did not mean that they were overall happy with every aspect of their life but they communicated being able to deal with the other challenges of life or any other mental health diagnoses that presented. Though some had diagnosed
depression or anxiety, this was not the main feature of their interviews. Despite the fact that I was a clinical psychologist, participants did not seem to use this opportunity to discuss their depression or anxiety with me. There was a definite separation between being transsexual and other issues or other mental health diagnoses. Transsexualism was the one concern that appeared to be most significant to the participants in having it treated or having it addressed. At times, being transsexual may have made them depressed and/or anxious, perhaps regarding failing to pass, but this did not seem to be pervasive depression or anxiety that caused significant impairment to daily functioning and resulted in a diagnosis of a major depressive episode or an anxiety disorder. These feelings appeared to be better characterised as a normal reaction to having one’s identity invalidated.

The finding that participants were happy with their choice to live in their preferred gender is important for developing treatment protocols. If the person is presenting as a transsexual requiring treatment and assistance with them being transsexual, it would be inappropriate to assume that they are depressed and anxious simply by the fact of being transsexual. It would be counterproductive to implement a treatment program for depression and anxiety simply because the person is presenting as a transsexual. Therefore, if they do exhibit symptoms of other mental health diagnoses it would be important not to assume that this is related to their transsexual diagnosis. Such assumptions may result in the person being treated only for transsexualism when in fact they wanted to be treated for depression and anxiety which they see as being separate from their transsexualism.

The DSM IV, however, does not see depression and anxiety as being separate from a transsexual diagnosis. The question of dysphoria and the inclusion of transsexualism as a mental health diagnosis connect the distress and the dysphoria with
the transsexual experience. Even if the depression and anxiety are connected to transsexualism it is important to firstly change the focus of the assessment and diagnosis from being reliant on the DSM IV criteria and instead have the focus from the transsexual’s perspective. It may be that anxiety and depression when linked to transsexualism may come from external sources rather than from the transsexual’s internal sense of being unhappy. This therefore has implications for practice.

Furthermore, in assuming that the person is depressed or anxious because they are transsexual it may also convey the message that the person feels that they are depressed, anxious and unhappy about being a transsexual and that therefore they have made the wrong decision in commencing to live in their preferred gender. This is particularly important with transsexuals who might present with many classical symptoms that might be seen as contributing factors of depression and anxiety such as being isolated, having no family supports, problems with employment and problems in relationships, violence and abuse. These should not be misdiagnosed as depression and anxiety when they represent particular features of the transsexual experience.
Chapter 7

General Discussion

This chapter provides an overview of this project. It incorporates a discussion of Study One, Study 2 and Study 3 and what they aimed at achieving and where they fit with regards to previous research findings. The implications of the study for theory, research and practice are discussed. Finally, the limitations of the project and the contributions it makes are also discussed.

Previous research into transsexualism has largely focused on samples who have presented at gender centres and clinics seeking SRS. These samples have therefore been biased towards those who have undergone medical transition with SRS as the end point (Cohen-Kettenis & Gooren, 1999; Karasic & Drescher, 2005). The findings of these studies report that satisfaction with SRS is high and regret after SRS is very low (Rakic, et al., 1996). Furthermore, some would argue that satisfaction with SRS can also be taken as an indicator of good mental health outcomes. In some cases mental health has been directly measured using various mental health measurement instruments, but these studies have not conclusively demonstrated improvement in mental health following SRS. Additionally, several empirical generalisations have been found regarding predictors of satisfaction with SRS and therefore of mental health (Gagne, et al., 1997; Lawrence & Zucker, 2012; Megeri & Khoosal, 2007; Rakic, et al., 1996). However, some research has suggested that while satisfaction with SRS may be reported as high, transsexuals may still experience distress with aspects of themselves that hinder their ability to pass in their preferred gender (Carroll, et al., 2002; Gagne, et al., 1997; Kando, 1972; Rakic, et al., 1996). It was therefore an aim of this project to explore the concept of passing through the use of self-discrepancy theory. This was achieved by exploring whether transsexuals’ perceptions of themselves and of how they see others
perceive them with regards to physical aspects of themselves in their preferred gender played a mediating role between the predictors from previous research and mental health outcomes (see Chapter 2). Passing was also explored through self-reports on their ability to pass and the personal importance of this.

For transsexuals who wish to undergo SRS, the pathway is relatively clear. There are three components in the process after a diagnosis and differential diagnosis has been completed. This involves hormone therapy, the real life experience (RLE), in which the transsexual is expected to live in their preferred gender for up to two years, and finally SRS (Coleman, et al., 2011; Myer, et al., 2001). There is an assumption that once the transsexual has completed this process that they have transitioned into their preferred gender.

In Australia a survey by Couch et al., (2007) found that of 253 respondents throughout Australia and New Zealand, 25.1% had been through SRS. The study sample included all people who identified under the umbrella of transgender which included those who identified as transsexual.

There are gaps in the research literature. Little is known about transsexuals who are living in their preferred gender and who have not followed the path of the medical model. Little is known about what constitutes living in your preferred gender apart from what is expected through the medical model.

The three studies conducted for this thesis attempted to address these gaps. To address the gap of understanding transsexuals who had not gone through SRS, a broader definition of transition was developed. All transsexuals who considered themselves to be living in their preferred gender were included in the sample irrespective of whether they had had SRS or planned to have SRS.
Study 1 sought to develop an assessment tool that would cover essential elements of the concept of living in your preferred gender. To achieve this objective, the Living in your Preferred Gender Inventory (LPGI) was developed. The LPGI was then utilised as an instrument in Study 2 and was further validated in Study 3.

The second study sought to test the concept of achieving gender congruence by utilising self-discrepancy theory as a conceptual framework (Higgins, 1987) and using the self-lines measure (Francis, et al., 2006) as an instrument to measure gender congruency. It was hypothesised that self-discrepancy would mediate between the predictors from previous research and mental health outcomes. Study 3 sought to explore from a qualitative perspective using in-depth semi structured interviews what is involved when a transsexual makes the decision to commence living in their preferred gender.

The results did not support the primary hypothesis. Self-discrepancy was not a mediator. Nevertheless, self-discrepancy was found to be a significant variable as an independent variable in a trimmed regression model when mental health outcomes were measured by the DASS.

The results of Study 3 showed that the moment a person commenced living in their preferred gender was salient for all participants in the sample. This finding provides useful information with regards to the phenomenon of transition that has implications for practice, theory and research. The study also showed that the need to pass was not universally discussed nor was it seen as important by all participants in the qualitative interviews. However, the finding that self-discrepancy was not significant in the quantitative study but that passing was important to many of the participants in the
qualitative study suggests that how transsexuals’ preferred gender identity is validated is important.

Of the predictors investigated in the trimmed DASS model, sexual orientation and age commenced were observed to be significant but not in the expected direction. Social supports was also found to be significant and in the direction hypothesised. Finally, post commencing living in their preferred gender, the transsexuals in this sample on average did not exhibit symptoms of depression, anxiety or other mental health distress irrespective of those who had SRS and those who had not. Individuals may have had other mental health diagnoses such as depression, anxiety, and substance abuse but they saw this as a separate diagnosis to their transsexualism. The low rate of mental health concerns was supported by Studies 2 and 3.

The LPGI showed that transsexuals differed in how they achieved living in their preferred gender. They had their transition moments at various stages, with for example, some continuing to work in their birth gender despite believing that they were living in their preferred gender.

Of particular significance was the fact that social supports were important in the process of living in your preferred gender. Additionally, not all behaviours in the LPGI which were modelled on the Standards of Care for the RLE (Myer, et al., 2001) were undertaken by all the participants prior to commencing living in their preferred gender. This was further supported by social supports being a significant variable in relation to the impact on mental health in Study 2 and it was further explored through asking participants “who was in the picture” in Study 3. Friends were found to be more supportive than family. SRS was not identified as a marker in commencing living in
preferred gender. This included those who had had SRS and those who proposed to have SRS in the future.

**Implications for Theory and Concept Development**

The concept of who is in the picture offers a unique way to assess who has been and is currently involved within the transsexual’s environment. Using the broader term of who is in the picture rather than social supports overcomes a problem associated with the term “support”, which may unduly focus on only the positive aspects of helpful social contacts. The Social Support Questionnaire explored only aspects of support that were helpful. Additionally, it explored how satisfied people were with the supports they received (Sarason, et al., 1983). This study has highlighted that who is in the picture includes individuals that have negative and unhelpful consequences on the transsexual’s life and their ability to make decisions associated with transitioning to living in their preferred gender.

Based on the findings of this study, the transition moment is possibly experienced by all transsexuals. It is also a very individual experience. It is a profound moment and one that involves great psycho-social change and adaptation. The concept removes the focus from trying to do something to the transsexual by way of treating the condition from a medical perspective and instead requires the willingness to engage in openness and understanding of the transsexual’s individual perspective. This knowledge together with an assessment tool such as the Living in your Preferred Gender Inventory is useful in developing assessment for treatment.

Even though the original model was not confirmed, identity theory is still worthy of further investigation as a model to explain mental health of transsexuals. Study 3 showed that passing was important and it has further being noted in the
literature as important (Edwards-Leeper & Spack, 2012; Nuttbrook, et al., 2002; Rakic, et al., 1996). However, while being noted in previous research, passing has previously not been anchored within a theoretical framework. The current study findings that self-discrepancy theory does not mediate mental health in transsexuals suggests that the distress transsexuals may experience in relation to passing may not be coming from within the transsexual, but from without, that is from social expectations.

The concept of passing reported by transsexuals in the qualitative study showed that overall transsexuals wanted to be accepted by the general community in their preferred gender. Therefore, future research may use passing as a mediator in the model rather than self-discrepancy. While self-discrepancy and passing complement each other in that they are anchored in a person’s identity, they measure different aspects of identity. They both look at self-discrepancy. However, self-discrepancy theory looks at the transsexual’s perception of them being gender congruent in their preferred gender. Passing is a broader concept which goes beyond the individual and significant others. Passing is based on what the general community perceives as being gender congruent. Future research might look at passing using such theories as social distance and measure passing based on what the general community upholds as important to pass. This will isolate the transsexual’s experience of distress as being either endogenous or exogenous (Devor, 1997; Edwards-Leeper & Spack, 2012; Rotondi, 2012; Tewksbury & Gagne, 1996; I. Wilson, et al., 2002).

The literature talks about SRS as being an endpoint in achieving preferred gender status and gender congruence in their preferred gender. The fact that no interview participants discussed SRS as a marker throws doubt on the usefulness of the medical model in the way that it is presently formulated. According to the findings in
the present project, even for those who had SRS, this surgery was not the point at which the person believed they were living in their preferred gender.

**Implications for Research**

These findings show that the DSM IV and the draft of the DSM 5 (American Psychiatric Association, 2011) do not reflect evidence like that found in this study and point to the need for further discussion on diagnostic criteria. The proposed changes to the DSM 5 in adding that the clinically significant distress could be pre-existing or the person could be at increased risk of experiencing clinically significant distress is an acknowledgement that transsexuals do not necessarily have to be clinically depressed to experience gender dysphoria (American Psychiatric Association, 2011). The whole area of transsexual diagnosis as a mental disorder with regards to whether it should be associated with dysphoria and depression is a controversial topic. The findings of this study may have bearings on this discussion.

Research is required on how the field defines and uses concepts such as transition, passing, mental health and who is in the picture. The current development of these concepts may be problematic in that they represent a restricted, narrow vision based on the perspective of experts. This may have the effect of forcing concepts into a template that may not be useful for the treatment and understanding of all transsexuals.

More research is required on what constitutes living in your preferred gender for transsexuals. This research needs to include all transsexuals irrespective of whether they have had SRS or not. The evidence of previous research as previously noted has been focused on those who progressed through the medical model of treatment with SRS as an endpoint. This study, within the limitations noted below, has provided evidence that being happy and commencing living in your preferred gender does not depend on SRS.
The findings of this study have shown that SRS is not the point at which transsexuals believe they are living in their preferred gender. This is not to say that SRS is not important or is ineffective. However, it suggests that SRS may be one among many strategies that transsexuals use to commence living in their preferred gender and the point at which a transsexual commences living in their preferred gender is individually determined by a number of factors. What these factors are and how they impact on a transsexual’s decision to commence living in their preferred gender will therefore benefit from further research.

The relationship between the transsexual and isolation from the broader community and the LGBT community and how this impacts on self-discrepancies and mental health is an area that warrants further research. It may be that the impact of being part of a broader community and the LGBT community may have protective consequences in relation to the concepts of the transition moment and mental health.

The concept of passing is an area that would benefit from further research as it was salient and was accompanied with a strong sense of identity validation and invalidation when it was discussed by some participants. Future research needs to adequately capture its meaning for the transsexual. More detailed information as to what constitutes passing and what impact passing or not passing has on the person would benefit the further understanding of this concept. The who, what, when, where and how of passing needs to be developed within a conceptual framework.

The effects of hormone therapy administered professionally and monitored and how it relates to passing may also be an important area of research. Additionally, hormone therapy and its effect on well-being would be a useful area of research. Hormone therapy may have negative and positive impacts on mental health and would
therefore affect how individual respond to measures of mental health and as reported by Gomez-Gil et al. (2012) not only do hormones affect mood but the length of time on hormones may also have an impact (Gomez-Gil, et al., 2012). Other studies have also reported positive effects of hormones (Gorin-Lazard et al., 2012).

Research into the influence of negative (unhelpful) and positive (helpful) supports overcomes the assumption that all supports are helpful. Research may be guided by questions that explore the source, the types and the impact of negative supports. Additionally, what can be done to assist transsexuals cope with negative supports may be a useful field of research. Edwards-Leeper and Spack (2012) are among the many researchers who have noted the importance of the acceptance of the transsexual by family, friends and the general community as a major contributor to the mental health outcomes of the transsexual (see also Maguen, et al., 2005; Rotondi, 2012).

Sexual orientation and specifically the sub type asexual/bisexual needs further investigation as it was the most common response in this sample and the findings that it increased scores on the DASS was inconsistent with previous findings. Future research may develop an understanding of how this attribute impacts on mental health outcomes after a person has commenced living in their preferred gender.

The age transsexuals commenced living in their preferred gender would also benefit from further research. Future research may look at why people who commenced living in their preferred gender when they were older had better mental health than those who commenced living in their preferred gender when they were younger. Additionally, the Australian National Survey of Mental Health and Wellbeing (2007) reports age as being a protective factor in the experience of mental health conditions (26.4% in 16-24
age group and 5.9% in 75-85 age group) for both sexes (Australian Bureau of Statistics, 2007). There may be a number of reasons for this age difference. As a person gets older they may have established relationships, supports and careers that they have proactively created or have sensitised the workplace to being more conducive to a transsexual lifestyle. This would then give them the support structure that most research has reported as being important for dealing with the changes of living in your preferred gender. Also as a person gets older their support structures, family and friends also have grown older and with this age there may be greater tolerance of transsexualism. Age may have resulted in greater exposure to transsexualism and with this may come an understanding and sensitivity to the issues. Another reason may be that the person has achieved many things in life, “life milestones”, and now feels that they are ready to take on the challenge of living in their preferred gender regardless of whether they have support or not. Being older the person may have the benefit of having being able to research transsexualism and therefore may be more prepared to deal psychologically with what is required to live in their preferred gender. The older a person is the more financially secure they may be and therefore they may be more willing to take the risk in living in their preferred gender knowing that if they had problems associated with their choice either in the workplace or in their personal lives they could afford to deal with it at least from a financial perspective. Additionally, after many years of reparative therapy where the transsexual tries to cure themselves, the older person may have reached a point where they realise that they no longer can sustain a life denying who they are. This was the case with a few participants in Study 3.

Apart from the predictors used in this study and in previous studies other variables need to be investigated. These include work and career aspirations, job satisfaction, being able to participate in health outcomes and how they impact on mental
health outcomes for transsexuals. Transsexuals in this sample reported experiencing problems in employment and also problems with health care professionals. These are common areas where transsexuals report difficulties (Clements-Nolle, et al., 2001; Sobraitske, 2005) and barriers to employment and health care can have repercussions on transsexuals’ ability to access such services. As noted by Maguen et al., (2005) employment is a particularly challenging experience for many transsexuals (see also Michel, et al., 2002). The Australian Survey of Mental Health and Wellbeing (2007) found that people who were employed had the lowest prevalence of mental disorders (Australian Bureau of Statistics, 2007) and the Whitehall II Study conducted in Britain found that workforce participation and being able to participate in health outcomes was also protective in mental health outcomes (Marmott, et al., 1997 see also; Marmott & Wilkinson, 2006).

Research that explores self-categorisation theory and social distance theory as a mediator may provide beneficial in understanding what mediates the predictors found in previous research with mental health. The findings of this project suggest that achieving gender congruence and passing in the preferred gender are important but the use of self-discrepancy theory and the self-lines measure was not shown to be the appropriate means to explore these concepts. Social distance may provide us with what are the social expectations of the transsexual from the general community and assist in developing strategies that influences a societal shift in values attitudes and beliefs. This is considered vital for transsexuals in order to decrease their risk of psychological distress (Edwards-Leeper & Spack, 2012).

Research into the existing knowledge base of health care practitioners would be valuable. This will give an audit of the knowledge and skills available and what is
needed to address deficits. It will also show how and where knowledge that does exist is acquired. This may provide a good base for future dissemination of education strategies.

**Implications for Practice**

**Clinical practice.** Transsexuals separated mental health problems and their social experiences, such as discrimination and transphobia, from how they felt after they commenced living in their preferred gender. All participants in the qualitative study reported being happy with the decision to transition. This has important implications for practice as it offers useful insight into planning treatment for transsexuals. Psychiatrists and psychologists may assume that any symptoms of depression or anxiety are due directly to the person’s gender dysphoria. However, this is not always the case (Rotondi, 2012). Transsexuals as noted in previous studies may see themselves as well adjusted and not pathological (Wolfradt & Neumann, 2001). Therefore the psychologist or psychiatrist needs to realise that any depression and anxiety symptoms described or observed may not be seen by the transsexuals to be associated with their transsexualism. Stringent assessment is required to verify if other symptoms are associated with transsexualism or are separate diagnoses requiring separate treatment protocols. It is also important to treat the person from the standpoint of the person and not just from the perspective of the mental health professional (Edwards-Leeper & Spack, 2012; Vitale, 2010).

It is often the case that therapists focus on the negative aspects of what transsexuals have been through and how this has affected their mental health. This is a normal process in identifying precipitants and risk factors in a psychosocial assessment (Groth-Marnat, 2003). However, clinicians would also do well to acknowledge the immense resilience, strength and experience in adapting to change and challenging
situations that transsexuals often experience. Maguen et al. (2005) give a good account of some of the social and cultural challenges that transsexuals have to face. These characteristics demonstrate how important the transsexual’s need is to live in their preferred gender and to what lengths they will go to fulfil this need. These positive characteristics may be a useful tool for the clinician in building the therapeutic alliance (Safran & Muran, 2006) and as a tool in therapy in acknowledging and empowering the individual transsexual. The therapist may harness these qualities that the transsexual has to develop a strong, positive relationship.

The LPGI may be an appropriate tool in assessing where a transsexual is in relation to living in their preferred gender. When a person claims to be living in their preferred gender but states on the LPGI that they do not engage in a particular behavior, e.g., going to work in their preferred gender, the clinician may then use this response to assess what might be preventing the transsexual from doing this and appropriately support the transsexual in achieving their goals.

**Education of health care providers.** Health care professionals within Australia and New Zealand need to develop knowledge about the treatment of transsexuals. Education of primary and secondary health care practitioners needs to be undertaken with broad and specific curricula covering the spectrum of issues and concerns for this complex condition (Centre for Excellence for Transgender Health, 2011; Meyer, 2001; Sobraiske, 2005). These include legal issues, psychosocial issues and psycho-medical issues. Additionally, education on detailed and open assessment methods which make no assumptions and use no “one size fits all” template is required. This needs to be based on established guidelines such as the Standards of Care of WPATH (Coleman, et al., 2011; Myer, et al., 2001) and competent clinical assessment (Feldman, 2003). Education also needs to be based on a client and individual focused intervention that
addresses and focuses on the needs of each individual and which are complemented by the clinician’s competence in the area (Edwards-Leeper & Spack, 2012; Vitale, 2010). This includes the use of appropriate language (Cauldwell, 1949; Listernick, 2003; Osborne, 2002; Van Houten, 2011), assessment of the needs for support, and assistance from people who might be in the picture and who pose a risk to the transsexual’s continued development and well-being. As Midence and Hargraves (1997) point out, the medical model that transsexuals have to rely on limits a client centered approach and therefore restricts our understanding of some of the psychosocial factors affecting this population. Furthermore, as this project has reported, many of the problems reported by transsexuals who are living in their preferred gender such as passing, employment, and social support would benefit from psychotherapy and counselling. This view is shared also by others who are well established in the field of transsexual research and practice (Cohen-Kettenis & Gooren, 1999; Midence & Hargraves, 1997). Practitioners also need to be confident in their approach to treatment with proper knowledge and skills and also know when and how to appropriately refer on.

**Ethical guidelines.** The development of ethical guidelines for the treatment of transsexuals within all health care professions such as psychologists, social workers, psychiatrists, doctors, nurses, occupational therapists and all other allied health care professionals is important. Ethical guidelines provide a framework for professional conduct and in their design and implementation they place transsexual issues on the agenda of these professional bodies and will define a commitment to professional practice. Clinicians need to be exposed to transsexual issues so that they may be sensitised to their specific needs and may be better prepared to provide interventions based on competence, and respect (Di Ceglie, 2000; Feinberg, 2001; Granucci Lesser,
1999). As reported by Rachlin (2002) transsexuals were appreciative of therapists who provided them with a care plan that was sensitive and respectful of their needs.

**Limitations of the Study**

**Measures.** There were limitations to the current study. First is the use of the self-lines measure as a mediator and the choice of physical characteristics to measure self-discrepancies. Future models may use other characteristics of gender congruence and identity validation such as job satisfaction or social distance (refer to discussion Study 2).

The current project did not analyse differences between ideal and ought discrepancies nor between transsexuals’ perceptions of themselves and their perceptions of what their significant others expect of them. In retrospect it may have been useful to analyse the ought and ideal and self and significant others separately. It may have also been useful to measure self-discrepancies from the standpoint of the general community. Perhaps transsexuals may have had higher discrepancies based on what they felt were the important physical attributes they needed to have for them to pass in their preferred gender from the standpoint of significant others and the general community. This may be related to perceptions of gender stereotyping (Carroll, et al., 2002).

**Sampling.** The sample may have been biased towards people who knew how to use the internet and who were proactive in seeking transsexual related content. Similarly, while some people could have found out about the research face-to-face, many learned about the research through posters in relevant agencies and relevant web links. This may have provided a biased sample of transsexuals who were engaged with the community and had a support structure and who knew how to use and had access to
the internet. Given that anxiety disorders and mood disorders include symptoms of the person not wanting to socialise or actively take part in daily life activities it may have excluded these people as they may not have found out about the research. It was hoped that using a web based opportunity to participate may have allowed for people who were isolated and or who were not engaged in the general community to participate but this may have not been the case.

The concept of saturation and what sample size can adequately provide saturation is still debated and the debate is inconclusive on what constitutes an adequate sample in qualitative research (Guest, Bunce, & Johnson, 2006; Marshall, 1996; Mason, 2010; Thomson, 2011). In Study 3 the sample of 13 participants may be an adequate sample for a qualitative study but it was difficult to achieve theoretical sampling to the extent that I would have preferred. This meant that I was unable to seek out people that may have further confirmed or refuted theoretical development. However, the sample in Study 3 did achieve redundancy in that the information being given and the concepts and codes being developed from the interviews reached a point where no new codes that were conceptually different were being developed.

**Model specification.** Since model specification was identified as a problem in the discussion in Chapter 5, the models developed for this study need further consideration. Other independent variables may be important predictors of transsexuals’ sense of gender congruence. Future research models may want to deconstruct what constitutes passing as a construct of gender congruence. There may be other features of passing that would be more appropriate than what was found using self-discrepancy theory.
**Method of Study 3.** Semi structured interview format may have limited the focus of participants’ way of recalling information from memory. Rather than allow participants to think openly and give all the information they wished, participants may have only given a limited range of information on some topic areas such as social supports in an effort to answer the question asked. The study may not have adequately captured all of the social supports that a transsexual experienced over their lifetime in living in their preferred gender. The social support question demanded that people give a response to what might have been in some cases a sixty year process. In responding, transsexuals may have been providing a mentally selected set of social supports rather than the full range of supports they received.

The study was retrospective. This could have influenced how participants viewed their past memories and the recall may have been less painful that was actually the case. This may have resulted in participants reporting a watered down rosier picture than was actually the case and therefore reporting being happy when they were not or stating that people were helpful when they were not. The recall may have been nostalgic rather than what was actually the case. Participants may have also have had problems in recalling as a result of lapsed time from when they commenced living in their preferred gender and the time of the study which would have affected the accuracy of what they reported.

**Contributions of Study**

To conclude, the findings of this study have made several contributions to the understating of transsexuals who are living in their preferred gender. First of all the study provided a unique conceptual understanding of transsexuals from a psychological
perspective in Australia and New Zealand. Such a study has not been conducted previously.

The study also used a unique model of participatory research that involved engaging the transsexual community in the research process. It also involved the development of a consultative committee comprised of transsexuals to provide input into the research. This enabled the research to be sensitive to the needs of transsexuals in Australia and New Zealand.

The study contributed a useful way to explore the concept of living in your preferred gender that expands the parameters of medical transition proposed in the medical model. This new model is inclusive of all transsexuals who may seek treatment but may not wish SRS as an endpoint. This is a move that is in the direction of the proposed changes to the DSM 5 which does not require transsexuals to seek SRS as the only diagnostic criteria (American Psychiatric Association, 2011).

The study also contributed a conceptual framework that used theory to explore the usefulness and validity of empirical generalisations found in previous research. It also used psychometrically reliable and valid tests to measure the variables in the model.

The development of the Living in your Preferred Gender Inventory provided a potentially valuable assessment tool for health professionals working with transsexuals. The qualitative study provided a rich understanding of the pertinent and complex issues of transition and passing from the perspective of the transsexual. Finally, from this project there are useful insights into how to work with transsexuals and what areas of research might further our understanding of the transsexual phenomenon.
Conclusion

Transsexuals are often viewed as abnormal individuals who live with a mental health diagnosis. Although research into transsexualism has often mentioned mental health, it has most often been linked with SRS satisfaction: the assumption being that satisfaction with SRS leads to the amelioration of mental health problems. This study found that most transsexuals who were living in their preferred gender had not undergone SRS, and most participants had mental health outcomes within the normal range regardless of whether or not they had SRS. There were no participants who had abnormally high mental health concerns.

This project’s aim was to understand the mental health of all transsexuals who are living in their preferred gender by applying self-discrepancy theory to the findings from a sample of transsexuals. Both quantitative and qualitative research designs were used.

The quantitative study tested a model which attempted to predict and explain mental health outcomes by using independent variables previously found to have predicted satisfaction with SRS. It was found that self-discrepancy and social supports were the strongest predictors of positive mental health outcomes.

Qualitative interviews with transsexuals confirmed the importance of these concepts and especially documented the importance of the relationship between self-discrepancy and passing and the overall feeling of being happy after they had commenced living in their preferred gender.

The findings of this project provide valuable information at a time of great debate on the inclusion of transsexualism as a mental health disorder in the DSM 5. The results will also be useful for future research and clinical practice.
References


Goldberg, J. (2006). *Care of the patient undergoing sex reassignment surgery (SRS).*


Preston, F. (2010). Transsexual sues over sack claims: Support worker says she was ousted for dressing as a woman, *Grimsby Telegraph*.


Toward a plain meaning approach to analyzing title VII: employment discrimination protection of transsexuals (2009).


APPENDIX A

Terms of Reference
Griffith University  
School of Psychology

Terms of Reference

“Griffith University, School Psychology, Transsexual Research Project Consultative Group”

**Date:**  April 2007- to – April 2010

<table>
<thead>
<tr>
<th><strong>1. Purpose:</strong></th>
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<tr>
<td>1.1 The purpose of this consultative committee is to provide a transsexual consumer focus to the PhD research which is culturally sensitive</td>
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<th><strong>2. Scope and Functions:</strong></th>
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<tr>
<td>2.2 * To provide feedback on terminology and research instruments (any other things???) used in the research to ensure it is culturally/ transsexual sensitive</td>
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<tr>
<td>* To assist researchers with advice regarding local transsexual community networks (both formal and informal)</td>
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<td>* To provide feedback and advice regarding strategies to recruit research participants</td>
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<th><strong>3. Membership:</strong></th>
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<td>- The committee shall be comprised of: Ashley van Houten and 2-4 members of the transsexual population who are willing to participate.</td>
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<tr>
<th><strong>4. Chairperson:</strong></th>
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<td>4.1 Ashley van Houten</td>
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<th><strong>5. Reporting Relationships:</strong></th>
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<tbody>
<tr>
<td>5.1 The research supervisors, Dr. Heather Green, Associate Professor Dr.Alfred Lizzie &amp; Dr. Jessica Grainger</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>6. Frequency of Meetings:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Every 2-3 months by Teleconference Link i.e. 4-6 meetings per annum.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>7. Quorum:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 May need to decide this at the first meeting.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>8. Agenda items:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1 It is expected that the Griffith University Research Team will generate a number of the agenda items to ensure agenda items meet the needs of the research project and aims of the consultative committee, however, additional agenda items relevant to the research project can be submitted by any committee member.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>9. Minutes:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1 Unconfirmed Minutes shall be disseminated to all members within 7 working days of the meeting</td>
</tr>
<tr>
<td>9.2 Minutes confirmed by the committee will be forwarded to all members.</td>
</tr>
<tr>
<td>9.3 The minutes shall be informal and record the general discussion of the committee members and the agreed outcomes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>10. Access to Information / Confidentiality:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1 It is acknowledged that the content and specific aims of the research and certain issues being examined are of a confidential nature, which will require members of the committee, to exercise tact and discretion and ensure any identifiable personal information will remain confidential</td>
</tr>
</tbody>
</table>
APPENDIX B

Living in your Preferred Gender Inventory.
Living in your Preferred Gender Inventory.

The Living In Your Preferred Gender Inventory is designed to see all the things a person did before and to the point at which they say “now I am really living as a man/woman”.

Here is an example of a question.

**did you engage in employment in your preferred gender?**

never         occas (up to 49%)         freq (50% - 99%)         always.         na

Below are some examples to assist your in answering the questions properly.

1. Person A always went to work in their preferred gender; always lived with their friends in their preferred gender; and also after a year occasionally lived in their preferred gender with their family; at this point they believed “now I am really living as a man/woman”. After this they commenced study full time.

They would answer ALWAYS to questions 2, 4 and OCCASIONALLY to question 5. They would however answer NEVER to question 3 “to what extent were you a student in your preferred gender?” because this occurred after the point at which they believed “now I am really living as a man/woman”.

2. A 40 years old person who lived as their preferred gender from an early age and at age 27 believed “now I am really living as a man/woman” would ONLY answer the survey according to all the things they did in living in their preferred gender until age 27 years and not from 27 years to 40 years.

Now think back to the time when you first began living in your preferred gender. Which of the following came BEFORE the point at which you believed **“now I am really living as a man/woman”**. In other words the questions below do not refer to what you have done up until now BUT rather what you did PRIOR to the point at which you believed **“now I am really living as a man/woman”**.
1. For how many years have you believed “now I am really living as a man/woman?” ______________ (number of years or NA = not applicable).

To what extent:

2. did you engage in employment in your preferred gender?

☐ ☐ ☐ ☐ ☐ ☐
never occas (up to 49%) freq (50% - 99%) always. na

3. were you a student in your preferred gender?

☐ ☐ ☐ ☐ ☐ ☐
never occas (up to 49%) freq (50% - 99%) always. na

4. did you live in your preferred gender with friends?

☐ ☐ ☐ ☐ ☐ ☐
never occas (up to 49%) freq (50% - 99%) always. na

5. did you live in your preferred gender with family?

☐ ☐ ☐ ☐ ☐ ☐
never occas (up to 49%) freq (50% - 99%) always. na

6. did you engage in general social activities such as going to a bar, the movies, going for a walk, going to the gym, shopping, etc in your preferred gender?

☐ ☐ ☐ ☐ ☐ ☐
never occas (up to 49%) freq (50% - 99%) always. na

7. did you engage in sexual activities in your preferred gender?

☐ ☐ ☐ ☐ ☐ ☐
never occas (up to 49%) freq (50% - 99%) always. na
8. (a) did you acquire a gender-appropriate name?
   Yes □  ➔ Go to Q8(b)  No □  ➔ Go to Q9

8. (b) did you change your name legally?
   Yes □  No □

8  (c) To what extent did you use your gender appropriate name on a daily basis?

□  □  □  □  □  □
never    occas (up to 49%)  freq (50% - 99%)  always    na

9. Did you undergo gender confirmation surgery?
   Yes □  ➔ Go to Q12  No □

10. Have you since undergone gender confirmation surgery?
   Yes □ (Go to Q12)  No □

11. Do you ever plan to undergo gender confirmation surgery?
   Yes □  No □

12. Did you begin hormone treatment?
   Yes □ FINISHED  No □ (Go to Q13)
   Thank you

13. Have you since undergone hormone treatment?
   Yes □ Finished Thank You  No □ (Go to Q 14)

14. Do you plan on having hormone therapy at some stage in the future?
   Yes □  No □
APPENDIX C

Web Site
Welcome

Are you a transsexual: that is were you born either male or female but believe that you are of the opposite gender? Then this research is of interest to you...read on.

The Transsexual population is a marginalised group that experiences significant disadvantage within society. Many are discriminated against at work, and in social settings, ostracised by family and friends; underemployed; and are subjected to abuse and violence. Constructive, well designed, representative research can assist the transsexual community to have access to more culturally sensitive professional services that will benefit the community in the long-term. However, research into the transsexual population is still in its early years compared to other areas of psychological research. While there has been much written on transsexual issues and some research in the area, there is a lot more we can do to understand and assist the transsexual community and the broader community in understanding the transsexual experience.
This research is being conducted as part of the requirements for a research Doctor of Philosophy (PhD) in Psychology at Griffith University, Gold Coast, Queensland by Mr. Ashley van Houten (refer About Us). This study will build on previous research into transsexualism. Furthermore, the study develops a theoretical framework to assist our understanding of the experience of transsexuals after they have commenced living in their preferred gender.

The results are expected to provide information that may guide the development of best psychological practice to understand the needs of transsexuals and in assisting transsexuals and significant people in their lives enjoy positive outcomes for the life they wish to live.

Participation is voluntary. Participants would be eligible for a draw of 6 prizes if you wish to provide your name and contact details for the draw. The prizes are 6 beauty packs containing a range of beauty products by Jansen Cosmeceutical from Germany and each valued at approximately $100.00 AUD. Please refer to research consent for details of terms and conditions.

Prizes are kindly donated by: Elke's Beauty Therapy at Shop 6 & 7, 150 Bay Terrace Wynnum. Brisbane, QLD. Tel: 07 339 66015

Eligibility Criteria

You are eligible to participate in this research if you are a transsexual who considers him/herself to be living in your preferred gender and you are an Australian or New Zealand resident. If YOU believe that you are currently living in your preferred gender, regardless of what others may think, then you are eligible to participate in the research. Living in your preferred gender can include but does not have to include gender confirmation surgery.

Some transsexuals have undergone surgery and some transsexuals have not had surgery. In this research we are interested in those who have not had surgery as well as those who have had surgery. The main thing is that you are currently living in your preferred gender.

Are you an Australian or New Zealand Resident?
Are you a transsexual?
Are you currently living in your preferred gender?

Thank you for reading. This research phase is now complete. Thank you to the participants for your valuable responses.
Are you a transsexual: that is were you born either male or female but believe that you are of the opposite gender? Then this research is of interest to you... read on.

The Transsexual population is a marginalised group that experiences significant disadvantage within society. Many are discriminated against at work, and in social settings, ostracised by family and friends; underemployed; and are subjected to abuse and violence. Constructive, well designed, representative research can assist the transsexual community to have access to more culturally sensitive professional services that will benefit the community in the long-term. However, research into the transsexual population is still in its early years compared to other areas of psychological research. While there has been much written on transsexual issues and some research in the area, there is a lot more we can do to understand and assist the transsexual community and the broader community in understanding the transsexual experience.

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Are you an Australian or New Zealand Resident?

Are you a transsexual?

Are you currently living in your preferred gender?

**Thank you for reading. This research phase is now complete. Thank you to the participants for your valuable responses.**

Gender Eyedentity 2011
About Us

Ashley van Houten

Ashley van Houten is a Clinical Psychologist registered in NSW and Queensland with many years experience working in the private sector and public sector on a range of sensitive issues, including child protection, adolescent development and adjustment, sexuality and HIV/AIDS. He is currently working in private practice with the adult population.

Ashley’s research interests are in the area of identity development, sexuality and sexual identity and in gender identity development.

Ashley is a member of the Australian Psychological Society (MAPS) and a member of the APS Gay and Lesbian Special Interest Group. He is also a member of the World Professional Association of Transgender Health (WPATH).

Ashley’s interest in transsexualism has developed over a long time. It began with his involvement with Theresius House (now the Gender Centre) in Stanmore in Sydney in 1985. In 1990 Ashley did a video interview for a psychology subject with a very close friend who was a transsexual. The aim of the video was to bring the transsexual experience into the realm of prospective psychologists to sensitise them to the needs of transsexuals.

Ashley has had many friends who are transsexuals and he has seen many transsexuals in his private practice as a Clinical Psychologist. Drawing from all these interests and experiences Ashley felt it important to do further research into transsexualism at a PhD level as there is very little study done in this area at this level.
Based on the research findings of his PhD, Ashley hopes to develop specific guidelines for Australian and New Zealand clinicians sensitising them to the needs of transsexuals.

Ashley has presented two papers at the International conference of WPATH in Chicago, Illinois, USA in 2007 and has presented at the Health In-Difference Conference in Brisbane in May 2007. He has also reviewed two books on transsexualism for the APS and he has held discussions with the APS about developing ethical guidelines for psychologists working with transsexuals.

Ashley and his partner of 22 years are both members of the Gay, Lesbian, Bisexual and Transgender communities (LGBT). When asked at an Australian LGBT conference what could be done for transsexuals Ashley stated among a list of other things, that he did not want the “T” in LGBT to always come last and to stand for tokenism.

**Supervisors**

Dr Heather Green is a lecturer at Griffith University and plays a key role as the principal supervisor on this research project. Dr Green has previously worked as a Clinician in Sexual Health and her research interests include gender identity, sex hormones and sexual orientation.

Associate Professor Alf Lizzio is the Head of School in the School of Psychology, and senior lecturer at Griffith University. Assoc Prof. Lizzio is the secondary supervisor on this research project and brings a wide range of both academic and work skills and knowledge to this project.
In Profile

Georgina Beyer

Georgina has been a member of the consultative committee for this research since 2006. She has been a firm supporter of the research offering her assistance in networking, and advice on cultural sensitivity and her own experience as a transsexual.

Georgina Beyer, né George Bertrand, is reported to be the first transsexual in the world elected to a national office. Even more noteworthy is that she was sent to the New Zealand Parliament by a mostly white, rural, conservative constituency that was aware of her background. It says a lot about the irrepressible politician whom everyone calls "Georgina." Georgina was elected first as mayor of Carterton and then in 1999 she was elected as the representative of the picturesque Wairarapa district, the country's largest. Georgina used her time in parliament as a voice for transsexual people.

Georgina tells her own story with her trademark candor and a sense of humour. She offers a level of sympathy for others and inspires people through the narrative of her life’s journey including her gender transformation. Georgina is eloquent, spontaneous, funny, and honest about her life and experiences. Georgina is invited around the world by heads of government to offer advice on public policy and as a keynote speaker at conferences on human rights and anti discrimination.

Shaun Menon
Shaun Menon has been an active member of the consultative committee since May 2007. He has provided invaluable feedback on various aspects of the research including cultural sensitivity, conference presentations and participant recruitment.

Shaun is from a culturally and linguistically diverse background and brings to the study his personal experiences as a transsexual man and also the knowledge of an honours Psychology graduate.
Research Information

Why is the research being conducted?

Please note that this research phase is now complete. Thank you to the participants for your valuable responses and cooperation.

Gender Eyedentity 2011
APPENDIX D

Research Flyer
Are you transsexual: that is were you born male/female and believe you are of the other gender?

This research needs you:

- Are you currently living in your preferred gender?
- Are you OZ or Kiwi Resident?

Then please be a part of this exciting and valuable research.

What you will be asked to do
If you agree to take part, you will be asked to fill in some surveys which will take about 60 minutes or less. I will also ask you if you will agree to take part in an optional interview which would take about 60 minutes. You may complete the questionnaires face-to-face or you have the option of completing them on line through a web site www.Gendereyedentity.net. All participants will be eligible for a draw of 6 prizes of beauty packs each worth approximately $100 AUD.

Thank you for your interest in my research and for your generous time in participating. If you would like any more information please call me on my mobile: 0403194566 or go to the web site: www.gendereyedentity.net

Ashley - Researcher:
Ashley van Houten BA MSc (Psych) M Psych (Clinical)
Clinical Psychologist
Member of the Australian Psychological Association (MAPS)
Member of the World Professional Association of Transgender Health (WPATH)
Registered Psychologist Current PhD Candidate
School of Psychology
Griffith University, Gold Coast
Email: a_vanhouten@griffith.edu.au mobile: 0403194566
APPENDIX E

General Information Survey
General Information

Please circle the most appropriate response

1. What is your birth gender?
   1) Male
   2) Female

2. What is your preferred gender?
   1) Male
   2) Female

3. How old are you?----------------------

4. What is the highest level of education you have attained?
   1) Less than year 10
   2) Year 10
   3) Year 12
   4) TAFE or equivalent
   5) University.

5. Prior to living in your preferred gender, were you sexually attracted to?
   1) Men
   2) Women
   3) Both men & women
   4) You were not sexually attracted to either men or women.

6. What is your current relationship status?
   1) Single
   2) Married/ De facto relationship
   3) Divorced/Separated
   4) Other (Please specify)__________________
7. What is your current employment?

1) Full-time  
2) Part-time  
3) Casual  
4) Unemployed  
5) Other (Please specify) ____________________

8. Are you currently studying?

1) Yes - Full-time student  
2) Yes - Part-time student  
3) No

9. Are you currently seeing a health Professional in relation to your transsexualism?

1) Yes  
2) No - Go to Q11

10. Which of the following health professionals are you seeing in relation to your transsexualism? (Circle all that apply)

1) A General Practitioner  
2) A Specialist  
3) A Psychiatrist  
4) A Psychologist  
5) A Social Worker  
6) Other (Please specify) ___________________________
11. Are you currently involved with a Gender Clinic?
   1) Yes
   2) No

12. Are you currently part of a transsexual support group?
   1) Yes
   2) No

13. What state/territory or island do you live in? (E.g. QLD for Australia or North Island for New Zealand)____________________

14. At what age did you begin to live in your preferred gender? _____

15. What was the language usually spoken in your home when you were growing up? ________________________

16. What country were you born in?____________________

17. Are you of Aboriginal or Torres Strait Islander descent?
   1) Yes
   2) No
   3) Do not know

18. Are you of Maori or Pacific Islander descent?
   1) Yes
   2) No
   3) Do not know
APPENDIX F

Depression, Anxiety, Stress Scale (DASS)
The Application of Self-Discrepancy Theory

The DASS21

Name: Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I found it hard to wind down</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>I was aware of dryness of my mouth</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>I couldn't seem to experience any positive feeling at all</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>I experienced breathing difficulty (e.g., excessively rapid breathing,</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>breathlessness in the absence of physical exertion)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I found it difficult to work up the initiative to do things</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>I tended to over-react to situations</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>I experienced trembling (e.g., in the hands)</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>I felt that I was using a lot of nervous energy</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>I was worried about situations in which I might panic and make a fool of</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>myself</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I felt that I had nothing to look forward to</td>
<td>0</td>
</tr>
<tr>
<td>11</td>
<td>I found myself getting agitated</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>I found it difficult to relax</td>
<td>0</td>
</tr>
<tr>
<td>13</td>
<td>I felt down-hearted and blue</td>
<td>0</td>
</tr>
<tr>
<td>14</td>
<td>I was intolerant of anything that kept me from getting on with what I</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>was doing</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I felt I was close to panic</td>
<td>0</td>
</tr>
<tr>
<td>16</td>
<td>I was unable to become enthusiastic about anything</td>
<td>0</td>
</tr>
<tr>
<td>17</td>
<td>I felt I wasn't worth much as a person</td>
<td>0</td>
</tr>
<tr>
<td>18</td>
<td>I felt that I was rather touchy</td>
<td>0</td>
</tr>
<tr>
<td>19</td>
<td>I was aware of the action of my heart in the absence of physical exertion</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(e.g., sense of heart rate increase, heart missing a beat)</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>I felt scared without any good reason</td>
<td>0</td>
</tr>
<tr>
<td>21</td>
<td>I felt that life was meaningless</td>
<td>0</td>
</tr>
</tbody>
</table>
APPENDIX G

Kessler Psychological Distress Scale (K10)
These questions concern how you have been feeling over the past 30 days. Tick a box below each question that best represents how you have been.

<table>
<thead>
<tr>
<th>Question</th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. During the last 30 days, about how often did you feel tired out for no good reason?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. During the last 30 days, about how often did you feel nervous?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. During the last 30 days, about how often did you feel so nervous that nothing could calm you down?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. During the last 30 days, about how often did you feel hopeless?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. During the last 30 days, about how often did you feel restless or fidgety?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. During the last 30 days, about how often did you feel so restless you could not sit still?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. During the last 30 days, about how often did you feel depressed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. During the last 30 days, about how often did you feel that everything was an effort?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. During the last 30 days, about how often did you feel so sad that nothing could cheer you up?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. During the last 30 days, about how often did you feel worthless?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
APPENDIX H

Self-lines Questionnaire
Self Lines Measure.

**Part 1** The Ideal You/Own.

The following items all refer to your physical characteristics as you would wish them for your preferred gender.

Physical characteristics include all visible aspects of your appearance e.g. facial features, mannerisms, voice, lips, beauty, and body language.

**Step 1: THE “IDEAL” YOU.**

Could you think for a moment about yourself and the Ideal you as it relates to your physical characteristics? Please use up to 5 words/short phrases to describe how you would ideally like to be in your preferred gender. Do not worry about correct spelling. Near enough is good enough.

1. ------------------------
2. ------------------------
3. ------------------------
4. ------------------------
5. ------------------------

**SELF LINES INSTRUCTIONS**

1. Now please write down the first attribute you wrote that you would ideally like to have here.

2. Now, please think of the opposite of that word and write it here.

**Step 2:** Now, please do this for all the words you chose for the IDEAL YOU in Step 1.
Part 2: The “Ideal You”/ Other.

**Step 1: SIGNIFICANT OTHERS**

Please think of 3 significant people in your life - Write down their relationship to you e.g. mother, partner, friend.

1. _________________________
2. _________________________
3. _________________________

**SELF LINES INSTRUCTIONS**

(1) Looking back at Step 1 Part 1 write down the attributes that you would ideally like to have here.

(2) Now, write the opposites of the attributes from Step 1 Part 1 here _________________________

Now, please complete the process for all the words you chose for the IDEAL YOU in **Part 1 Step 1** and for each significant other you wrote in the box above. You may abbreviate.

Significant Other 1 _______________

_________________  ___________________  ___________________  ___________________  ___________________  ___________________
Significant Other 2 ________________________

Significant Other 3 ________________________
Part 3: The OUGHT You/Own

The following items all refer to your physical characteristics that you believe you OUGHT to have for your preferred gender.

Physical characteristics include all visible aspects of your appearance e.g. facial features, mannerisms, voice, lips, beauty and body language.

THE “OUGHT” YOU.

Think for a moment about yourself and the physical characteristics you believe you OUGHT to have for your preferred gender. Write down up to 5 words/short phrases to describe the physical characteristics you believe you OUGHT to have.

1. -----------------------.
2. -----------------------.
3. -----------------------.
4. -----------------------.
5. -----------------------.
Now, please do as before and write the word and its opposite for the “OUGHT YOU” on the horizontal lines and mark the vertical line (with -) to indicate the location of what you are actually like right now. Do this for all the words.
Part 4: The OUGHT YOU/Other

Now, please complete the process for all the words and their opposites you chose for the
“OUGHT YOU” on page 4 and for the 3 significant others you specified in Part 2 Step 1.

Please mark the vertical line (with -) to indicate the location of what you think your significant others believe you are actually like right now.

Significant Other 1_____________________

- - - - - -
APPENDIX I

Consent Form
Self Discrepancy Theory applied to Mental Health Outcomes of transsexuals who are living in their preferred gender.

Who is conducting the research

Chief Investigator:  Scholar Investigator:
Dr Heather Green  Ashley van Houten
Lecturer, School of Psychology,  Current PhD Candidate
Griffith University, Gold Coast  School of Psychology
Ph: (07) 5552 9086  Griffith University, Gold Coast
Email: H.Green@griffith.edu.au  Email: a.vanhouten@griffith.edu.au

Why is the research being conducted?

This research is being conducted as part of the requirements for a research Doctor of Philosophy (PhD) in Psychology for Mr. Ashley van Houten. This study will build on previous research. Furthermore, the study develops a theoretical framework to assist our understanding of the experience of mental health distress in transsexuals after they have commenced living in their preferred gender. The results are expected to provide information that may guide the development of best psychological practice in treating transsexual clients. Participants would be eligible for a draw of 6 prizes if they wish to provide their names for a draw. The prizes would be 6 beauty packs containing a range of beauty products and each valued at approximately $100.00 AUD.

What you will be asked to do

If you agree to take part, you will be asked to fill in some questionnaires which will take about 60 minutes.
The instructions for each questionnaire are given at the beginning of each separate questionnaire. If you have any difficulties understanding what is required of you at any time or in any questionnaire, please do not hesitate to ask the researcher. In addition to the questionnaires the researcher is conducting interview and if you would like to volunteer to be interviewed by him please complete the details on the cover sheet giving your contact details. The interview will be confidential and will ask you about your experiences as a transsexual since you commenced living in your preferred gender. The interview will last for approximately 90 minutes.

The basis by which participants will be selected or screened

Participants will be included in the research if they are transsexuals who consider themselves to be living in their preferred gender. Transsexuals who do not consider themselves as currently living in their preferred gender will be excluded from the study as the study is focused on experiences post living in your preferred gender. A person will be considered as living in their preferred gender if the person identifies as overall currently living in their preferred gender.

The expected benefits of the research

It is anticipated that the research will be of benefit to the broader transsexual community by providing a profile of the Australian and New Zealand transsexual communities. There has been limited research on the transsexual communities in these two countries. Additionally, the results may assist in the development of a set of standards in relation to the psychological care of transsexuals and it may invoke further research in this valuable under researched area.

Risks to you

Some people may find filling in the questionnaires mildly distressing. The distress would possibly be similar to the distress you encounter when talking about your transsexual status to an understanding friend.
The questionnaires have been used in many previous studies and are usually found to be quite quick and easy to complete. If you feel in any way distressed during the completion of the questionnaires you may ask to stop and request to speak to the researcher. If needed, you may take a break from the questionnaire at any time. Please keep in mind this is not in any way a test. There is no right or wrong answers. Answer the questions honestly as they relate to you. You may take your time in completing the questionnaires.

If you at any time after completing the questionnaire feel distressed you may contact your local Sexual Health Centre, your local transsexual support group, the Gender Center nearest to you or ask your doctor for a referral to see a Psychologist.

Your confidentiality

Your confidentiality will at all times be respected. You are not required to provide your name or any other details that may identify you, No data will be collected that could identify you. All questionnaires are stored securely.

Your participation is voluntary

Your participation in this research is voluntary. You may stop at any time if you do not wish to continue.

Mechanism for distribution and return

The questionnaire will be given out at suitable venues where the participants can complete the questionnaires in comfort and in confidence.

Questions / further information

If you would like further information, please contact Dr Heather Green or Mr. Ashley van Houten.
The ethical conduct of this research

Griffith University conducts research in accordance with the *National Statement on Ethical Conduct in Human Research (2007)*. If you have any concerns or complaints about the ethical conduct of the research project you should contact the Manager, Research Ethics, Office for Research, Bray Street, Nathan Campus, Griffith University (ph 3735 5585 or research-ethics@griffith.edu.au).

Feedback to you

As no identifying information will be collected, it will not be possible to give feedback on individual results. A summary of the results will be available from the research team in when the research is completed. In addition feedback will be provided through national and international conferences, and the Gay, Lesbian, Bisexual and Transgender Press where appropriate.

Debriefing

Should you feel you need to be debriefed directly after the completion of the questionnaire please make your wish known to the researcher who will spend time debriefing you.

Expressing consent

If you fill in and return the questionnaire, you will be deemed to have consented to participate in the research. Please detach this sheet and retain it for your reference.

Terms and Conditions of Entry

1. When you enter the competition, you accept these terms and conditions of entry.
2. Members of the research team and their immediate family are ineligible to enter.
3. Entry into the competition is by:
   a. Placing a completed original coupon into the box marked “competition box” located at the front table.
4. The first six random drawn entries will receive each, a gift pack of beauty products valued at approximately $100 AUD each.
5. The decision of the University is final and no correspondence will be entered into.
6. The prize is not transferable and the beauty packs cannot be redeemed for cash. The prize is not refundable.
7. The winner releases the University from any and all causes of action, losses, liability, damage, expense (including legal expenses) cost or charge suffered, sustained or in any way incurred by the winner as a result of any loss or damage to any physical property of the winner, or any injury to or death of any person arising out of, or related to or in any way connected with the University or the prize.

8. Any winner drawn for the prize who is unable to fulfill all of these terms and conditions will forfeit the prize and another winner will be drawn.

9. The winner will be notified by email or phone by no later than a week after the draw.

10. The competition opens to entries at 9am 18th September 2009 and the competition closes at the completion of the study. The competition is drawn at Griffith University, Gold Coast Campus. You do not have to be present at the draw to win.

11. The prize will be posted to the winners after the draw if the winner cannot claim it in person.

Thank you for your time and for participating in this research.
APPENDIX J

Semi Structured Interview Questions for Study 3
Questions for Study 3.

**Italics=your talk**

**Regular type = question**

**Upper case = instructions**

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**Introduction:** I want to discuss with you a few things about your life in relation to your transsexualism. I want to look at your life from the point where you believed “now I am living as a man/women”. I want to discuss a few things that occurred before that point and a few things that came after. I want to let you talk freely and not direct you too much. Therefore I will only guide you at times with some questions. I will use your answers to the tests that you completed for me as my own guide at times. If there is anything you are not sure about just ask me. Do you have any questions?

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**Section 1: Process of Living in your preferred gender**

*I want to start by looking at the time when you believed “now I am really living as a man/women.”*

---

**Q** Looking at your inventory here you say you have been LM/W for XX years.

- **a)** What happened at that time to make you feel “now I am really living as a man/women”?

- **b)** Why was that a crucial/important time? – key moment-> consequences; reasons, why was that an important time; what did it lead to> transition as a specific event.

*I also can see from your inventory that prior to LPG you had come out to your (select appropriate group ) and eg changed your name at least informally*

- **c)** What, if anything, important has happened since you have begun living as a man/women?

   If said plan on having hormone therapy you might ask when
Section 2: Supports: and Barriers

Introduction: *Now I want to talk about some of the things that may have being helpful or unhelpful to you in the process of LM/W.*

Q2 What types of things did you find were helpful in the process of living as a man/women?

PROBE FULLY TO GET A COMPLETE LIST  DO NOT PROMPT

*Now I want to go back and find out more about each of the helpful things.*

Q2a How was (INSERT THING) helpful?

Q2b What were the results/consequences of having this helpful thing? What difference did this make (Ask question for each helpful thing)

Q3 What types of things did you find were not helpful or made the process of your LM/W more difficult? PROBE FULLY TO GET A COMPLETE LIST  DO NOT PROMPT

*Now I want to go back and find out more about each of the unhelpful things.*

(ASK QUESTIONS FOR EACH UNHELPFUL THING)

Q3a How was (insert thing) not helpful or how did this make the process more difficult?

Q3b What were the results/consequences of having this helpful thing? What difference did this make (ASK QUESTION FOR EACH UNHELPFUL THING)

1. Is there any indication that a supportive environment is necessary to begin and/or continue the process of living in your preferred gender? (LM/W).

2. Was being alienated from family and friends for a period of time important as a step?
What if any other support would have made it easier to LM/W?

IF AT THE END OF THESE QUESTIONS THE PARTICIPANT HASN’T MENTIONED SOME SUPPORT YOU ARE INTERESTED IN, PROMPT HERE.

EG I noticed that you have not mentioned anything about other transsexuals, family.

Q. What contact if any did you have with them.

Were they helpful non-helpful?

Section 3: Passing- Appraisals

Now I want to discuss with you how you feel and experience your preferred gender in public settings such as social settings, with friends, family and work. Research in transsexualism suggest that “passing” in your preferred gender is important. Can we talk about what your experiences of passing are?

Specifically:

Q7 What do you think about the importance of passing from your own perspective and your own experiences?

What are some of the consequences to you personally, socially and at work when you do pass?

and when you don’t pass?

Q8 How do you believe others see you as “passing” or “not passing” as a man/women?

FOLLOW UP

Q8a Are there some situations or some people with whom you find it easier to pass?

Q8a1 Why do you think this is?

Q8b Are there some situations or some people with whom you find it more difficult to pass?

Q8b1 Why do you think this is?
1. How important and relevant was passing in their preferred gender?

2. Was passing in their preferred gender particularly important with some people? And why?

3. Was passing in their preferred gender less important with some people? And why?

Section 4: Sexual Orientation:

*I now want to discuss your sexual experiences if that is ok with you? I don’t want to know what you did etc but more about what they felt like to you and how you viewed them.*

Could you tell me about your first sexual experience? What were you feeling and thinking at the time? NOTE: try to bring out what gender the sexual partner was.

How did you think at the time of the experience in terms of your sexual orientation?

Did you see yourself as a man/man/women/women having sex with a women/women/man/man. How would you define or classify your orientation during this time?

PROMPT IF NECESSARY: homosexual/heterosexual/bisexual?

Was that before the time you believed “now I am living in my preferred gender”?

How have your sexual experiences evolved since you commenced living in as a man/women? Note: try to bring out what gender the sexual partner was.

How would you define or classify your orientation during this time?

Section 5:

The following questions are only guides for the researcher. They are to be used as a check list guide rather than as direct questions.

More direct questions to be asked at the end (if necessary). To be discussed- Most of these would have to be asked in an indirect way so as not to lead or prompt.
1. Do they consider themselves as a normal man/women.
2. What is normal for them.
3. What other factors do you consider important at the beginning of the process of LM/W.
4. Are there things that seem to facilitate the process? E.g. research etc.
5. Are there things that seem to stifle the process?
6. How do you think about your past life?
7. How do you feel about your past life?
8. How do you think about your birth gender?
9. How do you feel about your birth gender?
10. Was the ending of your birth gender like a death of that person?
11. Was the new gender like the birth of a new person?
12. How do you feel about your gender now?
13. Do you see yourself as a man/women?
14. Do you see yourself as a transsexual man/women?
15. Do you see yourself as transsexual?
16. Did they feel at any stage that they lived in their preferred gender, then reverted to their birth gender?
17. Did gender reversal occur frequently?
18. What caused gender reversal?
APPENDIX K

Nvivo Codes Developed in Study 3
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Gender: 0
Female: 0 male:
Gender Identification: 0
Female or Woman: 0
Male or Man: 0
Trans: 0
Transman: 0
Transwoman: 0
Image: 0
Appraisal by others: 0
Sel-appraisal: 0
Self appraisal (others): 0
Life Stages: 0
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**Physical Characteristics**

1. Body
2. Face
3. Mannerisms
4. Passing
5. Physical Presentation

**Physical Strategies & Changes**

1. Natural Body Change
2. SRS
3. Taking Hormones

**Reality Shock**

1. Bisexual
2. Heterosexual or Straight
3. Homosexual or Gay or Lesbian
4. Queer

**Sexual Orientation**

1. Bisexual
2. Heterosexual or Straight
3. Homosexual or Gay or Lesbian
4. Queer

**Social & Psychological Strategies & Tactics**

1. Apeasing
2. Being True to Self
3. Coming-out
4. Committing
5. Defying
6. negating
7. Relapsing
8. Renouncing
9. Reparating
10. Resisting
11. sorting self out
12. Submitting
13. Suicidal Ideation
14. Validation