Transgender: A study of quality of life

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ABSTRACT

This research presents a new way to improve inclusiveness for the variety of transgender self-identities in clinical settings. The spectrum of transgender identities were clustered into two groups: the *fixed* – representing transgender individuals who preferred identification with the gender binary male or female, and the *fluid* – representing transgender individuals that favor openness and flexibility on the gender continuum. Furthermore, different scales, the Memorial University of Newfoundland's Scale of Happiness (MUNSH) (Kozma, & Stones, 1980) and Bradley's Well-Being Scale (BWB) (Bradley, 1994), Self-Confidence Scale (Oakley, 1996, 1998) and Perceived Stress Scale (PSS) (Cohen, 1994) were investigated for their reliability with transgender clients. The fixed and fluid transgender groups were then used as the key criterion for investigating differences in quality of life (QOL), self-confidence, stress and counselling satisfaction. Using combined quantitative as well as qualitative methodology, data was analyzed for a sample of 145 transgender people. Mean age was 42.27. Quality of life for the fluid transgender group was <extremely low,> the group difference was not significant. Stress was expectedly very high in both groups, but interestingly self-confidence was also high. The mean difference between the fixed (M=17.44) and fluid (M=20.82) transgender groups was statistically significant. One in four transgender individuals identified either as <neutral> or <dissatisfied to very dissatisfied> with their counselling experience. The dissatisfaction was higher in the fluid transgender group. One hundred eleven transgender participants (111) completed seven open-ended questions and 11 participated in a semi-structured, face-to-face interview process, guided by thirteen questions. The stories of the participants demonstrated how a gender specific upbringing affects transgender individuals through: themes of shame, guilt, and anger. While, transgender individuals developed survival techniques such as daydreaming and fantasizing, negative coping methods such as alcohol abuse, drug abuse and self-harm were also common. Family was identified as the dominant factor in reinforcing gender appropriate behaviour. To improve clinical care these findings should be taken into consideration.

RÉSUMÉ

La présente recherche expose une nouvelle façon d'améliorer l'inclusivité des différentes autoperceptions des transgenres dans des conditions cliniques. Le spectre de l'identité transgenre a été regroupé en deux groupes : la catégorie *fixe* – transgenres qui ont préféré s'identifier selon la séparation binaire (homme ou femme), et la catégorie *fluide* – transgenres qui préfèrent l'ouverture et la flexibilité pour s'identifier à l'éventail des identités transgenres. En outre, différentes échelles de mesure, notamment la Scale of Happiness de la Memorial University of Newfoundland's(MUNSH) (Kozma et Stones, 1980), la Well-Being Scale de Bradley (BWB) (Bradley, 1994), la Self-Confidence Scale (Oakley, 1996, 1998) et la Perceived Stress Scale (PSS) (Cohen, 1994) ont été examinées afin d'évaluer leur fiabilité dans le cas des clients transgenres. Par la suite, les catégories fixe et fluide groupes ont servi de critère principal pour examiner les différences sur le plan de la qualité de vie (QOL), la confiance en soi, le stress et la satisfaction à l'égard des services de counselling reçus. À l'aide d'une méthodologie autant quantitative que qualitative, les données issues de l'étude d'un échantillon de 145 transgenres ont été examinées. La moyenne d'âge des participants était de 42,27 ans. La qualité de vie des transgenres de la catégorie fluide était « extrêmement basse », tandis que la différence entre les deux catégories n'était pas significative. On prévoyait que le stress serait extrêmement élevé, mais de façon intéressante, nous avons constaté que la confiance était élevée elle aussi. La différence moyenne entre la catégorie fixe ($M = 17,44$) et la catégorie fluide ($M = 20,82$) était significative sur le plan statistique. Un transgenre sur quatre s'est identifié comme étant « neutre » ou « insatisfait à très insatisfait » à l'égard des services de counselling reçus. L'insatisfaction était plus élevée dans la catégorie fluide. Cent onze participants transgenres (111) ont rempli un questionnaire composé de sept questions à réponses libres et 11 ont participé à des entrevues en personnes non structurées, orientées sur 13 questions. Les récits des participants ont mis en évidence l'incidence de l'éducation en fonction du sexe sur les transgenres, laquelle les amène à ressentir plus que les autres de la honte, de la culpabilité et de la colère. Bien que les transgenres aient développé des mécanismes de survie, comme les rêveries et l'affabulation, des méthodes d'adaptation négatives, comme l'abus d'alcool et de drogue et l'automutilation, sont courantes. La famille a été identifiée comme l'un des facteurs dominants du renforcement des comportements propres à chaque sexe. Pour améliorer les soins cliniques, on doit prendre en considération ces conclusions.

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Chapter 1

Debates and challenges in working with transgender individuals

Overview

My interest in conducting research in the area of transgenderism was initially influenced by having been raised in an environment in which transgenderism and homosexuality was part of my family experience. This awareness later developed into my clinical counselling practice as a social worker in which 80% of my clientele are transgender. Through my professional involvement with transgender clients, I realized that in order to provide transgender clients with appropriate treatment, the community of healthcare professionals and counselors needed to increase its knowledge of transgenderism. Within this context, I feel it is especially important to further existing knowledge of the impact a socially constructed gender binary has on transgender individuals' gender identity development, quality of life (QOL), psychosocial stressors and medical needs.

In order to do this, clinicians need tools to measure QOL, stress and self-confidence of transgender clients. These tools have to be reliable and easy to use in the clinical setting. Additionally, while acknowledging the vast diversity that exists on the gender–sex continuum, we must make the distinction between transgender individuals who make use of the gender binary and those who require gender fluidity. A variety of gender identity expressions come together under the transgender umbrella. However, the current typologies and terminology used to refer to transgender people by healthcare professionals lacks inclusiveness, 'fitting

individuals into a rigid concept', which does not take the variety of gender identity expressions into consideration (see diagnostic typology and views in this chapter). The commonly used typologies too often consider only transsexuals, individuals who transition with the help of hormone-replacement therapy (HRT) and sex-reassignment surgery (SRS). In addition, the aforementioned typologies do not acknowledge new transgender identities (i.e., bi-gender, cross-gender, transgendered 24/7 without HRT) which leads to misdiagnosis or refusal of treatment (Denny, 2006).

A significant difference between the older terminology and the one used for this research was achieved by clustering a variety of gender identities into two groups – fixed or fluid – creating a more inclusive typology for clinical use. The fixed transgender group included: transgendered 24/7 without HRT, transgendered 24/7 with HRT, transsexual (pre-op), transsexual (post-op); the fluid transgender group was composed of: cross-dresser/cross-gender, bi-gender, gender-bender, androgynous, gender questioning, drag-king (gender-questioning), drag-queen (gender-questioning). The fixed cluster includes transgender individuals who prefer the explicit category of either male or female within a gender binary, while the fluid group prefers a fluid interpretation, in which gender is experienced as potentially flexible and on a continuum.

Understanding the difference is for the benefit of both healthcare clients and healthcare professionals (general healthcare practitioners as well as mental healthcare practitioners). My clinical knowledge, which emerged from years of

experience of working with this population, is that treatment too often is based on fitting the client into a rigid concept of a medical diagnosis. However, treatment should be based on harm reduction which is client-centered, therefore, it is imperative to understand the difference between the fixed or fluid transgender groups in order to facilitate decisions on appropriate treatment modalities.

The intention of this study is to help clinicians improve their understanding of the vast variety of gender identities that exist and the different requirements these clients have. Understanding the diverse transgender client's needs is important but clinicians also require reliable tools to determine QOL, stress and self-confidence to be able to measure treatment outcome. The outcome of this research is important for both transgender people and healthcare providers.

Research Questions and Objectives

In order to help both healthcare clients and healthcare professionals, the research identified several problems. The current nomenclature, terminology, and diagnostic labeling of transgender clients often leads to misdiagnosis and refusal of appropriate treatment, therefore, a more inclusive typology is required. Creating a more inclusive typology for clinical use was achieved in this study by clustering the spectrum of transgender identities into two groups – fixed or fluid – for the basis of comparison. This division permits a more in-depth understanding of the differences within transgender individuals. For this research the key criteria was the difference in transgender self-identity (fixed or fluid transgender groups) which was the key criterion used in all of the analysis.

The objective of this research is to understand how relating to a transgender identity as either fixed or fluid can influence the way someone seeks and responds to services such as counselling. It also influences decisions on appropriate treatment modality and ultimately on the failure or success of treatment outcome. In order to pursue this objective a variety of transgender identities, which are found under the transgender umbrella, had to be divided into two groups – fixed or fluid (see Table 1).

The contemporary term 'transgender' has become an 'umbrella' term that is used to describe a wide range of identities and experiences (Currah and Minter, 2006). At the same time, it is more commonly used in advocacy and "ultimately, *transgender* refers to a collective political identity" (Currah and Minter, 2006, p. XV). In contrast to this, is the medical/psychiatric understanding of transgender, which resulted in many different typologies (more on typologies can be found in this chapter, the *DSM* diagnosis can be found in different sections throughout the thesis). Denny (2006) recognized that the medical typologies resulted in a narrow definition based on a stereotypical notion of masculinity and femininity, clearly representing the gender binary. Over the years, the existing, diagnostic labeling according to the gender binary allowed too many misdiagnoses or refusals of treatment of gender variant clients that did not meet the clear cut definition of transsexual (Denny, 2006).

For many years transgenderism was viewed as deviant (McKenzie, 1994). This point of view later changed and transgenderism was viewed as a medical issue that could be divided exclusively into two categories, 'transsexuals and transvestites'

(Benjamin, 1966). In 1989 Blanchard, coined the term autogynephilia. In 2000 some started recognizing gender as a continuum which is due, in part, to new labels created by transgender individuals who have increasingly popularized self–descriptive terms, challenging the capacity of the overarching categories of 'transsexual' and 'transvestite' to encompass the multiplicity of emerging identifications (Cole, Denny, Eyler, & Samons, 2000).

However, viewing transgender as a continuum has not reached the current nomenclature, terminology, and diagnostic labeling of transgender clients, excluding transgender individuals who do not fit into the rigid concept of diagnostic labels. This is what makes clustering the spectrum of transgender identities into two groups – fixed or fluid – so important. Even though there are only two groups, each of the groups includes a variety of gender expressions, demonstrating flexibility and inclusiveness.

Lev (2004) and Meyer et. al., (2001) found that transgender people did not trust counselors, therefore transgender people's levels of satisfaction with counselling experiences needed to be investigated. The difference between this and other research was to determine whether there was a difference in counselling satisfaction between fixed and fluid groups of transgender people. As previously stated, understanding the difference between the two groups can influence the way someone will seek and respond to clinical services such as counselling.

Failure or the success of treatment outcome is also influenced by how much we know about difference in QOL between the fixed or fluid transgender groups.

Treatment can only be successful if we acknowledge broader psychosocial and environmental factors such as stress, daily functioning, social situations, self-confidence, life satisfaction, past traumatic experiences and depression. The aforementioned are clearly issues that affect transgender peoples' QOL. Consequently, investigating the difference between the – fixed or fluid – transgender groups QOL, stress and self-confidence was important.

My clinical experience is not only that the fixed and fluid transgender groups need different treatment, but also if the selected treatment modality is client centred the treatment outcome will be successful. Bockting et. al. (2006) suggested that in any treatment clinicians have to consider the clients QOL in order to engage them in the therapeutic process. Bockting et al. (2006) found that "[w]hen there are multiple co-existing mental health concerns, a staged approach is recommended that begins with the issue that most negatively impact the client's quality of life and/or ability to engage in treatment" (p. 58). Therefore, all the aspects of a client's life (i.e., upbringing, traumatic events, stress, self-perception) have to be taken into consideration. Understanding what and if there are differences between the two groups is important for clinical management, to engage the client in treatment and final treatment outcome.

Diagnosis and treatment has to be evidence-based, therefore clinicians need proper tools to establish suitable treatment modalities. The tools need to be reliable and easy to use in the clinical setting. For that reason, it was important to identify an appropriate scale to measure QOL among transgender clients. In this research, both

the Memorial University of Newfoundland's Scale of Happiness (MUNSH) (Kozma, & Stones, 1980) and Bradley's Well-Being scale (BWB) (Bradley, 1994) were tested in order to determine which one would demonstrate higher reliability in measuring QOL among transgender people. The scale that proved most reliable was used to examine what differences exist between the fixed and the fluid transgender groups' QOL. Group differences were examined through quantitative questionnaires relating to demographics and QOL, self-confidence, and stress (see Chapter 6).

The final part of the research was to offer participants an opportunity to talk in length about their life experience, gender pressures and traumatic events they experienced in childhood, adolescence or even as adults. Difficult life experiences influence self-confidence and often create stress which has an impact on transgender individuals' QOL. Bockting, Huang, Ding, Robinson, & Rosser (2005) found that transgender people have less family support which influences their QOL and it is important to address these issues in the treatment process.

To this end, I chose to employ a mixed method of quantitative and qualitative approaches. Barbour (1998) suggested that using a multimethod study is often a pragmatic one in that it recognizes the incomplete view of using only one method over the other (see Chapter 5 section: multimethod research design). Qualitative and quantitative approaches have different epistemological, ontological and methodological supporting means. Even though this is an issue which often created conflict, I used both methods to compensate for any shortcomings the different methods might have. Moreover, using only one type only might provide us with a

partial view of the phenomenon under investigation, especially since this study is clustering the spectrum of transgender identities into two groups – fixed or fluid – for the basis of comparison was not done before. Gaston & Marmar (1989) recommend qualitative studies to establish patterns of events that create distress that influence treatment outcome. Awareness of specific events that may affect a transgender client's life by creating distress or influencing self-worth might help in the therapy process and further increase the transgender client's QOL. More on the issue of multimethod study designs will be discussed in Chapter 5.

Research Goals

The research addresses some problems in the field of transgender care: the most commonly used clinical typologies are too narrow. Therefore, this research suggests another, more inclusive approach that clusters the different transgender identifications into fixed and fluid groups. The suggested grouping allows clinicians to be more inclusive, yet to make a clear distinction between the groups, since treatment should be based on harm reduction and be client centered. Quality of life improvement is an important measure for treatment success. As such, another goal was to find an already well known and reliable QOL scale which is reliable in measuring transgender peoples' QOL as well as being easy to use in a clinical setting. This scale was then used to determine if a difference exists in QOL between fixed and fluid transgender participants. Self-confidence and stress between the fixed and fluid group were also investigated.

Participant's narratives were used to identify common threads of experiences, which were identified in previous research (Lombardi et al., 2001; Bockting et.al., 2005) as negatively impacting transgender individuals QOL, lowering their self-confidence and increasing their level of stress.

Some findings might warrant further investigations while others might be important to acknowledge in therapy to improve transgender individuals' QOL.

Finally, since transgender knowledge is often left out of the social work curriculum, the last goal was to make some recommendations on how this topic could be included, emphasizing the importance of teamwork between healthcare professions, the need for further research and recognizing the social vulnerability among the fixed as well as the fluid transgender group.

Diagnostic Typologies and Views

Both academic study and the professional practices that deal with transgenderism have been subject to fierce debate on typologies and the terminologies used to refer to transgender people. Diagnostic terminologies addressing transgenderism have varied through time and across cultural settings, often creating increased confusion and disagreements among healthcare practitioners. However, according to the standardized diagnostic nosologies (*DSM IV-TR*, 2000), clients must be labeled (*DSM IV-TR*, 2000) in order to provide them with the required eligibility criteria for treatment.

A wide variety of gender variations and terminologies can be found under the transgender umbrella, a state of affairs clinicians often find very confusing.

Individuals identifying themselves as transgender, cross-dresser (CD), transsexual (TS), hermaphrodite–intersex, bi-gender, androgynous, gender questioning, or transvestite (TV) approach clinicians requesting assistance in dealing with their internal (self-acceptance, psychological/emotional) as well as their external (acceptance by society) gender struggles. Ettner (1999) found that "clinicians in practice today face many challenges in providing care for this population" (p. xiv). Challenges include: assessment, finding appropriate treatment modalities as well as resources.

An added issue for clinicians and transgender people alike is the new trend toward self-diagnosis among transgender people, which occurs for several reasons. One is that there are not enough therapists available who are equipped to deal with transgender clients and their specific needs of assessment, counselling needs, for HRT and/or other transgender related issues. As Lev (2004) identified, transgender people do not trust health care providers. As such, some might avoid health care professionals out of fear of discrimination, of not being taken seriously by therapists and/or of having their requests for help refused. In my clinical experience, self-diagnosis too often leads to self-medication, with individuals sourcing and purchasing hormones from the internet before finally finding a therapist whom they can trust. Importantly, self-administering hormone treatments can be very dangerous if not medically monitored and controlled.

Constantly changing diagnostic typologies lead to difficulties in the clinical assessment process of transsexual, cross-dresser or transvestic fetishist, which is

important since this diagnosis determines decisions for appropriate treatment such as: psychotherapy, hormone-replacement-therapy (HRT), sex-reassignment surgery or working on self-acceptance of fluidity.

Classification and re-classification is not a new practice. Over the years, new terms for and classifications of transgenderism have been introduced. Hirschfeld (1910) established the term transvestism, whereas Prince (1997a) promoted her notion of the heterosexual cross-dresser. In contrast to this, was Harry Benjamin's (1966) typology, which clearly divided the population into two categories: the transsexual and transvestite. Person and Ovesey (1974a, 1974b) and Stoller (1980) used the terms primary and secondary transsexual. Sometimes, new terminology or classifications can be very controversial, as with Blanchard's (1989) work on autogynephilia, which was and still is supported by Lawrence (2004). More currently, clinicians and researchers all over the world continue attempts to find a definitive cause of transgenderism as well as better treatment modalities (Blanchard, 1993; Zucker, & Bradley, 1995; Zhou, Hofman, Gooren, & Swaaab, 1995; Xavier, 2000; Devor 1989, 1994, 1997; Bockting, Knudson, & Goldberg, 2006).

As previously mentioned, the current nomenclature, terminology, and diagnostic labeling are very narrow, albeit necessary typologies and standards assist clinicians in providing transgender individuals with the help they identify as needed. A more flexible and inclusive terminology will help clinicians to make decisions on appropriate treatment. A variety of therapeutic models – psychoanalytic, medical, cognitive–behavioural or eclectic – assist transgender clients in the process of

moving through the multifaceted trajectories of gender transition, beginning HRT, accepting and adjusting to gender fluidity, or coming out to loved ones and/or begin to openly express both genders.

The different typologies developed over the years by individuals such as Benjamin (1966), Person and Ovesey (1974a, 1974b), Stoller (1980), Blanchard (1989a, 1989b), and Lawrence (2004) are very narrow, lack inclusiveness and fit individuals into a rigid concept adhering to the gender binary.

In 1979, the Harry Benjamin International Gender Dysphoria Association (HBIGDA) developed the Harry Benjamin Standards of Care. These standards have changed over time and version six is available online (http://www.wpath.org) through the World Professional Association for Transgender Health (WPATH) (formerly the HBIGDA).

The Harry Benjamin (1966) typology of transsexual and transvestite was based on a 6-point scale that included seven categories, which is similar to Kinsey's (1948, 1953) sexual orientation continuum. Although the Benjamin scale was easy to use, it had some flaws: it applied predominantly to male-to-female (MTF) transsexuals (TS) and assumed heterosexuality. The scale divided the population into two categories: transsexuals as individuals who are considering SRS, and transvestites as individuals who cross-dress for sexual pleasure. Transsexuals were seen as a specific entity which needed to be differentiated and categorized. The broader concept of gender diversity was not taken into consideration.

Benjamin's (1966) model view's gender as a binary, it does not take into consideration gender as a continuum and therefore, this model does not recognize gender expression outside a socially accepted norm. The individual has to be placed into a narrow category and help is made available according to their suitability within the available categorical classification. Benjamin's typology was of considerable help to clinicians for many years. It is still useful for some transgender individuals; especially transsexuals, however, for today's emerging multiplicity of transgender identities and subsequent self-labeling (Cole et al., 2000), the two categories, transsexual and transvestite are arguably too narrow.

Even though I used two categories like Benjamin (1966) did for his transsexual and transvestite model, there was a significant difference: establishing two groups – fixed or fluid – was achieved through clustering a variety of gender identities, creating a more inclusive typology for clinical use.

Two commonly used terms were primary and secondary transsexual (Person & Ovesey, 1974a, 1974b). Individuals often used the primary transsexual interchangeably with Benjamin's "type IV, true transsexual," which had the effect of diminishing other types of transgender individuals by seeing them as inferior or not 'true'. Person and Ovesey (1974a, 1974b) portrayed the primary transsexual as an individual who is functionally asexual, proceeding very fast toward SRS without significant deviation toward either hetero or homosexuality. In contrast to this, the secondary transsexual is portrayed as homosexual and very effeminate from early

childhood. In addition, the secondary transsexuals are further split into two subcategories: the homosexual transsexual and the transvestitic transsexual.

Stoller (1980) also used these terms; however, his description of primary transsexual fits the one used by Person and Ovesey (1974b) for secondary transsexual. The aforementioned example shows how a similar concept used for different groupings could cause confusion and might lead to misdiagnosis. These models are outdated, however, we still find them discussed on the Internet as well as by transgender clients, who come into therapy with the belief that they fall into one or the other of these specific categorical classifications. Not only are these categories narrow, they also promote a very pathological portrayal of transgender individuals, confusing transgender people and too often clients explain that they were told that the primary transsexual or the 'true' transsexual is superior compared to the secondary transsexual. This has created, and still creates, divisions in the transgender community.

Since the 1980s, Blanchard devoted his research to transgender issues. Blanchard (1989a, 1989b) established his own ideas on transgenderism; his key concept was autogynephilia, understanding the dynamics behind obsessional focus on cross-dressing, a narcissistic, exhibitionistic behaviour. The term 'autogynephilia' was coined by Blanchard (1989a) to denote "a male's paraphilic tendency to be sexually aroused by the thought or image of himself as a female" (Blanchard, 1993, p. 241). In a series of papers (Blanchard, 1985, 1988, 1989a, 1989b, 1991, 1992, 1993a, 1993b, 1993; Blanchard, Clemmensen & Steiner, 1985; Blanchard et al.,

1987; Blanchard, Rachansky & Steiner, 1986), Blanchard came to the conclusion that there were only two types of gender dysphoric males: the androphilic, who were aroused primarily by males and who reported being very feminine as children, and the gynephilic, males who were heterosexual.

However, this theory does not fit universally across the spectrum. With autogynephilia, Blanchard intended to include transvestite–cross-dressers, who experience genital arousal and erotic stimulation in response to wearing women's clothing. Blanchard's focus was on behaviour rather than an individual's internal experiences of gender dissonance. Autogynephilia is found in the *DSM-IV-TR* (2000) explaining that the paraphilic focus of 'transvestic fetishism' involves cross-dressing and in most cases, sexual arousal is produced by thoughts or images of the individual as female, referred to as 'autogynephilia'. The *DSM-IV-TR* (2000) also explains very clearly that "transvestic fetishism is not diagnosed when cross-dressing occurs exclusively during the course of Gender Identity Disorder" (*DSM-IV-TR*, 2000, pp. 574–575).

Blanchard's idea of autogynephilia is controversial, as pointed out by Lawrence (2004), however some of Blanchard's findings were remarkable. Blanchard (1994) confirmed what researchers and clinicians (Bancroft, 1972; Meyer, 1974; Person & Ovesey, 1974a, 1974b; Stoller, 1971) before him had suspected: occasionally, if not predominantly, gender dysphoria intensifies as an individual ages. Blanchard (1994) also identified the role family and social pressure plays in regards to gender dysphoria in transgender individuals. He found that if a

transgender individual was married and fathered children, coming out was more difficult and the older he likely would be before he was at ease to present for clinical treatment.

Lawrence (2004) is a great supporter of Blanchard's concept of autogynephilia. She felt that it was unfortunate that autogynephilia was viewed as pathologizing transsexualism instead of acknowledging Blanchard's attempt to emphasize the role of sexual desire in transsexual's realities. Her review (2004) of Blanchard's concept created controversy among healthcare professionals as well as transgender individuals. Some transsexuals felt it clearly represented their feelings, while others felt mischaracterized and pathologized.

In a web-published essay, Lawrence (2000) speaks about transsexual's needs and desires to be attractive. She found that these desires are not different for transsexuals than they are for people who modify their bodies through piercing, tattoos or cosmetic surgery such as facelifts or breast implants. Lawrence (2005) also looked critically at some of the shortcomings of Blanchard's concept and found the following:

> And when we autogynephilic transsexuals take estrogen, our interest in genital sexuality is often diminished, but our desire for sex reassignment usually not. Such observations seemed to pose a problem for Blanchard's theory. He rationalized this apparent contradiction by suggesting that after a period of time, stimuli which have been experienced as sexually exciting come to be regarded as rewarding and desirable in their own right, even when they no longer evoke intense genital arousal (p. 5).

However, it could be argued that Lawrence is not adequately aware of the ways in which her own experience as a transsexual may have informed her critical

review of Blanchard's work. It becomes clear that sexual desire in transsexualism is of special importance to Lawrence herself, a sentiment she generalizes to all MTF transsexual individuals, as seen in the following statement: "we must honor our sexual desire as that which moves us most, as that which makes us feel most truly alive" (Lawrence, 2000, p. 12). Although I do not agree with some of Lawrence's views, it is important to note that her research findings on QOL after SRS suggested that transsexuals reported experiencing an improved quality of life (QOL), is significant.

Not everyone, whether outside or within the transgender community, is aware of the central role that Virginia Prince played in advancing her notion of the heterosexual male cross-dresser (CD). At age 82, she put in writing her experience of seventy years of gender struggle, in which she spoke freely about transgenderism. Prince (1997a) wrote: "We ain't broke—so stop trying to fix us" (p. 476). She stated, "As a matter of fact, I coined the words 'transgenderism' and 'transgenderist' as nouns describing people like myself who have breasts and live full time as women, but who have no intentions of having genital surgery" (Prince, 1997a, p. 469). Prince's opinion was that SRS as a possible solution for gender dysphoria was not working, asking how surgical intervention could have an effect on a psychosocial condition.

In the 1970's the cross-dresser was seen as deviant whereas Prince's work advanced the 1970s' stereotypical concept of cross-dressing, to be more positively viewed. My research is suggesting a more open and inclusive concept with clustering

the wide variety of transgender identities into two groups: the fixed and fluid. Prince pointed toward the concept of fluidity and inclusiveness when she downplayed "the importance of self-eroticism and homosexuality in cross-dressing and emphasized the evolution of a nonsexual 'girl within', a social woman with male anatomy" (Cole et al., 2000, p. 158).

According to Prince, sexual arousal comes with the possibility of having an orgasm, which has nothing to do with the pleasant experience of cross-dressing. She clearly identified her belief that sexual arousal has nothing to do with gender identity and focused on the guilt, shame, fear, and isolation transgender people experience. Prince also talks about the incorrect use of language, which leads to misinformation and confusion such as: that sex and gender are not synonymous and that much damage has been done by confusing the two. Her work helped cross-dressers to come out and to establish a group identity and community. Even though her work is based on a polarized concept of femininity and masculinity, she also subscribes to the notion of gender identity as fluid, and as located on a continuum.

Opinions in the field of transgender studies have been divided. Person and Ovesey (1974a, 1974b) and Levine and Lothstein (1981) did not agree with Stoller's (1980) view of primary and secondary transsexuals. There is no agreement that transgenderism is innate or that being raised in a society that adheres to gender norms that are based on a socially constructed gender binary is a cause of gender dysphoria. At the last WPATH conference in Chicago (2007), Luk Gijs discussed the controversies in the field of transgender studies and eloquently acknowledged that

everyone has the right to put forward their hypotheses even though we might not accept them.

The current typologies are too narrow and follow a rigid concept of eligibility criteria which adheres strictly to the gender binary. The typology I propose is flexible and inclusive and will hopefully encourage more transgender people to approach healthcare professionals when in need. In addition, a more open and inclusive typology provides healthcare professionals with more flexibility in the treatment approach. According to the eligibility criteria a young natal female who perceives herself as male, but does not want male hormones or a chest-reconstruction, often experiences rejection by clinicians since they will not acknowledge him as female-to-male (FTM).

The aforementioned is only one of many examples of individual gender self-identity expression. Clustering a variety of gender identities into two groups – fixed or fluid – creates a more inclusive typology for clinical use. It also acknowledges that gender is a continuum and individuals might need flexibility in regards to their gender self-identity development. Lev (2004) discussed transgender peoples' experiences of being discriminated against, of not being taken seriously, and of being refused help because they did not fit the eligibility criteria.

The field of transgender studies continues to be controversial and, with growing interest in this field, different opinions have emerged. Research in this field continues to be done and hopefully more healthcare professionals will acquire knowledge and skills in transgenderism. Treatment modalities will continue to

improve, nomenclature, terminology, and diagnostic labeling will change to meet individual's needs. Clustering a variety of gender identities into two groups – fixed or fluid – is a start and will provide clinicians with greater flexibility.

Chapters Outline

Chapter 2 explores how sexual orientation and gender diversities are found in animals as well as in linguistic structures. The power of language in the discourses on gender and sexuality shows some of the influences the socially constructed gender binary has on transgender individuals. Some examples of transgender history, from 621 BC to the present, are illustrated through acceptance or non-acceptance of transgender individuals, in the context of cultural differences, and experience of transgenderism in arts and sports. This chapter also identifies the influence that different religions have had on the acceptance or non-acceptance of transgenderism. The start of medicalization, of surgical interest in transgenderism and transgender research, is explored.

Chapter 3 introduces several theoretical perspectives—symbolic interactionism, post-structuralism, social constructionism, existentialism, pluralism, feminism and queer theory—since they might assist in the understanding of transgenderism from a social perspective. Different opinions in transgender studies, biological findings and speculations are addressed within this section.

Chapter 4 reviews literature relevant to transgender studies in general, studies pointing toward issues affecting QOL, as well as showing some of the themes found

in previous qualitative research. Furthermore, case studies, biographies, and nature–nurture debates and studies on quality of life (QOL) are presented.

Chapter 5 starts with exploring difficulties of studying vulnerable populations. Furthermore a review of the mixed quantitative and qualitative methodology and design was provided. This chapter also provides the reasoning for the use of a multi-method research design. In this section, I will outline the hypotheses, provide a brief description of the scales, open-ended questions and qualitative interviews. I will also discuss data analysis procedures and end with the discussion of the study's limitations.

Chapter 6 details the quantitative findings, starting with a description of the fixed and fluid group and why they are the central variable in this study. This is followed by the identification of the eight questions that were used with the demographic variables, two pertaining to counselling and seven pertaining to quality of life (QOL), confidence, and stress. The Memorial University scale of happiness (Munsh) (Kozma & Stones, 1980) and the Bradley well being (BWB) (Bradley, 1994) scale were used; the explanation, testing, and findings are described and discussed.

Chapter 7 addresses the qualitative data. The objective of the qualitative component was to gain a deeper understanding of the impact that family, friends and teachers had on transgender individuals' QOL. The findings include quotations from participants' answers. The discussion in this section includes my own clinical experiences, as well as those of other clinicians. It is hoped that the findings might

increase social workers' and other healthcare providers' understandings when working with transgender clients.

Chapter 8 begins with suggestions for further research topics, continuing with a summary of the findings and some implications for clinical treatment. Recommendations for education, especially for social workers, are provided.

More and more individuals who question their gender are coming out, requesting support and acknowledgment. In clinical settings, some transgender clients are diagnosed with Gender Identity Disorder (GID) and receive the required treatment, whereas many others do not fit the standardized diagnostic nosologies. More recently, there has been a growing realization among healthcare professionals that gender–sex diversity is universal (Cole et al., 2000). Yet, transgender individuals who desire physical or mental health care are often confronted with the reality that few healthcare professionals understand their needs or have the experience to assist them (Lev, 2004; Ettner, 1999).

This thesis is structured to increase current healthcare provider's knowledge, provide them with an easier typology which is more inclusive, and provide information on some tools to gather information on transgender clients QOL, self-confidence and stress level. I end the thesis with recommendations on how to include transgender knowledge into the social work curriculum.

Chapter 2 Historical Review

Diversity in Nature and Linguistic Structures

Sex, gender, gender identity, and gender norms are often not clearly defined and therefore lead to confusion and misunderstanding. Sex is the expression of the anatomical and genetic differences between male and female, including external and internal sex characteristics, as well as hormonal differences. Gender identity epitomizes the innate feeling and self-knowledge of an individual's true sex and gender. What is "true or false" can only be established by the individual themselves therefore, "true gender identity" is used to provide the individual with the human right to define him/herself. In contrast to this are gender roles, which represent the public expression of an individual's anatomical sex and socially assigned gender.

The biological makeup of humans is complex but also diverse, as can be observed in the vast difference in gender expression and sexual orientation, in all cultures throughout history. While it could be argued that the social order creates norms, these standards tend to be narrow and restricting regarding the expression of human behaviour and interaction. Yet these norms (gender roles and expectations) governing human behaviour are not everlasting; they are constantly changing because they are socially constructed by beliefs and values established by different religions, cultures, and political institutions, and these viewpoints are influenced by the evolution of technology and medicine.

These cultural and historical changes can be observed not only in the different theoretical models established over time but also in linguistic changes, the number of

genders in different languages, and the addition of new words into dictionaries. There are 6,800 known languages spoken in the 191 countries of the world. Of these, 2,261 have writing systems (Your Dictionary). Within linguistic structures, "gender" is not always considered as a binary construct; the number of genders in different languages varies from two to more than 20, some are grammatical and some are lived genders (*The American Heritage Dictionaries*).

The English, Latin, and German languages each recognize three types of gender variation: masculine, feminine, and neuter. In some languages, the gender of certain nouns that might be neuter in the English language might be either masculine or feminine in another language. For example, the pronoun of "parents" in modern English is neuter. In contrast, in French and Spanish there are two variations (masculine and feminine) and in the Scandinavian and Dutch languages there are four variations (masculine, feminine, neuter, and the common). The common variation is a gender-like distinction; however, there might be a variance in the use of this pronoun. The common variation is also found in the Algonquian language of the Aboriginal peoples of North America (*The Columbia Encyclopaedia*). This gender variation correlates in part with animate and inanimate objects, one referring to people, animals, and spirits, the other to things.

Dunham (1944) found that there are many different opinions of the source of the German, English, and French languages. English is said to be a hybrid between the Latin and Germanic languages, which is also influenced by French. Whereas French, Spanish, Italian, Catalan, Romanian, and Portuguese are all descended from

the Latin of the Roman Empire.

Money (1968, 1972, 1975, 1978, 1980, 1981, 1987, 1988, 1994, 1999) established that the term "gender" dates back to the fourteenth century and the etymological meaning comes from the English *gendre*, the French *genre*, and the Latin *genus*, generic. "Androgyny" is a term even older than gender. Its meaning was derived from the Greek *androgynos*, from *aner*, *andros* a man + *gyne* woman (Money, 1968). It was also used as a synonym for hermaphrodites, individuals born with both male and female sex organs, or individuals who possess both male and female characteristics. "Plinty the Elder (AD 23/24–79) explicitly remarks in his *Natural History*: "Persons are also born of both sexes combined—what we call 'Hermaphrodites,' formerly called 'androgyni' and considered as portents, but now as entertainment" (Brisson, 2002, p. 38).

Androgyny in terms of intersex has to be viewed in the context of anatomy, genetics, and sex. Whalen (1974) produced an orthogonal model on the sexuality of rats in which he argued that masculinity and femininity vary independently. This model describes androgyny based on behaviour. Whalen (1974) published his orthogonal model at the same time as Bem (1974) published her measurement on androgyny (*Bem-Sex Role Inventory*). Examples like these suggest that in the 1970s there was a development toward a more open social movement. In experimental tests in animal studies, scientists might be able to create clear-cut sex and (or) gender differentiations. However, in life, sex and (or) gender is often not clear. Devor (1989) found that: "Human sex differences can only be described in terms of

averages, tendencies, and percentages rather than clear-cut absolutes" (p. 1).

Androgyny is often viewed as a passing phase in gender choice and too often not included in the spectrum of gender diversity, although gender androgyny is an important concept. Israel (1996) found that transgender adolescents often use androgynous dressing and behaviour to establish an identity; "youth often embrace androgyny as a form of self expression" (p. 5). It helps them to relieve stress and allows them to get in touch with their opposite gender feelings, until a firmer gender decision is made in adulthood (Israel, 1996).

Not everyone wants to be boxed into the gender binary and therefore they might opt for androgyny. It provides them with the possibility to express both masculine and feminine genders. In the case of the adolescent and the CG individual, androgyny is used in the context of gender fluidity. Whereas in the case of gender transition, an individual's androgynous stage is clearly a physical–sex developmental stage as well as a gender expression. In the early stages in the transition process, there is a time when the phenotype, meaning the physical characteristics or specific traits determined by both genetic make-up and environmental influences, of a transgender individual on HRT are not clearly identifiable as male or female, and gender passing at this stage is, for some, often difficult since the individual is not clearly identifiable as feminine or masculine.

For most people, "gender" is a basic concept and never questioned. However, for some people, gender causes uncertainty and dissonance. The individual's discomfort is increased through the socially dominant discourse of a mutually

exclusive gender binary. This ultimately leads to gender stereotyping and the non-acceptance of transgenderism, which subsequently affects the QOL of transgender individuals. Without a socially constructed gender binary, with its explicit gender roles and expectations, we can only assume that there might be no problems and everyone could freely express themselves. However, it appears that not all people want an absolute gender binary-free world, some want and need the gender binary.

We know that gender/sex diversity exists. The problem is not the existence of difference; the problem is the acceptance of diversity. Presently, full acceptance of diversity is only a nice notion, not a reality. However, as clinicians, we have to deal with the individual's reality. The dilemma is that transgender people are caught in the framework of a socially constructed gender binary, a concept through which diversity of gender identity and expression is not always possible. Some individuals might not transition out of fear of losing everything (family, job, housing), others might not transition because they fear they may never live up to their expectations of "passing" as the opposite gender.

Yet, in every context of life, nature has created the material basis for diversity; sexual orientation and gender diversities are found in animal (primates, marine mammals, fish, hoofed mammals, carnivores, marsupials, rodents, and insectivores) as well as in human environments. Male-to-male and female-to-female attraction and transgender behaviour in animals are not new discoveries; some of the earliest testimonies of these phenomena date back to ancient Greece. Animal gender variability is also reported by Aboriginal populations around the world; their belief

in this observable fact is well documented in anthropological research. Zoological research on this subject was started in 1895 by Alexandre Laboulmene (Bagemihl, 1999). From that time onward, the scientific study of animal homosexuality and transgenderism emerged, found recognition, expanded, and in the 20th century, there was an increase in literature with more than 600 articles on the topic published by the scientific community (Bagemihl, 1999).

Learned gender roles and expectations influence our beliefs and values. These can lead to myths and misconceptions, which can then have an enormous impact on an individual's QOL, transgender identity development pre-, during, and for some transgender individuals, even post-transitioning.

Social Changes

In the 20th century, great social changes took place, changes involving the growth of social movements and attempts to recognize a range of diversities. These changes, however, were not always positive for those affected because, in some instances, they marginalized and even pathologized individuals and entire populations. Transgenderism went from social acceptance in some cultures to a non-acceptance and pathologization in most societies (how these changes happened can be established throughout the thesis).

Since the beginning of the new millennium, more and more transgender people are coming out and challenging the law, religious organizations, social institutions, gender standards, and stereotypes set by society. Examples of this increased exposure can be seen in the greater presence of transgender people in the

public domain, such as in newspaper articles and on television shows, and the acceptance of transgender behaviour in entertaining movies such as *Tootsie* (1982); *The Crying Game* (1992); *Mrs. Doubtfire* (1993); *The Adventures of Priscilla, Queen of the Desert* (1994); *Boys Don't Cry* (1999); and *Transamerica* (2005). Oscars are presented to the artists and filmmakers for their outstanding performances, and yet expressions of diversity are often looked upon as a new phenomenon. Transgenderism is not a new phenomenon, existing for as long as humankind has existed.

To better understand the argument as to the influence of the socially constructed gender binary on the QOL and the issues encountered during transgender identity development, some knowledge of transgender history is important. Transgenderism has a place not only in the areas of culture, religion, and politics, but also in the realm of literature, arts, theatre, sports, and among other formal and informal groups of individuals who reflect the beliefs and behaviours of this population. This complex history can only be addressed briefly in this thesis; those interested in further readings should consult Laqueur (1987); Devor (1989, 1997); Bullough, Bullough, and Elias (1997); Califia (1997); Brisson (2002); Lev (2004); and other sources cited throughout this chapter.

Opinions of Different Religious Institutions

Although the following examples of social as well as religious institutional attitudes are specific, they show the belief and practice of many different religious organizations. Jewish as well as Christian leaders use quotes from Deuteronomy

(Lev, 2004). Religious judgments led to the first written description of laws that clearly condemned transgender behaviour; these laws can be found in the biblical text of Deuteronomy. Deuteronomy means "second law"; it is the title of the last of the five books of the Pentateuch.

The Pentateuch refers to the collection of the first five books of the Hebrew Bible and the Old Testament. In the Jewish tradition, these books are referred to as the Torah, which means "instruction." The word is formed from the Greek terms *penta*—five, and *teuchos*—scroll, meaning the law (Larue, 1968). The English translations for the five books are from the Septuagint: I Genesis; II Exodus; III Leviticus; IV Numbers; and, V Deuteronomy (Larue, 1968). According to Graf Wellhausen (1957), Deuteronomy is dated 621 BC. Deuteronomy states that, "A woman shall not wear anything that pertains to a man, nor shall a man put on a woman's garment, for all who do so are an abomination to the Lord your God" (Deuteronomy 22:50).

This declaration addressed the fact of cross-dressing. Transgenderism existed and it appears that it was not accepted by Jewish social institutions of the time, as evidenced by the need to address this issue in its laws. Deuteronomy encompasses laws regarding obedience, customary rules, status, strict class divisions, and, socially accepted gender behaviours and expectations. Although socially accepted gender behaviours and expectations is not a prominent aspect of Jewish law, addressing it and establishing regulation for it makes it responsible for singling out transgender individuals as deviants and outcasts during this period. Gender ambiguity was not

acceptable and, to establish this, a patriarchal society ruled that clear distinctions between men and women were needed.

The Christian Bible, as we know it today, is a collection of didactic teaching, with the writings of different authors during different historical timelines and a wide selection of religious literature. Denny (1997) found that:

> Although factions within the Christian church, both in the Middle Ages and at the present time, have worked hard to eradicate any mention of transgendered behaviour from the bible and from history (and indeed, sometimes to eradicate transgendered person themselves), there is considerable evidence of transgender roles throughout Western history (Bullough & Bullough, 1993; Feinberg, n.d.) (p. 35).

Transgender individuals were often involved in social activism or religious wars, but the acceptance of transgender individuals often depended on a hidden agenda or was to the lucrative advantage of the church.

Cultural Differences: Ancient Greeks and Roman

Cultural differences are illustrated through facts, myths, and narratives. There are many versions of the myths and narratives presented in this section. Often they cannot be backed up with empirical facts, which creates disagreements among researchers as to which book has the better version. Despite these disagreements, we should not lose focus about why we talk about transgender history: MTF (male-to-female), FTM (female-to-male), or IS (intersex) , Stone (1991) stated: "Although the term transsexual is of recent origin, the phenomenon is not" (p. 282) and Devor (1997) said, "The evidence seems clear that there have always been females who felt

the need to live their lives as men" (p. 35), overall historical support should be considered as evidence that transgender people have always existed.

Brisson (2002) expressed that dual sexuality played an important role in the fifth Gnostic treatise written in A.D. 330-340. The religion was a mixture between Judaism, Egyptian and the Greek tradition. Duality could be described as encompassing two states which creates a wholeness leading to greater harmony, finally attaining greater unity. However, it also can be looked at as creating opposites and yet still dependent upon each other. "Anything that is at the origin of all things must be all-encompassing and itself imply the coincidence of opposites. In all the opposites that structure reality it must be possible, if only in exceptional circumstances, to pass from one pole to the other" (Brisson, 2002, pp. 1–2). Brisson (2002) talks about the archetype who simultaneously possesses both sexes. He argues that Adam began his existence as a hermaphrodite and then he divided into two individuals. "Forestalling them, Sophia-Zoe creates the psychic Adam, also known as Eve or Aphrodite—hence his/her relation to dual sexuality (*NH* II $^{5,161.12f}$)" (Brisson, 2002, p. 104).

Throughout history, we see differences in the treatment and acknowledgement of transgender. Differences cannot only be observed throughout centuries, they can be observed through different cultures' beliefs. Greek mythology was filled with countless references to hermaphrodites/intersex (IS).[1] Intersexuality was often portrayed in Greek figures and, today, some museums exhibit such Greek figures (e.g. *Sleeping Hermaphrodite*, Louvre, Paris), confirming their existence.

Greek culture not only acknowledged mortal hermaphrodites, heroes, and gods, it also represented them as transgendered and cross-dressing. For example, Zeus encompassed female and male (Brisson, 2002). Hermes and Aphrodite had a child who had the attributes as well as the sex of both parents. Unable to unequivocally ascertain its sex, they named the child Hermaphroditos. Another version of this myth is that Hermaphroditos was bathing in the waters of Salmacis spring in Caria when the nymph embraced him with such power that the two bodies merged together, and from this day forward he was no more than a half a man (Brisson, 2002).

In Aristophanes' story of the origins of men and women, the individuals were depicted as either having two male organs, two female organs, or one of each, and only the hermaphrodites would seek out the opposite sex to achieve union (Laqueur, 1990). Aspects of this myth might be reinforced by the medical beliefs at the time. Laqueur (1990) found the following:

> The original global creatures had their genitals on the outside and "cast their seed and made children, not in one another but on the ground, like cicadas." In the new cut-up state they did nothing but longingly embrace their missing halves and thus died from hunger and idleness. Zeus hit upon the idea of relocating the genitals of one half of the new creatures, "and in doing so he invented interior reproduction, *by* men *in* women" (pp. 52-53).

The story concludes with expressing that Zeus tried "to make one out of two" (Laqueur, 1990, p. 53). It gives the impression that, in this early stage of human creation, the sex of the human body was not important. Yet also, it emphasized the existence of more than two sexes and (or) genders.

The Greek goddess Venus Castina was assigned the task of responding with sympathy and understanding to the yearning of female souls locked in male bodies (Bulliet, 1928). During Greek antiquity, transgender people were often assigned positions in the priesthood for society held transgendered individuals in high regard.

In yet another mythological account, about the kingdom of Phrygia, priests serving the goddess Attis were obligated to follow the example of their goddess by castrating themselves and wearing women's clothes.

Spencer (1946) maintained that some of the priests went even further and removed their male genitals. Was this self-castration done out of religious dedication, or was it done to satisfy their own internal yearning to express their transgenderism? This question cannot be answered, but the important issue here is that through storytelling, different customs are kept alive. Larue (1968) suggests that myths are literary expressions of events that happened in the past; they become the foundation of the reality of that particular society, the expression of the psychological, emotional, spiritual, political, and social context of the past.

However, the narratives in Greek and Roman antiquity are not always favourable to transgenderism. There were times where IS was viewed "as a simple error of nature, an anatomical malformation that is rare but perfectly explicable" (Brisson, 2002, p. 31). The acceptance of hermaphrodites depended on the political and social climate of the time. For some societies IS people provoked superstitions and panic, they also called into question the social structure and survival of the human race, according to the medical knowledge at the time.

In the Roman Empire, hermaphrodites were viewed as a bad omen; however, this view changed. "Under the Empire, abnormal children continued to be committed to the waters to drown, but 'hermaphrodites' appear no longer to be considered as terrifying prodigies, no doubt thanks to rationalist reactions against superstition, of the type manifested by Diodorus" (Brisson, 2005, p. 38). Some cultures demonstrated some acceptance of hermaphrodites; however, the reality was that they were never completely included because they represented a variation from the norm, which also represented a difference in social roles and tasks.

From the Middle Ages to the Beginning of Modern Times

In antiquity, precise rules governed sex/gender diversity and, as indicated, acceptance of hermaphrodites depended on the sociopolitical climate of the time, including medical beliefs. The same can be said of later centuries. Physicians in the Middle Ages continued the classical theory of a sexual continuum (Fausto-Sterling, 2000). Classical medical texts promote the idea that the uterus is divided into several chambers. "The three cells to the right housed males, the three to the left females, while the central chamber produced hermaphrodites" (Faust–Sterling, 2000).

An example of one of these historical hermaphrodites was Hildegard of Bingen (1098–1179), a German abbess. Hildegard placed blame for her condition when she stated that: "A disorder of either sex or sex role is a disorder in the social fabric" (Fausto-Sterling, 2000, p. 34) and yet such a strong condemnation of hermaphrodism was unusual for the Middle Ages.

Garber (1992), Bullough and Bullough (1993), Feinberg (1996), Denny, (1997), and Devor (1997) reported the story of Joan of Arc. Born in Domremy, France around 1412, she wore men's clothing, yet historians downplayed this by referring to her as a woman wearing armour.

At the age of seventeen, Joan, dressed as a male, led her peasant army in the siege of Orleans. In this period, religion permeated everything; consequently, Joan of Arc had to assert that God directed her mission, actions, and way of dressing. However, two years later, at the age of nineteen, after being a heroine to her people, the Catholic Church discredited her behaviour of wearing armour and she was convicted of heresy, owing to her association with "fairies" and her other witchcraft activities. The Inquisition of the Catholic Church had her burnt at the stake. Knowing that the last words she spoke in her defense would condemn her to die on the stake, they confirm how deeply rooted her transgenderism was. "For nothing in the world, will I swear not to arm myself and put on a man's dress" (Feinberg, 1996, p. 35; Evans, 1978, p. 5); "I must obey the orders of Our Lord" (Evans, 1978, p. 5).

Sometimes religious institutions would make exceptions and tolerate transgender behaviour. Catalina de Erauso, a Basque, was born in 1592. Still in her childhood, she was placed in a convent (Devor, 1997). As an adolescent she dressed as a man, enlisted in the Spanish army and sailed as a conquistador to Latin America, under the name Alonso Diaz Ramérez de Guzman. Catalina de Erauso slaughtered many Native people and was considered a hero by the Catholic Church. Above all, Catalina de Erauso won the bishop's blessing to continue her transgender actions.

In witchcraft tales, there are two recorded examples of sex-change occurrences through the intervention of evil spirits. Witches were said to possess power that could change the sex of an individual and the effects were irreversible (Masters, 1962). Masters also cited a report in *Malleus Malificarum* (1489) of an eyewitness in Rome who was reported as seeing the devil changing a girl into a boy. In Renaissance Europe, medical beliefs and scientific knowledge of the time competed with elaborate doctrines of the Church as well as with the superstitions and fears of the population in general.

During the Middle Ages, women were usually not allowed to enter the male domain. This was not only in education but also in the areas of philosophy, poetry, and theatre. "Whenever and wherever drama began, it was automatically the man's business to play the women" (Baker, 1968, p. 51). Female impersonators were nothing new; the Elizabethans did not think twice about it; nor did the Chinese, Japanese, or ancient Greeks. Male actors playing female roles were well known and accepted; however, women were not permitted to act on the stage. However, in 1578, the 16-year-old Isabella Canali (Andreini) from Padua, Italy married Francesco Andreini and both were hired for the troupe of Flaminio Scala, an Italian theatre company (Rinaldi & Pulga, n.d.). Male actors were well respected, while female actors had a much harder time gaining stage acceptance.

Sixteenth to Nineteenth Century

Marie/Marin le Marcis (France, 1601) lived as a female for the first twenty-one years of her life (Fausto-Sterling, 2000). She decided to live as a male and to

marry the woman with whom she lived. She was arrested, condemned to be burned, but had her sentence reduced to hanging. In the end, she was set free under the condition that she dress in women's clothing until the age of twenty-five.

Devor (1997) established that the sixteenth century did not provide detailed accounts for FTM transgender expression, the stories were rather explained in the light of sexual orientation, which was viewed as deviant and was prohibited by law. Devor (1997) found that:

> [V]ery little information is available as to their reasons for passing as men, but the way in which the stories were recounted in public records makes it seem that their reasons had to do with their sexual orientation (p. 12).

Marie/Marin had committed a crime which was sodomy under the French law.

In the seventeenth century, one can find numerous accounts of females living as men. Different countries' legal and religious systems viewed cross-gender living in different ways. In England, Mary Hamilton changed her name to Dr. Charles Hamilton and married a woman (Fausto-Sterling, 2000).

Devor (1997) reported the story of Queen Christina of Sweden. At the age of eighteen, she was crowned Queen, but she renounced her throne after her people demanded an heir. "She abdicated her throne and her country in order to be able to live as the gender she preferred" (Devor, 1997, p. 13). For a while, she lived in Denmark before settling in Rome. The pope gave her special permission to wear men's clothing which she repaid by generously supporting the pope.

In Piedra, Italy, a young soldier named Daniel Burghammer shocked his regiment when he gave birth (Fausto-Sterling, 2000). He confessed to his captain

that he was one-half male and one-half female. Uncertain to what action to take, the captain called upon the Church to make a decision. Because the role of a husband and giving birth were incompatible, the Church dissolved Daniel's marriage. Daniel was allowed to nurse his child with his female breast (Fausto-Sterling, 2000). The Church declared the child's birth a miracle and decided to baptize the child.

It appears that while English laws found cross-gender living offensive and French laws were rigid and tried to control their people, the Italians as bewildered as they were by the phenomenon were more open and accepting.

MacKenzie (1994), Califa (1997), Devor (1997), and Fausto-Sterling (2000) reported the story of the chevalier d'Eon de Beaumont. In the eighteenth-century the chevalier d'Eon de Beaumont was a French nobleman who served his country as a diplomat and spy, first in Russia and later in England. Questions as to his or her gender were widespread and apparently high bets were placed upon the determination of his or her actual sex. His behaviour was especially confusing as he engaged in male pursuits, such as performing duels, dressed in female attire. King Louis XVI eventually ordered the chevalier back to France. However, the order included that d'Eon had to give up his gender ambiguity and live as a male for the rest of his life. The chevalier did not like this and returned to England, where he made the decision to live as a female. In his earlier years, he referred to himself as a man and sometimes as a woman. During his later years, he preferred to talk about himself as a female and even in his journals he referred to himself by using feminine pronouns.

For many years he lived with Mrs. Cole, a female companion. To her surprise, she was informed, when d'Eon died in 1810, that his biological sex was actually male. Although the medical community declared that d'Eon's sex was male, this assertion cannot be taken as definite as, during the betting frenzy, the British Court appointed experts who affirmed that d'Eon was actually a woman.

Investigating this case, hermaphroditism enters one's mind; this would provide an explanation for the difference between the court's and medical experts' opinion. It appears that the law, medicine, and society in general could not tolerate d'Eon's gender ambiguity; they needed clarification about his or her gender, even though it seemed that d'Eon did not care about his or her own gender ambiguity. This was confirmed in a statement that d'Eon made to a friend: "I am what the hands of God have made me" (Califia, 1997, p. 12).

Another eighteenth-century TS was Dr. James Berry. The first Surgeon General to Upper Canada was discovered at the time of his death to have been a female. Devor (1997) wrote that Berry was born in 1795 a female, started living as a male at age ten, entered medical school in 1812, and continued to live as male until his death in 1865. Berry was credited as the first doctor to successfully perform a Cesarean section where both the mother and the child survived (Devor, 1997). He was also known for his argumentative temperament, which created problems in his career.

The nineteenth century brought many changes. Changes were not only seen with industrialization and technological progress but also in scientific medical

advances. The late eighteenth and early nineteenth century saw the emergence of the two genders theory (Laqueur, 1990).

In 1910, Hirschfeld wrote *Die Transvestiten,* in which he made a clear differentiation between cross-dressing and homosexuality. "Hirschfeld also perspicaciously pointed out that transvestism could be found in the lives of persons of any sex or sexual orientation" (Devor, 1997, p. 30).

Embryological findings in the first thirty years of the nineteenth century revealed female and male genital differences in the embryo (Laqueur, 1990).

Embryonic research identified that a fetus is genderless until six to seven weeks into the gestation period. At this time, a typical fetus with karyotypes 46, XX or 46, XY have both (female) Müllerian ducts and (male) Wolffian ducts. At about 6 to 7 weeks, the male XY fetus produces Müllerian Inhibiting Hormone (MIH); the gonads change into testicles, which manufacture testosterone. The testosterone prompts the development of the internal male reproductive organs and the MIH causes the Müllerian ducts to regress.

Whereas, for a XX fetus, there is an absence of testosterone and MIH, which allows the Müllerian duct to develop into the uterus, the fallopian tubes, and the upper part of the vagina. During weeks 6 to 12 of pregnancy, the external genitalia are formed. Laqueur (1990) found that "modern charts of genital embryology seem faithfully to reproduce Galen's lecture on woman as inverted male" (p. 170). This means viewing the two-sex theory again as one sex, the female is always viewed as the back-up system.

The endocrine system of the developing fetus is influenced by certain genes on the Y chromosome (Kawata, 1995; Mayer, Swaab, Pilgrim, Reisert, & Lahr, 1998). As well, it is postulated that the hormonal effects on the brain occurs on several different occasions during the development of the sexual organs, influencing sex/gender behaviour. Research of the mammalian brain has shown that sex differentiation starts in early fetal development; however, it continues after birth into adulthood (Chung et al., 2002).

In the last century it was established that there are also many atypical chromosomal configurations associated with diverse sex differentiation, karyotypes 45, XO; 47, XXX; 47, XXY; (Grumbach, 1998; Grumbach, Huges, & Conte, 2003; Diamond & Watson, 2004). This complicated chromosomal development provides many opportunities for the growth of gender diversity. The physical sex development and the sex differentiation in early brain development might differ, which would be one of the explanations for gender incongruency (Gooren, 1990; Swaab & Hofman, 1995; Vay, 1991, 1993; Zheu et al., 1995, 1997; Jones, 2002; Sober & Imperato-McGinley, 2004; Gooren & Krijver, 2002).

In 1952, newspapers broke the news that an American had successfully transformed, through the help of hormones and surgery, from George, a male, to Christine Jorgensen, a female. After Christine, many transgender individuals transitioned successfully with the help of hormones and SRS, which opened a new possibility for individuals with gender dysphoria. However, with this the controversy

about gender being nature or nurture continued. Ethical and legal questions of gender being a continuum and diversity seem to be never-ending.

The Twentieth Century

In the twentieth century, there was some social progress in transgender acceptance, especially regarding inclusion in sports. Yet this inclusion was not perfect because it still favoured the gender binary and excluded gender diversity. In 1912, Pierre de Coubertine, founder of the modern Olympics (from which women were originally banned), argued that "women's sports are all against the law of nature" (Fausto-Sterling, 2000, pp. 2–3). Like society in general, sports, or more precisely sports officials, were also interested in clearly identifying competitors as either male or female, with clear-cut distinctions between XX chromosomes and XY chromosomes.

The International Olympic Committee (IOC) required that female competitors bring a doctor's certificate stating that they were females. If an athlete forgot their certificate of femininity, they had to report to the "femininity control head office" (Simpson, Ljungqvist, De la Chapelle, et al., 1993). If a female competitor forgot her certificate of femininity, she was asked to parade naked in front of a board of examiners; breasts and a vagina were all that was needed to certify her femininity. This degrading procedure was discontinued in 1968 and the femininity testing was replaced by scraping some cells from inside their cheek or giving a sputum sample to test their DNA for Y chromosomes (Faust-Sterling, 2000). By 2000, the IOC finally suspended gender verification testing.

Maria Patino, the top woman hurdler from Spain, was barred from competing at the 1988 Olympics after she failed the sex test (Fausto-Sterling, 2000). Maria reported that she knows she is a woman, she feels like a woman, and she was raised as a woman, but she had a Y chromosome. Later she found out that she was born with a condition called *androgen insensitivity syndrome.* This means that she had a Y chromosome and she produced testosterone. But her body could not detect the testosterone and, therefore, she did not develop primary or secondary male sex organs. During puberty, she produced enough estrogen (all men's testes produce estrogen and testosterone) to develop secondary female sex characteristics (Fausto-Sterling, 2000).

After the discovery of the Y chromosome and her ban from competition, the story went public, the media reports were exceptionally harsh leading to her exclusion from the Spanish Olympic team and the loss of material possessions. But she did not give up; she fought the IOC and, after two-and-a-half years, the international Amateur Athletic Federation (AAF) reinstated her and, in 1992, she rejoined the Spanish Olympic team.

Erika Schinegger, an Austrian skier, was another example of the injustices done to individuals deemed to be outside the social gender norms for femininity and masculinity. During the August 1966 FIS World Alpine Ski Championships in Portillo, Chile, Erika won the gold medal in downhill racing (Schinegger & Echenz, 1988). Before competing in the 1968 Olympics in Grenoble, France, she had to

undergo a gender test. When the results of the saliva test came back, the examining urologist declared that Erika was a man.

Some Austrian sports officials asked her to resign for personal reasons; others blatantly stated that she was an embarrassment to the team and therefore should be kicked off. The day after Christmas 1967, she checked into a hospital in Innsbruck, Austria, where she had four surgeries in the next six months. She went from Erika to Erik and voluntarily gave back her gold medal. Today, Erik is living in Austria; he owns a ski school, is married, and has a daughter, Claire (Schinegger & Echenz, 1988).

As in sport, society's problem is that knowing an individual's physical sex leads to gender assumptions. However, gender is not as clear-cut as we would like it to be. Gender is more complicated; nature and nurture are not the only matter that we have to take into consideration in determining an individual's identity. Identity is a personal perception of *who I am.*

Although transgender athletes are now permitted to compete in Olympic Games, they have to fulfill certain requirements. The transgender athletes had to follow the Standards for transgender care, which includes being on HRT, living full-time in the opposite gender (1 year), and having completed SRS. This decision might help some people to express their gender identity, especially those who are born with genetic abnormalities and (or) those who can afford SRS. Being assigned female or male status and being raised as a female or male is, in most cases, decided by the

medical profession and by the parents. The majority of transgender people do not have any participation in this decision.

However, by arguing on the basis of the psychological and cultural meaning of the differences, the individual's own perception of gender was, and is, ignored. In sports, the focus continues to be on body anatomy, the gender binary, and ignoring the individual's knowledge of self-identity. In Greek culture, hermaphrodites and transgender individuals participated equally in sports events; the Olympic motto was and is "citius, altius, fortius" (faster, higher, stronger), which summarizes the excellence for which all athletes strive. Policies and narrow standards on sex/gender set by the IOC and other sports federations should not prohibit individuals from achieving their goals.

The physical advantage of the Y chromosome in transgender individuals with, for example, *androgen insensitivity syndrome* is still scientifically and socially hotly debated. However, the most important aspect for transgender athletes is that they can participate; and, at the 1996 Atlantic Summer Olympic Games, seven athletes identified with *androgen insensitivity syndrome* were allowed to participate (Reeser, 2005).

Aboriginal People and Transgenderism: Two-Spirited

In some cultures, transgender individuals had the respect of the community. One can find examples of this in the North and South First Nations cultures. Two-spirited people were considered to have spiritual powers and were called upon to be go-betweens in conflicts between the genders. Currently, indigenous people who are

transgender often prefer the English name of "two-spirited"; previously, the most common name was "berdache" (Roscoe, 1998). Although the word berdache is now out of favour, it is often used in explaining the third and fourth gender in First Nations cultures. A detailed explanation of the origin of the name can be found at a later point in this section.

In 1833, Denig, a European explorer, settled among the Crow Indians and "found that some of the most important and respected individuals were men and women who in American and European societies would be condemned, persecuted, jailed, even executed" (Roscoe, 1998, p. 1). Roscoe further reported that in over 155 North American tribes, male berdaches were found and they were considered to be a third gender. Female berdaches were found in Alaska, Canada, California, and in the Southwest (e.g. Aleut, Kaska, and Kutenai). In other tribes (e.g. Northern Paiute, Southern Paiute, and Shoshone), women who undertook a man's lifestyle and were recognized as berdaches were classified as the third or fourth gender (Roscoe, 1998). Female berdaches were sometimes also shamans; this association was strongly seen in the "Mohave; hwame" (Roscoe, 1998, p. 90).

Each tribe had its own term for the third and fourth gender; however, berdache appears to be the term most recognized by European anthropologists, such as Deliette in 1704, Washington in 1877, and Dorsey in 1890 (Roscoe, 1998). In native culture, storytelling was the main medium in which to keep history and language alive. However, through prohibition and oppression of colonialization by European settlers, much of native history and original language was lost. Many historians and

anthropologists with differing opinions describe the meaning and the origin of the term berdache. Roscoe (1998) reported that the term originally had Indo-European roots and meant to strike, to wound. Later, the term was found in the Italian, Spanish, French, and English languages, where the word was "catamite," meaning the younger partner in a homosexual relationship. However, for unknown reasons, its meaning shifted again and now its reference to age has been lost and its only focus is on homosexuality.

Courouve (1982) found a common meaning among the different languages using the term. The 1680 edition of the *Dictionaries francais* gives the following definition: "a young man who is shamefully abused" (Williams, 1986, p. 9). Over time, the word completely lost its sexual connotation and, by the mid-nineteenth century, it appears that the term was no longer used in Europe. No explanations as to why this term was excluded or died out in European languages have been suggested.

Knowing that berdache carried an already damaging connotation in Europe, why did anthropologists give native transgender people this name? In 1833, Denig found that native transgender people were respected but he also recognized that in Europe these kinds of people would be condemned (Roscoe, 1998). We might ask: How much did the use of a negative term and its implied attitudes influence the change from respect and positive acceptance in First Nations' cultures to viewing transgender people as deviant, including them in a medical model of abnormality and mental illness?

Throughout history, many societies have, and still have, difficulty in understanding and (or) explaining diversity. The North American First Nations offered explanations through their creation stories. In the Navajo language, the word for transgender is not berdache, it is *nàdleehi,* and its meaning is "changing one" or "one who is transformed" (Roscoe, 1998).

Hermaphrodites and transgender people are included and "such individuals were presented from the earliest eras of human existence, and their presence was never questioned. They were part of the natural order of the universe, with a special contribution to make" (Williams, 1986, p. 19). It is important to know how the native population viewed transgenderism, especially the flexibility that they gave to individual gender expression and the individual's gender self-identity. Native history illustrates that gender identity is intrinsically diverse but that gender roles are strongly influenced by socially-set norms, expectations, and stereotyping.

Widespread Beliefs

Throughout history, the reproduction of patriarchal institutions and practices has been evident in most societies. This has involved the establishment of cultural rules that discourage gender expression. It could be argued that, historically, transgenderism was, and is, present in all aspects of human existence. Some of the historical reports are about FTM transgenderists (Devor, 1989, 1997; Fausto-Sterling, 2000). Feinberg (1996) portrayed several females openly presenting as trans-men and passing for men in the military service.

Keating (1820/1989) assumed that FTM individuals only wore men's clothes

to achieve higher societal acceptance and ignored the psychological and emotional impact of transgender behaviour. Lothstein, 1983, pointed out that clinicians downplayed the FTM experience; "from another perspective clinicians may have played down the significance of female transsexualism because female transsexual seem to suffer less apparent anguish than their male counterparts" (Lothstein, 1983, p. 15). Life experiences of FTM individuals were considered to be of less importance, and this might be the reason why less importance is given to this subject (Cole, 1999). This changed in the mid-1990s as Devor (1989, 1997), Green (1998), and Kotula (2002) made an effort to address the life experiences of FTM transgender individuals.

In contrast, the MTF created a greater cultural shock and their presence often dominated the written historical as well as medical cases, which further supported the once prevalent belief by Hirschfeld (1910) and Pomery (1975) that transgenderism was an exclusively MTF phenomenon. Pomery (1975), an expert in the field of sexology, reported in his first writings that the ratio of MTF to FTM was 50 to 1, and over the years he changed his assumed ratio to 15 to 1, and soon after he found that the ratio of MTFs to FTMs was 4 to 1 (Pomery, 1975).

Gender clinics and specialists in the field still disagree when it comes to the ratio between MTFs to FTMs. Green (1998) found that FTMs were in the shadow of MTFs for a long time but that they are now coming forward in large numbers. This supports newer reports of more equity in the ratio of MTF to FTM clients. Brown and Rounsley (1996) reported that in the previous five years the MTF to FTM clients

in their clinical care fluctuated from as high as 20 to 1 at times, to 3 to 1 at others. Eighty percent of my clientele in my private practice are transgender. I also experienced an increase in FTM clients in the last 8 to 10 years, which now points toward an equal number of MTFs and FTMs coming forward and requesting help. That gender clinics come across a higher ratio of MTFs might be owing to more MTFs opting for HRT and SRS to pass as women.

Men have more flexibility concerning clothing and demeanour. For many females, passing as males (without HRT) in early adulthood is not difficult. Intense physical activity, sports, and weightlifting can influence menstruation, keeping the individual more androgynous. Androgyny is supported through adopting stereotypical behaviour and gender-specific clothing, which further influences social expectations of an individual's anatomical sex and socially assigned gender.

However, as a natal female ages feminization sets in, and if the individual is not on HRT, passing is often more difficult. In a case study, Ettner (1999) described that even though an individual can appear quite masculine, female traits such as breasts can influence people's perception of accepting the individual's self-identification as male. However, "With hormonal assistance and chest surgery, the visible telltale residue of femaleness recedes and successful identity consolidation can proceed" (Ettner, 1999, p. 74).

Another reason for the controversial findings about the ratio might be that MTF surgery is easier, less expensive, and has a higher success rate. The cost of FTM surgery, phalloplasty, or even metadoioplasty is significantly higher; although

the success rate for functionality or aesthetics has improved, it still is not as great as MTF surgical interventions. Depending on the type of surgery requested, more than one surgical procedure is generally needed, and the skin graft leaves scaring.

Medicalization and Pathologization

There are many historical explanations for the transgender phenomenon and not all of them are negative. Yet, with the inclusion of transgender into a medical model, the positive attitude of transgender decreased rapidly and medicine did its part to pathologize the issue. The inclusion of transgender into the fields of sexology, psychology, and especially medicine began with individuals such as Kraft-Ebing (1912) and Hirschfeld (1910). Many others, such as Ellis ([1897] 1975), Cauldwell (1949), Benjamin (1964, 1966), Money (1968, 1972, 1975, 1978, 1980, 1981, 1987, 1988, 1994, 1999), and Green, (1969, 1987) to name only a few, added new knowledge, sometimes positive, sometimes negative, to the field of transgender studies.

At the turn of the twentieth century, famous psychiatrists such as Krafft-Ebing argued that transgenderism came from horseback riding (Krafft-Ebing, 1912). Horseback riding, especially in the Native American population, caused injury to the testicles and resulted in impotence, with those affected being considered "failed men." The diagnosis of moral insanity was brought into it to highlight the immoral label of a behaviour which was considered to be outside the accepted norm.

Medicine at this time relied on moral judgments to increase the pathologization of problematic behaviours. Krafft-Ebing (1912) believed that there

was a cure for transgenderism and he prescribed hypnosis every two to three days, sometimes in conjunction with hydrotherapy. To paraphrase Krafft-Ebing: If the transgenderist mellowed a bit, he would be no worse than a good drunk and there was no need for confinement in an asylum. In *Psychopathia Sexualis* (1912), Krafft-Ebing described several cases of "Metamorphosis Sexualis Paranoica": "Eine weitere Entwicklungsstufe stellen Falle dar, wo auch das korperliche Empfindungen im Sinne einer Transmutatio sexus sich umgestelled (Another stage of development is illustrated in one case, which identifies the continuation from a psychological belief of being female is followed by the feeling of a physical transformation to female)" (Krafft-Ebing, 1912, p. 238). Krafft-Ebing thought that this was a rare condition and the reality was that the individual had experienced a severe mental illness.

For many years, gender issues and sexual orientation were considered together as the same pathological problem. During the Victorian era, only the male was considered sexually active and aggressive, while the female was considered sexually indifferent. Therefore, if two females developed a sexual interest, one had to be an *invert* (which was an early name for homosexuality). The same applied to males; one of the males had to be feminine and therefore he was also considered sexually indifferent (Fausto-Sterling, 2000).

In 1910, Magnus Hirschfeld, a German sexologist, published *Transvestism* (Hirschfeld, 1910, 1948). Prior to this, there were no categories for cross-dressing or transgenderism. "Transvestism" comes from Latin and the direct translation is "cross-dressing." One of Hirschfeld's important conclusions on the topic was that

sexual orientation and gender expression are not linked. Hirschfeld did not consider transgenderism as either negative or pathological. Before Hirschfeld's work in *Transvestism,* transgender people were often included with homosexuality. (McKenzie, 1994). "Hirschfeld considered the male invert to be hermaphroditic in both mind and body" (Fausto-Sterling, 2000, p. 288).

Homosexuality and transgenderism were clearly considered pathological problems. Another term for people with this condition was "sexual perverts." Early theories on homosexuality were actually elaborate theories on gender issues and sexologists often adapted theories concerning gender and sexual orientation as one and the same. Because the behaviour of sexual deviance did not lead to procreation, it was also considered a crime. Another term that was used to describe transgender and gay people was "criminals against nature." This term was not only used by the law but also by the religious and medical communities. Money (1978) found that "most or at least many transvestites are heterosexual" (p. 36) a view that might be incorrect but enabling discussion on the issue to open up.

Havelock Ellis used the name of Chevalier d'Eon de Beaumont to create his own term for transvestism, *eonism* (Meyerowitz, 2001). He used this term specifically for MTF cross dressers. This term is no longer used. Early nineteen hundred, many sexologists and psychoanalysts did not make a distinction between transgenderism and homosexuality. Freud, for example, argued that there was no need of a separation between cross dressers and homosexuals as these were all cases of "latent homosexuality." The only case that Freud ever reported that might be

considered a transgender one was "The Schreber Case." In 1911, Freud described Schreber as delusional, believing that his strong wish for a sex-change was only due to the repression of his homosexuality (Freud, 1962).

In 1949, Cauldwell, a general practitioner, used the term "psychopathia transsexualis" to describe the condition of a girl who wanted to change her gender (McKenzie, 1994, p. 27). Interestingly, Cauldwell's opinion was that transsexuality occurs in far more people than any survey would reveal. The explanation for hiding transgenderism should be understandable, since the issue is pathologized and thus forces people into isolation and silent suffering. Until the late-1940s, transgenderism was an issue for psychiatry, a specialization of medicine; however, with new knowledge, another area of specialization in medicine became interested in the issue of transgender. At that time, it was the surgical community that developed an interest in the subject.

Surgery, Technology, and Research

Depending on the definition of sex-reassignment surgery (SRS), we could consider that the first-recorded SRS occurred during the reign of the Roman emperor Nero. Nero was said to have murdered his pregnant wife, and subsequently argued that his male slave had a remarkable resemblance to his dead wife. Nero ordered the surgery of his slave, and shortly after the operation, Nero and Sporum were married. Sporum was "delighted to be called the mistress, the wife, the Queen of Hiercoles" (Bulliet, 1928, pp. 79–80). Rumour has it that Sporum "offered half of the Roman Empire to the physician who could equip him with female genitalia" (Green &

Money, 1969, p. 15). An actual description of the medical technology used for Sporum's surgery could not be found; therefore, I can only make an assumption that Sporum underwent either a penectomy or a bilateral orchidectomy.

Throughout history, SRS was not uncommon. The following are only a few well-known cases: in Germany, in 1882, Sophia Hedwig, born Herman Karl, underwent MTF SRS; in 1933, Lili Elbe, another MTF, also underwent SRS (Fausto-Sterling, 2000); and in 1949, an English FTM, Michael (Laura) Dillon, underwent SRS and is often described in historical accounts (Devor, 1997). There is now a growing literature on the history of sexuality, gender, and transgenderism (including the history of SRS, and HRT). For more detailed information, see Green and Money, 1969; Boswell, 1990; Bullough and Bullough, 1997; Devor, 1997; and Fausto-Sterling, 2000.

However, it was the development of anesthesia during World War I and II and the experience of treating war injuries that allowed surgeons to work on the ambiguous genitalia of hermaphrodites and to attempt penile reconstruction. Until 1952, it seems that SRS was done quietly and without greater public knowledge. This changed when the American George Jorgensen went to Denmark to have the surgery and returned as female named Christine.

Another highly publicized case (A & E documentary, newspaper articles) in Canada was that of Sergeant Marie Guylaine Sylvia Durand. Her SRS was the first knowingly paid for by the Canadian Forces. In July 1988, Lieutenant-General Romeo Dallaire approved policy changes to fund SRS for military personal.

However, Mr. Benoit, the Reform deputy defense critic stated that he believed that "This is complete insanity," after he heard of Dallaire's decision (*The Ottawa Sun*, 1998). Sylvia Durand had her operation in 2000; however, she was not the first transgender individual in the Canadian Forces; she was only the first case made public. Sylvia has since been promoted to warrant officer and is active within the Canadian Forces in peer support and in advocacy for other transgender individuals.

The historical discussion of SRS must be seen in the context of the medicalization of the transgender issue. Medical care is supposed to be available to everyone, often for moral and ethical reasons, and in Canada, it is considered to be a "universal," accessible health care program (Government of Canada, 2007). Under the terms of the *Canada Health Act*, all Canadian citizens and landed immigrants are entitled to receive medically necessary care. However, the reality is that health care is likely to be more accessible to a select group, which does not include most transgender individuals, especially when it comes to SRS. Moreover, there is a difference between the provinces. In British Columbia (number of cases are unlimited) and Alberta (limited to 16 cases per year), SRS is paid by the government. In contrast to this, in Ontario, the provincial government removed its funding for SRS on October 1, 1998. For transgender people, universal access to needed health care is a far cry from reality.

In the 1960s, John Hopkins University Hospital, aided by private money, opened the first gender identity clinic. Reed Erickson, the founder of the EEF, a nonprofit, philanthropic organization, "funded Harry Benjamin, John Money,

Richard Green, and other pioneers of treatment and research connected with transsexualism (Devor & Matte, 2006, p. 393). John Money was one of the cofounders of John Hopkins University Hospital gender clinic and he oversaw many of the surgeries there. Some of these cases were questioned as to their ethics.

Colapinto (2000) describes one of these landmark cases. It is the story of a little boy who suffered after a botched circumcision in which Money suggested to surgically alter the boy to a little girl. The nature/nurture debate was clearly under attack in this case. The outcome of the John/Joan case is well documented. Money theorized that gender identity development was dependent on consistent rearing in the presumed gender, which he assumed was fixed by the age of three. Money supervised the child-rearing practices of the child's mother and reported that it was a successful reassignment. It later emerged that Joan never felt comfortable in the assigned gender and was later reassigned as a male. The tragedy of this experiment with nature is that David Reimer ended his life on May 5, 2004 at age 38; two years earlier, his twin brother had also ended his life by suicide.

In a case recently followed up and reported on by Bradley, Oliver, Chernick, & Zucker (1998), an infant's gender was also reassigned to female; however, as an adult, the individual chose to remain female. This demonstrates that similar cases can turn out very differently and supports that sex/gender are not clear cut. It also confirms diversity and that more research is needed in this area. It might also provide evidence that the socially constructed gender binary has an influence on child-rearing practices and the impact this might have on expression of gender identity should not be ignored.

In 1980, the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (*DSM-III*) officially listed transsexualism in print. The current edition, *DSM-IV-TR (2000)* considers Gender Identity Disorder (GID) as:

> A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantage of being the other sex).
> B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
> C. The disturbance is not concurrent with an intersex condition.
> D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. (*DSM-IV-TR*, 2000, p. 581)

Adults with Gender Identity Disorder are preoccupied with a yearning to live as a member of the opposite sex.

Criteria A and B also lists some specific disturbances that manifest in children with GID. According to the *DSM-IV-TR*, cross-gender identification in boys is evident by a noticeable preoccupation with traditionally feminine activities, such as avoidance of rough play or, while engaged in play, taking on female roles, such as mothers, nurses, or other roles traditionally assigned to females. In contrast to this, girls with GID express intense negative reactions to parental pressure to accept female roles and attire or, while engaged in play, a preference for boys' toys and, in their fantasies, taking on male roles is frequent.

For criterion C: the condition must cause significant distress and dysfunction to the individual and is an important factor in the diagnosis of GID. However, if the specific conditions outlined in the *DSM* are not met, professionals use the term "Gender Identity Disorder Not Otherwise Specified" (GIDNOS). "This category is

included for coding syndromes in gender identity that are not classifiable as a specific Gender Identity Disorder, and include conditions such as:

> 1. Intersex conditions (e.g., partial androgen insensitivity syndrome or congenital adrenal hyperplasia) and accompanied by gender dysphoria[;] 2. Transient, stress related cross-dressing behavior[; and,] 3. Persistent preoccupation with penectomy without the desire to acquire the sex characteristics of the other sex (*DSM-IV-TR*, 2000, p. 582).

The diagnosis of GID is needed to qualify for HRT and SRS. The criterion adheres to set gender stereotypes and gender norms of masculinity and femininity, which often creates difficulties because too many clinicians require that the client follows an exact pattern when transitioning. This entails matching the diagnostic criterion in the *DSM,* followed by HRT for MTFs chest-reconstruction surgery and hysterectomy, all according to the gender binary. However, not every client wants or needs that set pattern. Some genetic females might refuse femininity because they fully know and feel themselves to be male and masculine, and only want a hysterectomy and a male chest. They are not ready to start HRT. As clinicians, we have to be flexible; however, some clinicians will not give a GID diagnosis because the client does not fit the exact pattern.

According to Diane Watson, a psychiatrist and one of the founders of Vancouver's Gender Dysphoria Clinic (GDC), the outpatient department of the GDC assessed 300 people in 1985 who suffered from varying degrees of gender identity confusion. Diane Watson explained that only people with a constant and intense desire for living in the opposite gender will opt for SRS; "in fact only 29 of the GDC

patients have so far opted for gender reassignment surgery" (Zenith Foundation, 1997).

Pierre Brassard and Yvon Menard, plastic surgeons from Montreal, currently operate Canada's only sex-reassignment clinic. In an interview with the newspaper *Le Journal de Montreal* (Nov. 13, 2001), they stated that 15% of their clientele come from Canada. "Effectivement; les Drs Brassard et Menard effectuent quelque 230 vaginoplasties (transformation d'un corps d'homme en corps de femme) par année et une dizaine de phalloplasties (transformation d'un corps de femme en corps d'homme) (In fact, Drs Brassard and Menard perform about 230 vaginoplasties (transformation of a man's body in the woman's body) a year and a dozen phalloplasties (transformation of a woman's body into the body of a man)" (*Le Journal de Montreal*, Nov. 13, 2001).

The discrepancy between MTF and FTM transgender individuals opting for surgery is largely a result of the costs of the different types of surgery. There are some other factors that might influence an individual's decision; however, these are issues that should be addressed in another study. The cost (in Canadian dollars) for FTM-SRS depends on the different types of surgery. For example, according to 2006 prices at Pierre Brassard and Yvon. Menard's Montreal clinic, a phalloplasty is $39,900; testicular implants (which is the second step after phalloplasty) are $5,400; a penile implant is $14,500; a metaiodoplasty is $20,000; and, chest-reconstruction surgery is between $4,000 and $7,000.

In contrast to this, for MTF-SRS, a vaginoplasty is $16,500. Prices are subject to change depending on the surgeon and (or) on yearly cost increases. SRS is very costly and the majority of cases are not covered by Medicare; hence, the individual has to pay for surgery, and clearly only a small percentage can afford this operation.

Counselling and other adequate professional care, before and after an operation, for transgender individuals, who may or may not opt for SRS, is often only available in private clinics. This is an issue that urgently needs addressing in our health care system. Until 2004, we had no accurate picture of the cost of transgender health care; the most accurate numbers we have are from an American study.

Horton (2006) conducted a longitudinal survey between 2001 and 2004. The survey was sent to all surgeons who performed SRS and related surgeries on US residents. In the survey, she asked how many surgeries were performed in 2001 and what the costs of these surgeries were. Data were collected for 800 MTF and 430 FTM clients who underwent surgery and the average, combined cost for SRS was established at US$13,000. This research demonstrated that to include transgender health care would increase the annual cost per insured US resident, combining SRS, HRT, doctor's office visits, and therapy, by an insignificant amount of US $ .64.

In summary, the intent of this historical context is to provide some evidence that the phenomenon of transgenderism is not an aberration of modern society or an isolated cultural phenomenon—it is universal. Furthermore, it is not a new trend—it has existed since humankind has lived in this world. Therefore, transgenderism

should not be excluded and treated as immoral or as a mental illness. It should be understood as a natural occurrence of human diversity.

Chapter 3 Theoretical Frameworks

The objective of this study did not include undertaking an exhaustive survey of different theoretical concepts, but they are referred to in order to clarify the different understandings. An introduction to some relevant theoretical concepts was especially important because they assist in the understanding of gender and transgenderism from a socio-cultural perspective.

Symbolic Interactionism

The perspective of symbolic interactionism provides a powerful methodology for studying human groups and their interactions with each other. Scholars, such as Blumer (1969), Mead (1934, 1938), and many others, have contributed to its methodological foundation. According to Blumer (1969), symbolic interactionism encompasses three premises:

> The first premise is that human beings act toward things on the basis of the meanings that the things have for them. The second premise is that the meaning of such things is derived from, or arises out of, the social interactions that one has with one's fellows. The third premise is that these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters. (p. 2)

These three premises seem very clear. The position of the symbolic interactionist is that the meaning that things have for an individual are central to that individual, in his or her own right. The first premise is undoubtedly influenced by the second premise, which also influences the outcome of the third premise. This is exemplified in the instance of an individual suffering with gender incongruence. Social and peer pressures often force transgender individuals to conform to gender

stereotyping and gender role expectations; their internal knowledge of the self leads them to confront the issue that their body does not fit society's gender expectation. Over time the emotional distress of transgender individuals often leads to negative body image; this negative body image might be carried forward during the transition process in which a socially learned gender image becomes an obsession, longing for their own perfect male or female body.

Waltner (1986) used the theory of symbolic interactionism, to explore the way that the physical and the social world take meaning through symbols; the body is such symbol. People interact with each other and through these interactions meanings for animate and inanimate objects are established. Throughout a lifetime, an individual experiences change as new meanings are established through interactions with different people and groups. Each group adheres to their rules, creating their own group identity; however, these rules are subject to the dominant ideologies and beliefs of a particular social structure. Consequently, all meanings are socially derived products. These meanings are a result of our social contacts and, therefore, the social world clearly influences individuals and their concepts of self-identity.

Society is formed by human group life and, in these groups, people conform to set social norms. Fausto-Sterling (1985, 2000) explained that gender development is accomplished through interaction with others and is not merely an individually achieved identity. Early developmentalists used this concept and suggested that observations of family conflicts may hinder identification with the same-gender

parenting figure. Stoller (1968) and Kohut (1971) addressed transgender issues from a somewhat different perspective and came to the conclusion that "mirroring" of the self in relation to others might be distorted among transgender individuals. At this point, it becomes clear that, according to symbolic interactionism, the creation of identity formation is dependent on interaction with others: how we see ourselves, and the perception of how we are seen by others, helps us to establish self-identity (Higgins, 1999). It appears that the purpose of interaction is to socialize individuals to follow the discourse and material relations embedded in interpretations of "culture/society." Mead (1934, 1938) views the social self as an object and all the objects are products of symbolic interaction. This involves a subject–object relationship within a social field of interaction.

Within the perspective of symbolic interactionism, organized interactions depend upon language and symbols. Blumer (1969) distinguishes between three different kinds of objects: physical, social, and abstract. Physical objects include material items such as a desk, a chair, and a computer; social objects include a friend, a mother, and a father; and, finally, abstract objects include a value, an ethical belief, a feeling, a philosophy, or an idea. The notion of two separate genders is a social construct, and through gender assignment an individual is expected to adhere to certain norms and morals. The meaning of the social and abstract object of "gender" is learned through interaction with others. How individuals perceive themselves, the roles they play, and the role expectations to which they are required to conform are all influenced by what they learn through their interaction with

others. Society, culture, family, and peers are different social systems to which an individual belongs and through interactions with these systems an individual learns socially accepted behaviours and gives meaning to physical, social, and abstract objects.

Another important element of symbolic interactionist theory is that the nature of social interaction is not individualistic; it presupposes group life and group membership. Devor (1989) argued the following: "Individuals cannot create social meanings independently of the larger society within which they live" (p.149). Indicating that gender is a social product. If an individual's own perception of gender identity does not fit the social norm it creates dissonance. Furthermore, anybody and anything not fitting into the socially constructed norms is in danger of exclusion. Homeless people, people with a disability, gays and lesbians, and transgender people might find themselves on the outside.

The urge and need for belonging, acceptance, and socially constructed or biological commonalities connect them, and these clusters of people form their own groups: they become members of communities with common identities and interests. Societies establish labels and these labels are usually either positive or negative. Through social interactions, the individual takes the learned label and places themself into the social system either under a positive or negative self-conception. A mismatch between self-conception and input from socially expected role presentation is placed into memory as a negative affect (Cast, Stets, & Burke, 1999).

According to Nuttbrock (2002), transgender individuals can be successfully included in this social system in the context of relationships if they can find positive support and affirmation. I agree with Nuttbrock; if transgender individuals could be accepted they would, one would hope, fit more comfortably into the social structure. However, currently, transgenderism does not fall into any of the overall socially accepted gender norms and expectations, which, in most cases, leads to negative labelling.

Therefore, I would suggest that in order to establish complete self-acceptance and find a comfortable self-identity, transgender individuals need to see themselves from the outside first. Their social identity has to be deconstructed before an individual identity can be re-constructed and identity re-formation (Seidl, 2000) can occur. However, one has to recognize that this is not easy to do. Their upbringing is influenced by their family, society, cultural roots, peers, and social institutions such as the school system. To seek out belonging "is human nature." However, the idea of "human nature" is essentially a biological reductionism.

Transgender people, like all human beings, look for group membership and too often, like other social outsiders, they only find this in groups of their own kind. All human beings live in a world of subjects and objects, and our lives and activities are formed around our experiences. Usually the recognition of physical, social, and abstract objects in our social interactions provides us with comfort and safety. However, for transgender individuals, the social and abstract object of "gender" and the meaning society places on this socially and abstractly construed object, is the

cause of gender incongruence. Consequently, the goal of most transgender individuals is to "pass," become a member of the opposite gender group, fit into a socially accepted gender role, and conform to socially constructed gender expectations. The philosophy of symbolic interactionism might help us to understand why transgender people possibly will need the gender–sex binary, why it has an impact on their quality of life (QOL), and why they might have a hard time during the transitioning and identity re-formation process.

Post-Structuralism

According to Dunn (1997) post-structuralism rejects binary opposition in favour of a more fluid, diverse concept of identity. For Nietzsche, post-structuralism, is the construction of knowledge which is driven by necessity (Koch, 2005). To better understand this theory, pre–post-structuralist societies and their beliefs have to be brought into the discussion. John (1993) clarified the theory of post-structuralism by placing it into an understandable notion: post-structuralism is the reaction to modernity, which could be considered the foundation of a certain kind of "knowledge," which began with the philosophy of enlightenment and the "tradition of rationality." Enlightenment started as an eighteenth-century European philosophical movement, characterized by movement toward learning, critical observation, uncertainty, rationalism, and the assumption of humanism and objective reality. However, objective reality based on language is rejected by post-structuralism.

Ferdinand de Saussure (1974) argued that language is an abstract system of

different signs. The signs are made up of assorted sounds or written images, which he called the signifier and the signified, that to which the signifier refers. (The signifier is the language itself, while the signified provides the meaning of the language.)

The aforementioned concept might help to equip language with rules, but it does not point to reality (Weedon, 1987). However, Jacques Derrida was the first to question the social influence on meaning in fixed language and symbols (Doherty, Graham, & Malek, 1992). As pointed out in the second chapter, the linguistic structure of "gender" recognizes two to more than 20 variations. Derrida's explanation might help to understand the vast difference in the linguistic structure of "gender." Derrida talked about "intertextuality," by which he hypothesized that every text is infiltrated by other texts and none of them determines the ultimate meaning of the symbols (Norris, 1987).

In contrast to this is Foucault with his notion of "discourse," which could be considered as broadcasting the meaning of language. Foucault's approach was "to explore not only these discourses, but also the will that sustains them and the strategic intention that supports them" (Foucault, 1990, p. 8). Foucault further expanded on the meaning of discourse; it cannot exist without the historical context, social practices, a form of subjectivity, and power relations. But, foremost, the individual holds an imperative position in the subjectivity of the discourse; the individual self-identifies with the meaning.

Despite Foucault's confidence that the individual holds a vital place in and around the discourse; it is society that clearly imposes restrictions on an individual, such as each person's knowledge of their own sex/gender, their sexual as well as their gender identity and, through these restrictions, society takes away an individual's rights and freedom of self-expression; society imposes "knowledge of and therefore power over bodies" (Foucault, 1980, p. 165). With this Foucault also maintained that social interactions that produce the discourse are controlled by institutions such as educational facilities and medical, religious, and legal organizations.

Leonard (1994, 1997) further explored this in his discussion on the dependent subject, in the context of psychological and social dependency within the welfare state. "The discourse of universal and objective Truth, separated from the False, was the foundation upon which professions came to be established" (Leonard, 1997, p. 97). Through the creation of professions, which control knowledge and power, and decide what is true and false, society decides what is accepted or rejected and, once more, we see the concept of a binary system, rejecting fluidity and diversity. No grey area; no uncertainty is accepted.

Labelling populations, organizing them into categories, including the establishment of a mutually exclusive gender dichotomy was done by experts in various disciplines, such as medicine, psychology, psychiatry, and social work. These professions hold power over people (Foucault, 1991). To be included in the political arena one has to be included in society, even if it is only in a negative way.

In the binary conceptualization of gender, transgender individuals are outsiders because they do not fit into the mutually exclusive male or female gender category; however, it may be argued that professionals fit them into society by placing them in the category of social abnormalities.

It has been established that, on the one hand, transgender individuals are, for example, excluded in the UN and Canadian Human Rights Act, while on the other hand, their categorization and inclusion is guaranteed through labelling and institutional organizations such as medicine and the *DSM-IV-TR* (2000). Institutional organizations engage in categorizing populations and, consequently, we all live within the social construction of norms and practices. The aforementioned implies social discomfort with anything outside the "norm"; humans do not like blurred objects, they like clarity. Individuals who cannot easily be categorized as female or male have to be first excluded, then labelled and re-organized to fit into the dominant social discourse.

Butler argues that discourse works by means of exclusion and "the construction of the human is a differential operation that produces the more and less 'human,' the inhuman, the humanly unthinkable"; she goes even further by indicating that socially constructed categories such as gender are political categories (Butler, 1990, 1991, 1993).

Post-structuralism and symbolic interactionism have many commonalities. Both argue that social structure and language are never stable; social structure and language are in a constant state of evolution. Social structure uses language to

express thoughts, meanings, and actions. As indicated previously, language, as well as thoughts, are influenced by the political and social thinking of the time. Post-structuralism engages in the deconstruction of the knowledge claims of Western academia and this leads to the reassessment of the basic ideas of "objective" research in many disciplines, opening the way for new investigations, and continuing the process of rethinking the social construction of gender identity.

Post-structuralist ideas might provide directions and space to include new ideas, however, the current model needs work to include gender identity and expression as a more diverse and open concept. Monro (2005) theorized that post-structuralism sees both gender and sex as constructed, while the post-structuralistic model is concerned with social and political processes. Monro (2005) further argues that through their focus of the social and political, the theory denies transgender people's real experience since everything is based on the deficiency of the body. "James Green discussed his experience of having an essential self, which was more than his body, and that such experiences are common among people who suffer injury, for example, severe paralysis" (Monro, 2005, p. 9).

Social Constructionism

The social construction of the body has been the central theme in the construction of femininity and masculinity (Gorely, Holryd, & Kirk, 2003).

Burr (1998) expressed that the relativistic view from which social constructionism is often explained leads to personal paralysis. Burr (1998) feels that one has to abandon the idea of the ultimate truth to achieve an alternative

perspective. Only then does it become possible to reconstruct socially constructed concepts such as gender, sex, and illness. She questions language, and views the concept of "talking," in itself, as part of the social construct. How we talk, the words we use in speech, and the meaning of these words is guided by social as well as cultural influences. Social institutions (such as politics, medicine, and education) usually have an implicit, invested interest in discourse.

According to Burr (1998), the individual has a choice. However, having a choice depends on several factors: justifiability and improvement for certain people is important (Burr, 1998). In the case of the Samoan culture of the fa'afafine, which was overpowered by Western civilization, they did not have a choice. How the fa'afafine viewed gender was not justifiable to Western culture and it was not to the Western society's advantage, therefore making change necessary.

Schmidt (2003) investigated the shift of social acceptance in the Samoan culture of the fa'afafine—biological males who express feminine gender identity. The Samoan society created their perception of accepted gender expression. Gender diversity and fluidity were accepted as "normal" until westernization influenced the social acceptance of the concept of the fa'afafine; it also influenced the Samoans' cultural view and knowledge of gender diversity and fluidity. This example shows that gender is socially constructed and that the perception of what is considered "normal feminine and normal masculine" varies from culture to culture.

Humans feel comfort through knowledge; the origin of knowledge comes through thinking, categorizing, and processing of given information (Gergen &

Davis, 1985). Knowledge is a product of discourse, of language and symbols; together they establish perceptions and create blueprints that satisfy cultural expectations. However, if something does not fit into an established blueprint, we find ourselves at odds with the world. After westernization of the Samoan society, the fa'afafine experienced dissonance. Westernization forced them to exclude the existence of the fa'afafine in exchange for "new" mutually exclusive gender binary and new social values; the population's assumptions about culturally produced normality were destroyed.

Whereas, in the second case, in Saudi Arabian society, the patriarchal structure is dominant (see case illustration below). Usually the improvement is in favour of the dominant one, which, in most cases, excludes marginalized people or societies. In Saudi Arabian society, in which the patriarchal structure is dominant and, in cases of 46, XX intersex children with congenital adrenal hyperplasia (CAH)—a inherited malfunction of the enzyme that aids in the making of steroid hormones—the child would be born with masculinized genitalia and, therefore, would be initially identified as a boy.

Saudi Arabian doctors trained in either Europe or North America would suggest gender reassignment, and the child would be raised as a girl. Not so in Saudi Arabia with Saudi-trained doctors, where male infants would bring greater joy and pride to their parents. Suggesting gender reassignment would be countered with strong resistance from the parents. In this case, the cultural context of patriarchal institution, especially with the beliefs and practices confronted the assumptions of

Western medicine (Kessler & McKenna, 1978). Not only are the cultural beliefs and values that influence the social environment different from those of Europe and North America, these differences also influence medical practice and individual identity development. This is a very important factor in every transgender individual's QOL or transgender self-identity development.

The social constructionists' theory is open to questioning and critical analysis, as it calls into question claims to knowledge of Western modernity, as well as those of non-Western traditions. The openness of this specific theory might be especially interesting in the context of transgenderism. Kessler and McKenna (1978) examined the social construction of gender. They explored the possibility of breaking down the conceptualization of gender as a binary in favour of an alternative system for recognizing gender differences. The theory's position is that the behaviour, and consciousness of the self, is not influenced entirely by biology, but it is the direct outcome of socially constructed concepts and practices that are the product of historical context and cultural differences.

Existentialism

In direct contradiction to the previous theories is existentialism. Existentialism is a twentieth-century philosophical movement preoccupied with the existence of "being"; it questions right and wrong—do they exist, and is there any difference between them. Existentialism supports a belief of depersonalization—a loss of personal identity for the greater good of society as a whole. It is often described as the "science of morality"; knowledge comes from the church and medicine.

Throughout history, social institutions, such as the church, were considered the only bearers of social knowledge, and they strongly influenced the individual's perception of self within a dominant discourse. Some church doctrines have not changed; some church leaders still consider themselves as the bearer of knowledge and they still invalidate the individual's knowledge of self. The Ministry to the Gender Confused (1997) established the following:

> Where clothing of the opposite sex is worn, either covertly or openly, for the purpose of deception as to one's true sexual identity, or for false comfort, the Bible states that such practice is idolatrous. However, this word and the stern rebuke of any who rebel against God's obvious design for them (Isaiah 45:9-10) clearly point to the transsexual lifestyle and gender reassignment surgery being contrary to the Lord's best intentions for anybody and therefore sinful. (p. 10)

This church organization not only claims that they can heal and convert transgender individuals, but also place blame on these individuals for being different, and also blame the parents.

In the nature versus nurture debate, the church blames nurture (the environmental side), since nature is "God's" creation and "it seems 'impossible' to conceive that God could create somebody with a predetermined wish to change sex, having been born into the wrong type of body" (Evangelical Alliance Policy Commission, 2000, p. 17). The church persuasively and conveniently dismisses any biological proof that science has made to the contrary. God does not make mistakes (no biological errors); only humans (the environment) make mistakes. The Evangelical church appears to believe that the state and its institutions play their part in the production of knowledge, through the acceptance of transgender individuals'

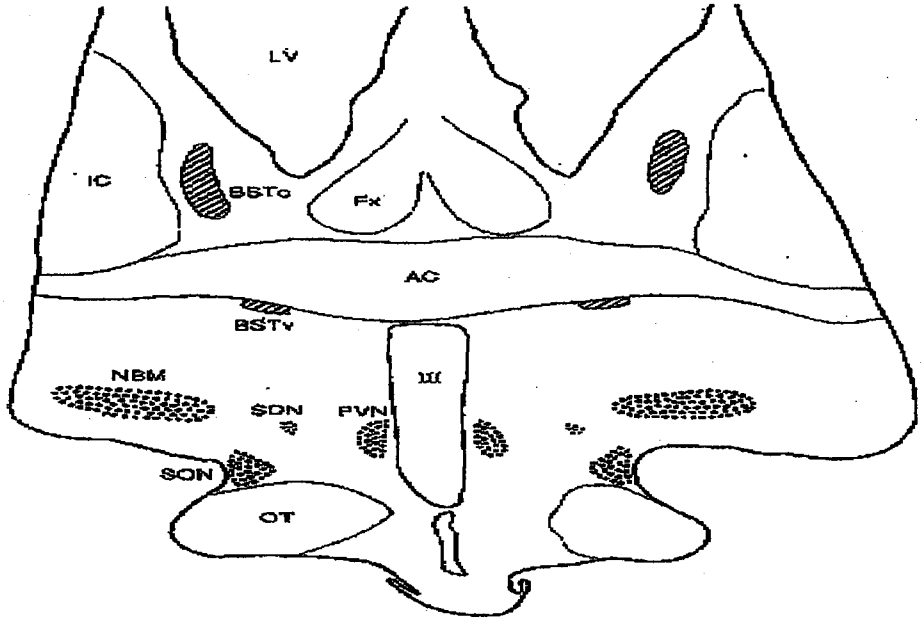
illusions (being born in the wrong body) and allowing them to change their sex. The Evangelical Alliance Policy Commission states that: "We affirm God's love and concern for all humanity, but believe that God creates human beings as *either* male *or* female" (the Evangelical Alliance Policy Commission, 2000, p. 84) and that transgender individuals should never be allowed to amend their birth sex.

Existentialism had an important influence in the medicalization of transgenderism. Medical classification created a division between hermaphrodites, in being the "true" or the real thing or the "spurious" or the pseudo-hermaphrodite, and also created gender dichotomy (Fausto-Sterling, 1985, 2000). Foucault (1980) pointed out that working with medicine and adding a medical condition and labels to sexual differences might help to redirect the focus away from moral sin and insanity toward a more relaxed subject; however, it could be argued that the medicalization of transgenderism is only another way of exercising social control over people's gender identity. Understanding gender from an existentialist point of view, one has to understand power and power relations.

With all of the improvements in science and technology, it appears more promising to find a biological cause for transgenderism. LaVay (1991, 1993) reported a difference in the hypothalamic structure between hetero and homosexual men. This was an important finding in providing a biological reason for homosexuality. Zhou, Hofman, Gooren, et al. (1995) studied the central subdivision of the *bed nucleus of the stria terminalis* (BSTc), a brain area that is essential for

sexual behaviour. Below is a depiction of the brain area by Zhou et al. (1995) that indicates the location of the BSTc.

Figure 1: Cross-Section of the Brain



The BSTc area is 44% larger in heterosexual men than in heterosexual women. The hypothalamuses of six MTF transsexuals were studied over a period of eleven years. This study found that the mean BSTc volume in the MTF was even smaller than the BSTc in biological women. The BSTc size was independent of the sexual orientation of the research subjects.

The Zhou et al. (1995) hypothesis, that gender identity variation may be a result of an alteration between the developmental brain and sex hormones, was not repeated. Secondary literature on this topic made firm assertions, such as, "Transsexualism can be considered to be a neuro-developmental condition of the brain" (Playdon, 2002, ¶ 2). Diamond and Sigmondson (1997a) found that

transsexualism is a form of intersex. Researchers are constantly working on biological explanations for transgenderism. However, as long as we have no indisputable proof for the cause, the current findings have to be seen as suggestive rather than definitive and perhaps there is more than one cause—i.e. multiple etiologies?

It seems like an oxymoron to use the medicalization of transgenderism to reach a paradigm change for transgender individuals. However, as pointed out previously, using medical conditions to draw the focus away from abnormality, using medical knowledge to point out genetic preconditions and, subsequently, using this as the basis to initiate a discourse on the non-disorder of transgenderism might be the way to reach acceptance of gender diversity.

We cannot forget the advantages that medicine brought to the treatment of transgenderism, HRT, SRS, and therapeutic interventions that assist individuals who request help to deal with their gender dysphoria. Transgenderism might be innate, we don't know for sure, however, we cannot overlook the impact that child-rearing, family, peer and social institutions (e.g. education) have on the re-enforcement of socially constructed gender norms and expectations. Both the innate as well as the social might influence transgender individuals QOL, self-confidence and the level of stress they experience.

There are not only different opinions on appropriate typology for, and the possible causes of transgenderism, but also about transgender treatment itself. There are two fundamentally different explanations for the cause and treatment of

transgenderism, which are based on the influence of the nature versus nurture debate on transgenderism. According to the 'nature' view, gender differentiation starts with the baby's development in the mother's womb. Although the exact reason for transgenderism is still unknown, different perspectives provide a growing body of evidence that the cause of gender identity disorder (GID) is biological (Zhou, Hofman, Gooren, & Swaaab, 1995; La Vay, 1991, 1993). However, variations in the genetic makeup, such as Klinefelter syndrome 47 XXY (Herzog & Money, 1993), 5 alpha-reductase deficiency (Imperator-McGinley, Peterson, Gautier & Sturla 1979; Imperator-McGinley, Sanchez, Spencer, Yee & Vaughan 1992), or congenital adrenal hyperplasia, are only some of the genetic/endocrinological variations identified as causes for transgenderism or intersexuality.

In contrast to the nature view, is the 'nurture' view. Money and Ehrhardt (1972) were of the opinion that the social influence in raising a sex-reassigned child is powerful enough to override the prenatal sexual biology. They revealed reports about children who had their penis accidentally ablated during circumcision and how, in one case, the parents were advised to raise the child as a girl, (Money, Hampson & Hampson 1957; Money, 1975; Money, 1984). Money's theory regarding the all importance of gender rearing was largely based on his belief that the reassignment of John-Joan had been a success story (see Chapter 2). While Money's idea was widely accepted in the 1970's it has subsequently been called into question.

Pluralism

Pluralism is a more inclusive theory; Monro (2005) envisioned a pluralistic theory of gender that "would develop notions of sex and gender as a spectrum, with standpoints which would include female and male as well as a range of (probably) less common, but socially viable, other gendered positions" (p. 19). This is why existentialism, from the standpoint of medical knowledge and pluralism, with its greater potential for diversity, might be seen as an improved theory. It may help us to understand the individual's point of view and experiences during their primary identity development; it may also help us to comprehend the creation of the internal conflict and the struggle of establishing a self-identity throughout the primary and secondary self-identity formation and re-formation process.

However, symbolic interactionism, post-structuralism, social construction, and existentialism are all based on the conception of socially constructed gender–sex binary, the sociopolitical, and the biological–existential influence on an individual's identity development. All these theories showed great improvement over the years; they all have important points and create understanding to add to the debate on sex–gender as a binary only or as a continuum. "However, it can be argued that while Butler and other poststructuralists account for the psychic constitution of the self, they fail to satisfactorily explain notions of self-essentialism. It is not enough to dismiss these as false consciousness, as it denies people's lived experience" (Monro, 2005, p. 9). Therefore, it should not be surprising that perhaps the pluralistic theory

of diversity is the one that truly allocates space for diversity in the gender–sex category. Since pluralism incorporates the understanding and tools of many theories.

Social Work and Transgenderism

"Social work's history with transgender persons can best be described as an invisible relationship" (Mallone, 1999, p. 7). Accreditation standards were revised to include gay and lesbian studies in the curriculum to provide comprehensive services to the GLB community (Humphrey, 1983; Newman, 1989; Mallone, 1992a). However, there is no movement toward including the "T"—transgender knowledge—into the social work curriculum.

Transgender people are virtually ignored: they are not acknowledged in the Canadian Human Rights Act, most provinces erased SRS from their list of essential services provided by Medicare, and there are few healthcare professionals interested and educated in dealing with transgenderism and the struggles this population face on a daily basis (Lev, 2004; Ettner, 1999). Further, there are few academic publications on this topic written by social workers. The latter will not change as long as transgenderism is ignored and left out of the social work curriculum.

Feminism and Queer Theory

There is an increasing amount of feminist and queer literature that addresses diversity issues such as transgenderism; however, during these attempts, their point of view too often only applies to some of the individuals integrated into the rather large continuum under the transgender umbrella. Too often feminist and queer theory are also based on the socially constructed gender binary and, even though sexual

orientation–identity is recognized as a continuum, it is still constructed on the basis of the binary system of gay male, male–male, gay women, female–female, or bisexuals who are sexually and emotionally attracted to either gender–sex within the binary, leaving out the individuals who want and need gender–sex fluidity, or the individuals who are attracted to transgender people.

> Queer theory refers primarily to lesbian, gay, or bisexual subjects, and the terms "lesbian, gay and bisexual" are founded in a gender binaried ontology, thus problematically reasserting, as well as challenging, binaried systems of categorization. (Monro, 2005, p.19).

Golombok and Fivush (1994) argue within feminist social theory that the term sex should be restricted to an individual's biological genital manifestation and the term gender should be applied to an individual's social qualities. Golombok and Fivush (1994) further indicate in their research that gender development does not only come through the interaction between child and parent, but rather that it is the result of the more complex interaction between the child and the overall social environment, a view we can trace back to social interactionism.

Feminism, is working toward changing socially created constructs and increasing knowledge and empowerment; traditional feminist theory is based on the distinction between genders and with this it has kept the binary concept of gender alive. The interest of feminist scholars is mostly on topics such as women rejecting traditional gender roles as mothers (Gillespie, 2003), women working in traditional male-dominated work, such as the military (Sasson-Levy, 2003; Kummel, 2002; Heinecken, 2002), gender inequalities at work (Kennelly, 2002; Dellinger, 2002),

and gender differences in scholarly achievement (Francis, 2000). Feminist scholars argue for womanhood and feminism from a perspective of political discrimination, the historical perception of the traditional female role in motherhood, and inequality. They identify women in relation to rejection of traditional created gender roles and expectations, pointing toward discrimination and exploring power differences between genders seen within a binary perspective.

Conversely, the post-structural feminist model, and queer theory, is a theoretical model that accepts the concept of the deconstruction of gender, arguing for transgender rights through their notion of "truth and difference" (Sandland, 1995). Hird (2002) suggested the presence of two typologies for the notion of gender, viewing transgender individual as either a "real woman" or a "real man," again keeping the binary concept alive or, according to Hird's second notion, viewing transgender as a "hyperbolic enactment" of gender, rendering the gender binary outdated. However, not everyone might find a genderless society desirable.

In the process of studying transgender people's QOL, confidence, and stress, significance has to be placed on the impact that social movements, political actions, professional notions, and social theories (e.g. post-structuralism, existentialism, pluralism) have in the creation and continuation of the gender binary and the acceptance or non-acceptance of gender diversity. Acknowledging their influence, addressing them in the clinical treatment, and viewing gender on a continuum (that envisions gender as a binary and fluidity) could be a start toward dispelling stigma

and discrimination, and would help clinicians in their work with transgender individuals.

Chapter 4

Explorations of the Literature: From Scientific Findings to Everyday Experiences

Overview

Anecdotal literature on transgender activism, medical findings on potential physiological causes of transgenderism, transgender care, transgender needs in relation to HIV, and biographies have been published with increasing frequency since the mid-1990s. However, in comparison to other topics, there is still very little scientific research being done, especially in the area of genetic research on the origin of transgenderism. Currently, when it comes to the question of what causes transgenderism, the short answer is, no one really knows. Three things we do know are: historical records trace transgender individuals as existing thousands of years ago, they are usually misunderstood, and their reality is often ignored. Ettner (1999) stated: "Doctors in general and particularly psychiatrists, responded with impassioned support of this position" (p. 41). Healthcare professionals are not the only group having difficulty accepting transgenderism; family, teachers, peers, and many people in the general population also have difficulty with individuals who are different; therefore, we should not blame healthcare professionals alone.

Increasing our knowledge of transgenderism by listening to transgender individuals' stories and by conducting further research in this area will improve our understanding. Goldberg (2006) found that practice guidelines and clinical training is

needed to promote consistency and quality of care for transgender people. Since transgender care is multifaceted, many levels of health care providers have to be included. Training clinicians to have transgender knowledge and sensitivity has to start in the educational institutions. Goldberg (2006) reviewed postsecondary training and found the following:

> In 2006, four educational frameworks were developed to guide the Vancouver Coastal Health Authority in creating systematic training for health and social service students as well as professionals already in practice. The frameworks are based on (a) review of course outlines from British Columbia post-secondary undergraduate and graduate programs in counseling, medicine, nursing, psychology, social work, and speech; (pp. 219–220).

However, in other provinces and educational institutions, transgender education is ignored in social work education and barely acknowledged in healthcare education in general. Medical students at the University of Ottawa only receive nine hours of education on sexual health which includes sexual orientation and transgenderism (personal conversation with Dr. Norman Barwin who teaches at the University and has many years of experience treating transgender people).

To understand the influence that a socially constructed "gender" concept has on QOL, identity development, and beliefs that healthcare professionals have about transgenderism, one has to understand the phenomenon in its historical context, past and current literature, and from various theoretical frameworks. Understood from this context, the impact that the socially created and mutually exclusive gender binary has on macro (institutions, medical system, organizations) and micro (family, peers, teachers) systems will be clearer. The influence these factors have on

transgender individual's QOL, confidence, stress and self-identity development and re-formation can be better understood in the context of socio-cultural historical precedents. The final chapter will include some recommendations for inclusion of transgender knowledge and care into social work education.

For this particular research, a number of different theoretical positions were examined in order to understand why transgenderism is such a problem for society and whether we need only a gender binary or both a gender binary as well as the possibility of gender fluidity, and why (see Chapter 3).

Literature Search

To cover as much information on the topic as possible, both published and unpublished material, several search engines (Google, Ingenta, MEDLINE, Sociofile, Psychfile, Social Work, and others) and libraries were accessed. The search for relevant material comprised data from the previous millennia until 2007. The material investigated and selected for use in this dissertation includes books, published and unpublished articles, newspaper reports, magazines, movies, documentaries, transgender people's experiences, Internet publications in three languages (English, German, and Spanish), personal conversations with Diane Watson, who has more than 25 years of experience in working with TG individuals, as well as my own experience as a therapist and Gail Knudson a psychiatrist and well known transgender researcher. Dr. Norman Barwin, Obstetrics and Gynecology, HRT treatment for transgender people, he is an advocate for the transgender population rights.

Some of these selections might not appear to be directly related to the research; however, all of this information contributes to a better understanding of transgenderism and this, in turn, leads to the focus and relevance of this particular research.

Academic Literature

The previous chapter addressed the literature on the creation of the gender binary through institutions such as the law, medicine, and religion, and how it affected individuals on a daily basis throughout the centuries, the historical context, and relevant historical aspects of transgenderism, from Deuteronomy, dated 621 BC, to AD 2007. Some authors used the historical context of transgenderism to bring awareness of the conflict between gender variations and the social importance of the fixed gender binary.

Brisson (2002) concentrated on the confusion that the phenomenon of transgender, especially androgyny and hermaphroditism, had on the social order. The discourse on transgender and social acceptance is still ongoing and, for anyone examining transgenderism, Brisson's work makes an important contribution in understanding the social resistance to diversity in gender and sexual identity.

Activists such as Wilchins and Howell (2002) debated gender–transgenderism in the political and civil rights context, and used gender and sexual identity interchangeably as if they were the same. Yet, throughout their argument, the social power of the non-acceptance of transgenderism can be recognized. The

focus in these writings is on the macro level, the institutional, medical, and legal exclusion of transgender people.

Bornstein (1994) argues that the idea of "being trapped in the wrong body" is influenced by social and cultural gender expectations rather than the true self-identity of the transgender individual. On one hand, she dismisses gender and opts for a genderless society; however, on the other hand, she also acknowledges that most people will conform to the gender binary in order to belong to the mainstream and traditional forms of gender and sexuality.

Califia (1997) noted the importance of educating the general public to accept and to support transgender individuals. Transgender education is not only needed for the general public, it is a very important aspect that has to be included in the curriculum of social workers and healthcare professionals in general. Further, Califia (1997) suspected that a genderless community is not the most attractive to most transgender people; they are individuals who, if they can, desire to "pass," preferring to blend into socially accepted masculine or feminine gender norms, clearly indicating the necessity of the gender binary.

Research done by Bullough and Bullough (1997) analyzed the knowledge of transgenderism and the Harry Benjamin International Gender Dysphoria Association (HBIGDA) Standards of Care, now known as the World Professional Association for Transgender Health (WPATH) Standards of Care, and the usefulness of it. Further, they examined transgender people's QOL as well as healthcare professionals' acceptance of transgender individuals' knowledge of self. Some areas of this

research are especially interesting; the participants' age group, 18 to 88 years, with a mean age of 44.3, is closely related to the participants' age group in my own study (which will be discussed in Chapter 6). Bullough and Bullough's (1997) research also demonstrated that transgenderism is a concern for transgender individuals throughout their life cycle.

Another area of investigation concluded that a large percentage of transgender individuals buy hormones through the Internet or from other sources not medically monitored and controlled. The overall findings of Bullough and Bullough's (1997) study indicated that many transgender individuals consider the HBIGDA Standards of Care to be important, that choosing either HRT or SRS is a life-changing decision, and that professional support is needed but very limited.

Boswell's (1998) paper was about a transgender paradigm shift where everyone should be able to express their gender identity freely, redefining transgenderism as a naturally occurring human authenticity. Szuchman and Muscarella (2000) also thought that transgenderism should be viewed as a naturally occurring human sexual variation. They found that using transgender as an umbrella term and adding various gender expressions helps to gain approval; "the modern transgender model is gaining acceptance by an increasing number of professionals" (Szuchman & Muscarella, 2000, p. 163).

In books on human sexuality, transgenderism is usually found in the section of sexual abnormalities and paraphilias. In their book, Szuchman and Muscarella (2000) place transgender in the same section as the male and the female gender. This

might indicate a small but significant paradigm shift as they were able to bring transgenderism into the forefront in an academic book about teaching human sexuality. This definitely was a step in the right direction in terms of normalizing transgenderism in the education of healthcare professionals.

Israel and Traver (1997), Ettner (1999), and Lev (2004) assisted professionals in understanding transgender individuals by providing guidelines in treatment as well as providing clients' personal accounts that illustrated the impact that social norms and gender expectations have on the creation of an individual's gender dissonance. Fear, shame, and guilt are not the creation of personal inadequacy; they are the domino effects of socially created gender norms and expectations. From birth onward, we all, including transgender individuals, learn social cues. Later, we use these cues to identify if others are male or female and, according to this information, we decide how we should interact with them. The transgender individuals self image is also influenced by theses learned cues, if these learned cues do not fit with their own gender feelings it will cause gender dissonance. Difficulties in finding and (or) keeping jobs, as well as problems in finding lodging, are well reported (Xavier, Bobbin, Singer, & Budd, 2005; Namaste, 2000).

Recently, there have been an increased number of studies in the area of needs assessment, including physical well-being of transgender people, especially in relation to HIV and STDs (Kenagy & Bostwick, 2005; Coan, Schrager, & Packer, 2005). Clements-Nolle, Marx, Guzman, & Katz (2001) found that 62% of transgender women in San Francisco were depressed. Several others found that

suicidal ideation, anxiety, and other forms of emotional distress were very high in this particular population (Pauly, 1993; Jones & Hill, 2002; Witten, Eyler, & Weigel, 2001; Feinberg, 2001). Hostile environments, negative body image, being on the "low end of the hierarchy of acceptability" in society (Herek, 1987) only add to the already damaged self-identity and self-acceptance.

Biographies

Biographies of transgender people express not only each individual's unique life story but also commonalities such as marginalization, suicidal ideation, depression, and many other issues experienced on a daily basis by transgender people. These narratives also demonstrate activism and determination, oppression through social norms and laws, and willpower to survive the odds. However, many of these narratives illustrate that the odds were too high for many. Hate crimes, sexual assault, chronic unemployment, denial of access to public space (such as restaurants, shops, public transportation, and education), abusive treatment by society (the law, the population in general, and mental health professionals), and retaliation for asserting their rights are all common stories.

Nestle, Howell, and Wilchins (2002) recorded the story of Silvia Rivera, a transgender woman and political activist. In her story, Ms Rivera explained that police raids on gay bars in the 1960s were very common in which the patrons were divided into three groups. "And here the law walks in and it's, 'Faggots here, dykes here and freaks over here' the queens and the real butch dykes were the freaks" (Nestle et al., 2002, p. 78). Each group was inspected and females had to prove their

gender with three articles of female clothing. To pass inspection, the clothing had to be whatever the police thought was socially acceptable female attire. This verification was required by law (Nestle et al., 2002).

There have been changes since the 1960s; however, there is still an enormous lack of protection for transgender individuals by the law enforcement sector. The data on violence experienced by transgender people are very limited. The Annual Report on Anti-Lesbian, Gay, Bisexual and Transgender Violence in the United States (2000) cited that of all the murders committed in the United States 20% were identified as anti-GLBT murders. Of those estimated 20%, the percentage of violent crimes committed against transgender individuals was 2% to 4%. The Annual Report on Anti-Lesbian, Gay, Bisexual and Transgender Violence in the United States (2000) also found that there was an immense difference between MTF and FTM; the report indicates that 98% of MTF experienced violent acts against them, in contrast to the only 2% of all anti-transgender violence experienced by FTM (Stryker, 1999).

Gender non-conforming individuals are at high risk of violence. Lombardi, Wilchins, Priesing, & Maloug (2001) pointed out that over 50 percent of participants in their study expressed that they experienced violence or harassment. For reports of violence against genetic women see: Tjaden and Thoennes (1998) who reported that violence against genetic women is higher in the United States compared with violence against genetic males.

Feinberg, a well-known transgender writer, expressed, in several of his books, how difficult life was and still is: "We live under the constant threat of horrifying

violence" (Feinberg, 1998, p. 68). Violence is often directed against people whose sexuality and appearance does not conform to the socially accepted gender norms (Tomsen & Mason, 2001).

However, there are some stories that provide evidence of how happy transgender people can be if they are able to change their sex through SRS and how this change positively influences their outlook on life. Patrick Verret, an FTM from Montreal, (*The Gazette*, 2003) is one of these fortunate individuals. The article in *The Gazette* provided statistics from the Directeur de l'état civil within the Government of Quebec; between 1997 and 2002, the total number of SRSs was 57, 16 of which were FTMs, and 41 were MTFs.

These numbers indicate that less than half of FTMs, compared with MTFs, will have SRS. As previously discussed, many transgender people cannot afford the operation. Gathering statistical data for this population is difficult. Further, transgender people born in Quebec but not living in Quebec and who transition outside Quebec or only transition with the help of HRT but not SRS experience great difficulties in changing their status according to the "Directeur de l'état civil." Therefore, they would not be included in the statistics, resulting in severely distorted data.

Desperation can drive transgender people to extraordinary and courageous acts; an example of such internal conviction is the story of Maryam Khatoon Molkara (*The Globe and Mail*, 2005). Although she was subjected to violence and persecution, she pushed forward with her plea to change her sex–gender and finally

persuaded Ayatollah Khomeini himself to introduce a new religious doctrine and, along with it, a new social law based on the assumption that transgenderism is a naturally occurring human variation.

The religious law changed in Iran, but, her constant fear of being stoned to death remained and demonstrates that even though laws can change, society needs a long time before it can accept change. Changing the "fundamental knowledge" that the human race only consists of male and female often creates an impasse between society and the law. Alec Casanova-Ferrer (2005) found that some higher courts will try and make recommendations such as the following:

> In 1989, The European Parliament approved a Resolution on the discrimination of the transsexual people *in whom* [italics added, sic] it requests to the *States members that pass* [italics added, sic] dispositions on the right of the transsexuals to change of sex of endocrinologic and surgical character, the procedure and the prohibition of discrimination, treating of which all the costs are responsibility of the National Health Service. (p.1).

However, the reality is that the treatment of transgender people is very unequal, even in countries that belong to the European Union, such as Spain, where transgender people are still discriminated against in social as well as legal areas.

Austria encounters a similar legal dilemma in the access to and treatment for Gender Identity Disorder; legalization of civil and family status is only regulated under a declaration of the "*Transsexuellen-Erlass,*" which is not obligatory to the courts (Grief & Kepler, 2004).

Bill Siksay, a Canadian politician, prepared Bill C-392 to include gender identity and expression in Section 2 and subsection 3(1) of the Canadian Human

Rights Act; the bill went into its first reading in May of 2005 and was re-introduced into Parliament on June 19, 2006; however, since then, no further action has been taken to extend the Canadian Human Rights Act to include transgender people equally (Siksay, 2005).

There are few publications that include narratives expressing the experiences and struggles of family members in which either they come to terms with accepting and loving their transgender companion, parent, or family member or they are letting go of them, disowning, and hating them (Howey, 2002; Boenke, 1999). Some are willing to share their own stories, their pain, laughter, oppression, fear, and isolation (Brown & Rounsley, 1996; O'Keefe & Fox, 2003; Kotula, 2002; Rudd, 2000) and yet, even though autobiographies are important and they bring about a certain dialogue that demonstrates sameness, we also have to be aware that they are not representative of most transgender people (Hausman, 1995).

Transgender literature, especially biographies, brought increased awareness to issues such as isolation, marginalization, suicidal ideation, depression, unemployment, retaliation, oppression, harassment, and being ridiculed and targeted, which are not uncommon realities for transgender people. It also demonstrated that despite not fitting into the gender norms and expectations (created by people), there is a need for belonging and social acceptance.

Although some of these books and articles are, overall, positive, they too often look at transgenderism neither as a naturally occurring phenomenon nor as part of a larger gender continuum; they either investigate transgenderism as a pathological

issue that has to be fixed, or as a political vehicle that can be used to blame somebody or something. However, they forget about the many transgender individuals that only want to make their own choice, of either belonging in a gender binary or choosing gender diversity and, in either case, to live their lives without being seen as freaks or used by others as showpieces for their political activism.

Academic Literature on Quality of Life

In the last several years, there has been an increased interest both in transgenderism and in studies on QOL. However, most studies found are in relation to the study of illnesses and needs assessments. Clearly these are all concerns that can affect QOL and self-confidence, as well as increasing levels of stress. Therefore, these studies are important to address in the context of what affects the QOL and self-confidence of transgender individuals.

To increase an individual's QOL, many factors have to be taken into consideration. Connection to others is only one of the factors that might make a difference between a reduced and a good QOL. If an individual is isolated and has to keep secrets it might cause stress and affect their QOL and self-esteem. Bockting, et.al., (2005) reported that transgender individuals have far less family and (or) peer support, compared with the non-transgender population. Although the Internet and transgender peer support groups provide an individual with increased access to other transgender individuals, research participants identified that they still feel isolated. Some report that they suffer from severe isolation. In a study done in Ottawa and

Toronto and environs, 80.6% of the participants ($N = 54$) reported that they suffered from isolation (Seidl, 2003).

Huba, Melchior, Sullivan & Panter (2002) investigated eight facets of health related to QOL, which included: physical functioning, role functioning, energy, social functioning, cognitive functioning, pain, emotional well-being, and current health perception. It was a qualitative study, with face-to-face interviews and focus groups, the interviews were conducted during February to April of 2002. The study was done as a needs assessment for HIV-positive clients. The participants included 217 males, 150 females, and 3 transgender individuals, for a total of 370, in the group aged 18 to 71 years. For emotional well-being, the researchers found that there was little difference between males (mean 59.71, SD 27.08, medium 60) and females (mean 58.80, SD 27.76, medium 60). However, there was no differentiation made within genetic males and females and the transgender category.

There was also no indication made if any of these three participants included themselves in the male or female group or if the QOL of these three transgender individuals was different. Again, only individuals who clearly identify within the socially constructed gender binary were considered. This does not provide us with information on the QOL and well-being of the great diversity in the transgender population. However, I think that it is worth pointing out that this study provided room for difference in the initial identification of the participant's gender.

Clements-Nolle et al. (2001) also investigated HIV prevalence, risk behaviour, health care, and mental health in MTF and FTM transgender individuals. The study

investigated 392 MTF and 123 FTM and found that HIV prevalence and risk was higher in MTF (35%), compared with 2% in the FTM participants. Most of the MTF (78%) and the FTM (83%) had seen a health care provider in the previous six months. It appears that transgender individuals will seek out health care for physical illness. However, their findings also indicated that 62% of the MTF persons were depressed and that an astounding 32%, both of the MTF and of the FTM, expressed that they had attempted suicide.

Gehring and Knudson (2005) investigated a clinical sample of childhood sexual abuse in transgender people. The sample included 42 transsexual individuals (34 = males, 8 = females) at birth. From this sample, 55% (n = 23) reported that they had experienced an unwanted sexual encounter before the age of 18. Other important aspects in this research were the high percent who reported being verbally abused (77%), insulted (81%), embarrassed in front of others (55%), or made to feel guilty by their parents (58%). The study found individuals reporting difficulties in making adjustments to major life stressors, which has to be taken into consideration in the process of coming out, transitioning, and (or) in acceptance of fluidity. Lack of self-confidence was also indicated.

Rakic (1996) reported an increase in QOL after SRS. The study was conducted by the medical team at the Belgrade Clinic. They designed a questionnaire that addressed four standard areas of QOL: the patient's attitude toward their own body, relations with other people, sexual activities, and occupational functioning. The study examined 32 TS individuals (22 males and 10 females). After the

operation, the follow-up period was from six months to four years. For most, QOL improved within the four aforementioned areas.

Lawrence's (2003) study also supported the findings of Rakic (1996). She investigated 232 MTF transsexuals during 1994 to 2000. All of the individuals investigated had to be post-operative for a minimum of one year to fill out a questionnaire concerning their experiences and attitudes. Lawrence reported that most participants stated that their QOL after SRS had improved. She also found that variables such as marital status, age at surgery, and sexual orientation were not significantly associated with QOL. Some dissatisfaction was reported in the area of physical and functional results after the surgery. Lawrence (2003) investigated only the results of satisfaction of one surgeon.

Xavier et al. (2005) conducted a needs assessment of transgender people in Washington, DC. The study revealed that transgender people in this area are at high risk for HIV/AIDS, violence, substance abuse, and suicide. Two hundred forty-eight transgender people participated in the study, MTFs (n = 188) and FTMs (n = 60). The median age of the participants was 27 (n = 22); 54% were included in the group aged 13 to19 years; most were between 30 and 39 (23%) years of age; participants numbers declined with higher age, as reflected in the group aged 50 to 59 years (7%); and only 1 participant was in the group aged 60 to 61 years.

Recruitment was done via convenience sampling, the snowball technique, and with a financial incentive of $10. Thirty-one percent of the participants reported health care provider insensitivity or even hostility. It was not clear if this was due to

their HIV status or due to their transgender status. Nearly one-half of the sample (48%) reported alcohol or non-specific drug problems. Thirty-eight percent reported suicidal ideations, with 63% of these reporting that their suicidal thoughts were due to their gender issues. A higher percentage (52%) of FTMs reported suicidal ideations, compared with 33% of MTFs. This study did not directly measure QOL or self-confidence, yet there are all factors affecting QOL and self-confidence.

Furthermore, the recommendations of the Xavier et al. (2005) study are excellent, pointing out the need for transgender education for health care providers, sensitivity training, insurance needs, and advocacy.

Nesteby (n.d.) found that transgender individuals often experience discrimination, violence, and poor access to health care. He starts by describing the broad terminology used to portray transgender people: "There is a wide variety of terminology to describe gender identity and expression (University of California Berkeley Office of Student Life, 2005).

Beemyn and Rankin (2006) found that transgender individuals' self-descriptions vary by culture, group belonging, religion, age, and self-identity (Nesteby, n.d.). This is very important, especially in Canada, where, for example, self-descriptions used in the West often do not have the same meaning in other parts of the country. As clinicians, we have to take into consideration that we have clients living in different provinces or even countries, especially because webcam (Internet) counselling is on the rise.

Another important issue that Nesteby (n.d.) addresses is that transgender individuals in the United States suffer from discrimination, as they are being fired or denied housing due to gender identity and expression. QOL is severely affected both MTF as well as FTM have a reduced QOL. Newfield, Hart, Dibble, and Kohler (2006) found that, compared with the non-transgendered population, FTMs had a reduced QOL.

Newfield et al. (2006) evaluated health-related QOL in FTMs in the United States. Four hundred forty-six ($N = 446$) individuals participated in this study. The data were collected over a twelve-month period. The study population was compared with non-transgender subjects and there was a significant difference in QOL between the two populations. An in-between transgender group correlation was also measured, which indicated that those who received testosterone (68%) and those who received chest-reconstruction surgery (37%) had a significantly higher QOL, compared with those who did not receive testosterone or chest-reconstruction surgery. The conclusion of the study was that the FTM-transgender group who did not receive testosterone or chest-reconstruction surgery demonstrated a significantly reduced mental health-related QOL and that extra concentration has to be placed on the determination of the cause for this increased distress.

Sjoberg, Walch, & Stanny (2006) developed a new standardized measure of adjustment for transgender adults. The instrument was tested at the 2001 Southern Comfort Conference held in Atlanta, Georgia. This annual conference is open to a wide variety of transgender people, spouses, partners, and families. The researchers

distributed 423 survey packages. A total of 195 (46%) were returned. Most participants were MTFs (n = 173, 89%), followed by FTMs (n = 13, 7%) and individuals who self-identified as IS (n = 3, 1.5%).

Two of the four factors for the transgender adaptation and integration measure scale (TG AIM) demonstrated high construct-related validity, which made this measurement a great source for measuring self-esteem and QOL. Both Gender-Related Fears and Psychosocial Impact of Gender Status were significantly correlated in the expected directions, with measures for QOL and self-esteem (Sjoberg et al., 2006). This positive correlation indicated that if a transgender individual's fear was low, their self-esteem and QOL were high. A moderate, positive association was found between psychosocial impact of gender status and psychosocial adjustment, which indicated that a good psychosocial adjustment is related to a higher QOL.

Sjoberg et al. (2006) hoped that "this measure may serve as a screening tool for gender dysphoria among MTF transsexuals and aid in the assessment of readiness for genital surgery, which requires demonstrable adjustment to gender identity and social and interpersonal issues" (p. 43). The sixth version of the standards of care for gender identity disorder are very clear in their readiness and eligibility requirements (Meyer, Bockting, Cohen-Kettenis, Coleman, DiCeglie, Debor, et al., 2001).

Therefore, if the findings of Sjoberg et al. (2006) could help clinicians in their assessment, this is a great and much-needed study. However, the study does not

establish if there is a difference in self-esteem and QOL between transgender individuals preferring the gender binary and individuals that prefer gender fluidity.

Witten, Eyler, and Weigel (2001) investigated aging and transgenderism in her study. One hundred twenty-one people answered her questionnaire. She investigated abuse, including mistreatment that individuals have experienced by religious, educational, and medical institutions, and in the home or family environment. The participants' answers revealed themes such as stigma, abuse, name-calling, harassment, as well as physical and emotional abuse. These are all issues that might affect a person's QOL and well-being. The following statement indicates some of the problems this population experiences as well as how difficult it is to research this population. Witten et al. (2001) found the following:

> Population estimates for the gender community are difficult to obtain and verify, due principally to the currently highly stigmatized nature of transsexualism, transgenderism and cross-dressing identifications and behavior, as well as the lack of available resources for the gender community in many geographic regions. (The latter phenomenon leads to the choice of private solutions, such as "passing" as the other sex without medical or mental health assistance, and therefore to "*epidemiological invisibility.*"
>
> (p. 10)

Access to health care for transgender, transsexual, and cross-gender was addressed; however, the struggles of the cross-gender were only touched upon, mentioning that if a cross-gender individual shaves their body hair they might avoid a visit to the doctor until their hair has grown back. This indicates a reality for the cross-gender population but it also provides some indication of the QOL experienced by some cross-gender individuals. This paper is important, not only because it

addresses issues that affect transgender individuals of all ages but also because it goes further by addressing issues of aging. The population, in general, is getting older, and this includes transgender people. Unfortunately, there is not enough research on how HRT, SRS, or past social mistreatment might affect this population in old age. It is important work.

With increased age, cardiac and pulmonary dysfunction, and issues with hypertension, may influence and even preclude eligibility for HRT and (or) SRS (Aronow et al. 2002). These are additional issues which may affect QOL.

Investigating geriatric care and management issues in transgender and intersex people, Witten (2002) found that transitioning in later life brings with it different challenges but that certain advantages are also enjoyed. As is generally the case with older people, the older transgender individual faces health issues that can definitely affect their QOL. Finding a physician, home care, or a nursing home that accommodates gender-diverse clients can be difficult.

The following are only two of many stories of such incidences of refusal by medical personnel. In the case of Cynthia Cousin from Quebec, appropriate medical care at the hospital was refused after the doctor discovered, during the physical examination, that she was transgender.

Tyra Hunter, a pre-operative MTF from Washington, D.C., was refused continuing care after paramedics, arriving at a hit-and-run accident site, found Ms. Hunter severely bleeding and in the process of providing aid discovered her transgenderism.

Two needs assessment studies conducted in Philadelphia found that 25% of the participants reported that they were denied care due to their transgender status (Kenagy, 2005). Some reports show that access to health care providers is limited (Kenagy, 2005; Lombardi, 2001).

Internal struggle related to GID is not always evident. Clinicians have to rely on their knowledge of transgenderism and standards of care, but foremost, the client's own report of self-knowledge, including social and occupational functioning. Therefore, research on QOL will help clinicians not only in assessing GID but also to provide the diverse transgender population with the help they need. Feldman and Goldberg (2006) stated the following: "It is vital for primary care providers to understand the diversity of the transgender community and to avoid a narrow idea of "transgender health" (p. 4).

Chapter 5 Methodology

Overview

The purpose of this study was multiple. Currah and Minter (2006) explained that the contemporary term 'transgender' has become an 'umbrella' term that is used to describe a wide range of self-identities and experiences. Even though there are many different terms for transgender self-identities my clinical experience as well as the experience of other clinicians (i.e., Diane Watson) is that there are two main categories which have to be taken into consideration in therapy, since they have different needs. Conversely it is important that the two categories are open and inclusive. Inclusiveness was achieved by clustering the spectrum of transgender identities into two groups – fixed or fluid – for the basis of comparison. The fixed cluster includes transgender individuals who prefer the explicit category of either male or female within a gender binary, while the fluid group prefers a fluid interpretation, in which gender is experienced as potentially flexible and on a continuum. The fixed cluster needs transitioning (MTF or FTM) whereas the fluid cluster needs to be able to live both genders (see Table 1).

As previously stated, understanding the difference between the two groups is important because it can influence the way someone will seek and respond to clinical services such as counselling. Clinicians have to be aware of this difference since it has a severe impact on the options of clinical management (i.e., HRT, SRS, acceptance of being transitory and different). The next step was to investigate

whether or not a difference exists between the two groups – fixed or fluid – in their QOL, self-confidence, level of stress and counselling satisfaction.

Diagnosis and treatment outcome is evidence based and in order to be accountable, especially with insurance cases, we need tools to measure treatment outcome. Improvement of QOL, a decrease in stress, and an increase in self-confidence provides evidence that treatment is working for the client. I wanted to use a quality of life (QOL) scale which is already well known for its high reliability and ease of use in clinical settings. Therefore, I chose Memorial University of Newfoundland's Scale of Happiness (MUNSH) (Kozma, & Stones, 1980) and Bradley's Well-Being scale (BWB) (Bradley, 1994). For more information on these scales see the instrument section in this chapter. Since none of the scales were previously tested with transgender people, I needed to check their reliability in order to measure QOL of transgender people. The scale that proved most reliable was then used to determine if QOL differences exist between the fixed and the fluid transgender groups.

Previous research (i.e., Blanchard, 1994; Lombardi et al., 2001; Lev, 2004; Bockting et.al., 2005) identified issues such as shame, guilt, anger and less family support, which are all concerns that have an impact on transgender peoples' QOL. Knowledge of the literature influenced my decision to offer participants an opportunity to discuss, in detail, their life experiences in childhood, adolescence and adulthood in the final part of the research. The individual's life experiences have to

be taken into consideration in treatment because it influences how the client will respond to counselling.

During the initial search for contacts I realized how difficult it was to locate and then recruit transgender people willing to participate on a volunteer basis in my research study. Transgender people have often been mistreated and/or misjudged and have frequently suffered marginalization and oppression by professionals, as well as by family and peers, and as a result, transgender individuals are often reluctant to reveal their transgenderism (Lev, 2004; Stryker, 2006). This challenge will be further discussed below.

Conducting Research with Transgender Individuals

When contemplating any kind of research, especially that which deals with sensitive issues, ethical considerations are key. Voluntary participation, informed consent, anonymity, and confidentiality are of the utmost importance for any research. In order to approach research with transgender individuals in as ethically sensitive a way as possible, the study was designed to be user-friendly, and allow space for a diversity of identifications and perspectives. Most importantly, participation was anonymous and confidential. Each of the scales in the questionnaire could be filled out and forwarded to the researcher independently, giving participants full control They could not only choose to leave out questions but also full scales that they found inappropriate or irrelevant to their transgender experience and/or identity.

Research should never harm people (Rubin & Babbie, 1997). Because this research project required participants to reveal aspects of their personal lives that are often unknown to friends and family, every precaution was taken to inform participating individuals of their rights and of the potential consequences of their involvement. All individuals were required to provide their consent in order to participate. Although this study did not intend to cause any physical or psychological harm, it is acknowledged that it did have the potential to bring thoughts or behaviours to light that could be in conflict with internally-held understandings and the dominant social norms which, at the very least, may result in feelings of discomfort. Accordingly, it was made clear to participants that they had the right to withdraw from the study at any time.

To gain a comprehensive picture of the transgender population, it is important to take its internal diversity into consideration. This could be achieved through a comparative approach. Comparative research is primarily used for cross-cultural studies in which sensitivity is required in dealing with cultural and political differences, as well as rules guiding social behaviours and differences (Neuman, 2000).

In this research, similar sensitivities had to be considered when comparing the various groups under the transgender umbrella (e.g. fixed or fluid). Individual development of a healthy transgender self-identity is often negatively influenced by our social learning of gender roles and expectations which are in accordance with a socially constructed gender binary. Devor (1989) argued the following: "Individuals

cannot create social meanings independently of the larger society within which they live" (p.149). Individuals learn about gender roles from sources such as family and peers at the micro-level or from individuals in educational, medical or religious institutions at the macro-level (Higgins,1999). Therefore, sensitivity was shown by means of providing the participant with the right to withdraw from the study at any time and by respecting confidentiality. Individual self-perceptions were also taken into consideration by providing the participants with a variety of transgender self-identities as well as a category of 'other,' in case their perceived self-identity was not included.

The study used a mixed methodology comprised of quantitative and qualitative research. First, a quantitative questionnaire comprised of several surveys and open-ended questions was distributed. This was followed by a qualitative segment in the form of 11 semi-structured, face-to-face interviews. As previously identified the quantitative part first investigated two QOL scales, MUNSH (Kozma, & Stones, 1980) and the BWB (Bradley, 1994). The scale that achieved higher reliability was then used to measure QOL of transgender participants (see Chapter 6). Gender-Related Behaviour Scale, Self-Confidence Scale, Perceived Stress Scale (PSS), and personal demographics were also used in the quantitative section. The scales can be found in Appendix 5.1; 5.6; 5.7; 5.8; 5.9 and 5.10. Qualitative data was used to better understand individuals' QOL, level of stress, self-confidence, family influences, and personal counselling experiences. Reasons for the use of mixed methods are explained in further detail below.

Why Mixed Methods

Barbour (1998) found that disciplines such as medicine, nursing, or social work have their own traditions in terms of research methods. Further, each researcher has his or her own agenda. I also had my own agenda (i.e., clinical experience), and although controversial, my decision to employ a mixed method was informed by several factors (i.e., my role as a clinician and researcher, funding issues, explaining findings which are on the periphery, improve the clarity of findings).

Since this research was not funded, money was a major issue. Therefore, using a quantitative method in the form of questionnaires allowed for Canada-wide distribution without incurring extensive travel costs. Additionally, previous research has established that transgender people tend not trust health care professionals (Lev, 2004; Meyer et al., 2001). Since I am also a clinician, I had to take this into consideration. Using questionnaires provides discretion and anonymity for participants, while also allowing me to be a researcher rather than my usual role of clinician. As well, it was important to find a way to permit participants to recount their own experiences with as little interference from the researcher as possible. Open-ended questions at the end of the quantitative section helped to make this achievable.

Participant responses in the open-ended questions produced complementary information that allowed new research questions to arise. The open-ended answers also provided information on how outside influences (e.g., family, peers, teachers)

lead to changes in the participants' self-perception, modification in interpersonal behaviours and life situations, which, for many, had a severe impact on their QOL. This information can be used to increase clinicians' knowledge of transgender people's experiences towards the aim of positively affecting treatment outcomes.

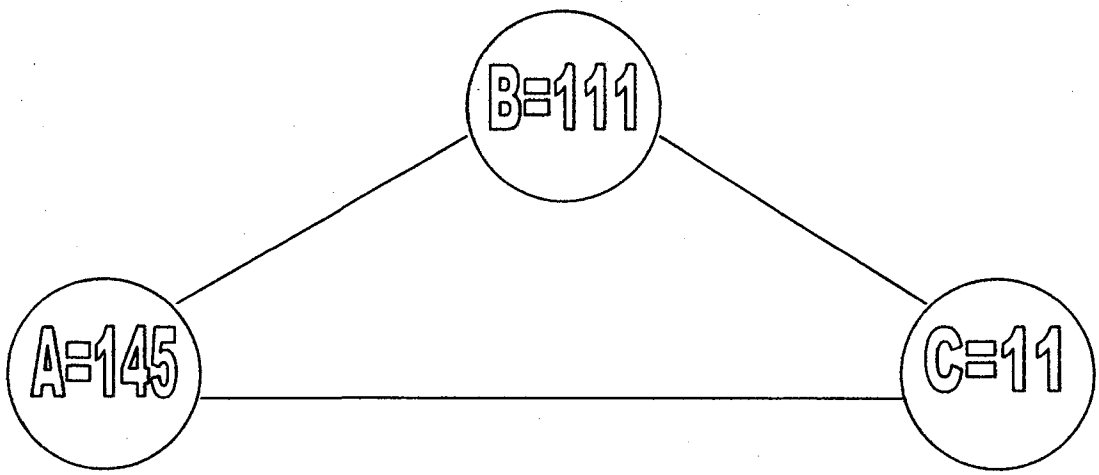
While authors scrutinized the ways in which research methods could impact people, Barbour (1998) found that of all of the qualitative methods tested, face-to-face interviews were the least criticized. However, this type of method can also be problematic. The researcher might influence the interviewees to accomplish their own agenda or the interviewees might be uncooperative as it resembles "a somewhat rarefied exchange, which is perhaps more akin to a therapy session" (Barbour, 1998, p. 357). As previously pointed out, transgender people tend not to trust health care professionals (Lev, 2004; Meyer et al., 2001). Therefore, if the interview seems to resemble a therapy session, both the researcher as well as the interviewee might influence the outcome.

Gaston and Marmar (1989) found that there are dual advantages of richer process-outcome findings when combining quantitative and qualitative approaches. Since themes that emerge from the face-to-face interviews might help to explain quantitative findings that are on the margins.

Another reason for using a multimethod research design was for the purpose of triangulation: "Triangulation assumes that the use of different sources of information will help both to confirm and to improve the clarity, or precision, of a research finding" (Lewis & Ritchie, 2003, p.275). Figure 2 provides a visual diagram

of the triangulation of methods and the number of participants in each of the different approaches. A = quantitative questionnaire, $N = 145$, B = qualitative open-ended questions at the end of the questionnaire, $N = 111$, and C = face-to-face interviews, $N = 11$.

Figure 2: Triangulation



Triangulation is achieved by using different methods (such as quantitative and qualitative data) as well as by using different sources (open-ended questions and face-to-face interviews).

Both the quantitative and the qualitative approaches have their own strengths and limitations (Gaston & Marmar, 1989; Lewis & Ritchie, 2003). The limitations of this particular research are explained later in this chapter. Even though using a multimethod research design is controversial and difficult, I believe that I achieved what I set out to do: finding a QOL tool which is easy to use in a clinical environment, establish the QOL of transgender participants (fixed and fluid), measure self-confidence, stress, counselling satisfaction and to identify themes

which seem to be prominent in the transgender participants' lives.

Quantitative Methods

Sample

The quantitative questionnaire was distributed to participants Canada-wide, some of whom volunteered for and were later recruited for the qualitative style, face-to-face interviews. The study's sample included a wide variety of individuals identified under the transgender umbrella. 15 commonly used transgender identities found under the transgender umbrella were offered to participants in order for them to select the identification most appropriate to their self-concept (see Appendix 5.10). Altogether, the participants selected 10 of the 15 available transgender identifications (see Table 1).

A purposive sampling method was used. The decision to use this method was informed by a variety of factors. One was that the research wanted to include existing knowledge such as common themes (i.e., shame, guilt, anger) identified by other researchers through qualitative research. Additionally gaps in knowledge were explored. This was done through the use of two QOL tools that were never tested with this population. After establishing their reliability the better tool was used to investigate the participant's QOL. Another gap identified and investigated was whether or not a difference exists between the fixed or fluid transgender groups. After clustering transgender self-identities into two groups - fixed or fluid- these groups were then used as the key criterion in all of the analysis. This type of sampling method ensures that the subject matter is relevant to the participants and if

needed additional samples and different methods can be added. As Ritchie, Lewis and Elam (2003) explain, this type of sampling does exactly what the name implies; it is for a specific purpose.

One hundred and sixty-nine ($N = 169$) participants filled out the survey. Data for 24 of the 169 participants were eliminated from analyses for the following reasons: too much missing data ($n = 15$); no chromosomal identity classification provided ($n = 4$); or no anatomical identity classification was given ($n = 1$). In addition, four individuals identified as transvestites and therefore did not meet the criteria. The set criterion was the occurrence of Gender Identity Disorder according to the *DSM-IV-TR* (2000) (see *DSM* criteria below). The four individuals who identified as transvestite expressed in the Patterns of Transgender Behaviour Scale (PTBS) in questions three, seven and eleven that they used female attire for sexual gratification, felt aroused by the clothing, and did not experience gender incongruence.

Even though the PTBS was constructed for cross-dressers, it also intended to clearly differentiate between the cross-dresser and the transvestic fetishist. According to Prince (1997a), individuals who experience cross-gender conflict have a need to cross-dress. Cross-dressing is considered a behaviour associated with a specific need of gender expression of being either female or male (Hogan-Finlay, Spanos, & Jones, 1997). Importantly, this population cannot be confused with 'Transvestic Fetishism 302.3' as described in the *DSM-IV-TR* (2000, pp. 574–575).

My exclusion of self-identified transvestites is further supported by the *DSM* (2000) criteria.

The Diagnostic Statistical Manual of Mental Disorders (*DSM*) gives clear guidelines to some of the medical categories for transgenderism. 'Transvestic Fetishism 302.3,' is found in the paraphilia section in the *DSM-IV-TR* (2000, pp. 574–575). In the *DSM-IV-TR* (2000), transvestic fetishism is described as a sexual, pathological behaviour, involving, "over a period of at least 6 months, in a heterosexual male, recurrent, intense sexually arousing fantasies, sexual urges, or behaviour involving cross-dressing" (p. 575). *The DSM-IV-TR* (2000) explains that the paraphilic focus of 'transvestic fetishism' involves cross-dressing and, in most cases, sexual arousal is produced by thoughts or images of the individual as female (this is also referred to as 'autogynephilia', a term invented by Blanchard, 1989a).

However, there are also exceptions which the *DSM-IV-TR* (2000) explains very clearly: transvestic fetishism is not diagnosed when cross-dressing occurs exclusively during the course of Gender Identity Disorder. In cases like this or if the client does not meet the criteria for Gender Identity Disorder 302.85 (see Chapter 2 for *DSM-IV-TR* criteria of Gender Identity Disorder) clinicians often use "gender identity disorder not otherwise specified, 302.6" (*DSM-IV-TR*, p. 582). The latter diagnosis is applied to individuals who experience "transient, stress-related cross-dressing behaviour" (*DSM-IV-TR,* 2000, p. 582), cross-dressers' experience Gender Identity Disorder. The cross-dresser does clearly express their need of validating their female-self as well as their male-self.

The final sample included 145 transgender participants. Participants were asked to self-identify and to choose an identity to which they felt they belonged. The following identities were chosen by the participants: transgendered 24/7 without HRT, transgendered 24/7 with HRT, transsexual (pre-op), transsexual (post-op), cross- dresser/cross-gender, bi-gender, gender-bender, androgynous, gender questioning, drag-king (gender-questioning).

The different transgender groups were then divided by the researcher and placed into two final groups, fixed or fluid transgender (see Table 1). The fixed cluster includes transgender individuals who prefer the explicit category of either male or female within a gender binary, clearly deciding to be either FTM or MTF. While the fluid group prefers a fluid interpretation, in which gender is experienced as potentially flexible and on a continuum, the individual needs to experience and live in both genders on a part-time basis.

Table 1 also shows the inclusiveness of the clusters. Fixed does not always include HRT or SRS, though the individual has to live 24/7 in the opposite to their assigned sex/gender at birth. Since fluidity is open and flexible the transgender individual might transition one day and live 24/7 in the opposite to their assigned sex/gender at birth or continue all their life living fluid. The key criterion of – fixed or fluid – was subsequently used in all of the analyses.

Table 1: Fixed and fluid transgender groups by self-identified transgender identity (after cleaning the data)

GROUP	FIXED TG group	FLUID TG group
Transgendered 24/7 without HRT	7	
Transgendered 24/7 with HRT	20	
Cross-dresser/Cross-gender		36
Transsexual (pre-op)	37	
Transsexual (post-op)	25	
Bi-gender		5
Gender-bender		2
Androgynous		1
Gender-questioning		11
Drag King (gender-questioning)		1
TOTAL	89	56

Population Distribution

The study included transgender individuals throughout, but not exclusively from, Canada. There were 11 participants from Alberta, 21 from British Columbia, two from Manitoba, one from New Brunswick, one from the Northwest Territories, four from Nova Scotia, 75 from Ontario, one from Prince Edward Island, 11 from Quebec, one from Saskatchewan, and 30 from the United States and Europe. Eleven participants opted not to fill out the question on location of residence in the survey.

Data Collection

Transgender people tend to be very isolated and self-shielding; as a result, I had to approach many different organizations working with transgender individuals (i.e., MTF and FTM support groups, social groups, chat groups, and political or advocacy groups) to recruit participants. I explained the research study to each

organization, after which they were asked to inform their members about this research. These groups were vital in referring interested members to the link on my website, distributing my web address, and/or in requesting and distributing paper copies of the survey to their members, thereby ensuring that participant anonymity was fully protected.

An advertisement was placed in the *Ottawa Citizen* – the leading newspaper in Ottawa – in order to attract transgender people who do not participate in any groups and/or might not have access to computers/internet. Further, contact information for different groups working with transgender people throughout Canada was obtained from the Internet, individuals, and known transgender organizations or supporters of transgender rights such as Egale, "a national organization that advances equality and justice for lesbian, gay, bisexual, and trans-identified people and their families across Canada" (Egale Canada, 2007, p. 1). The Ottawa office of Egale Canada provided me with a small list of support groups (10) for transgender people, which I contacted for the distribution of the questionnaire. Unfortunately, several groups provided by the aforementioned sources had since changed their contact information or had since dissolved. However, other groups provided information on newly established groups, including their contact information.

After five months of intensive research, I was able to establish contact with 118 Canadian groups that were active at the time of this research study (see Appendix 1). The groups were either contacted by telephone or email to request their

support and to distribute the quantitative questionnaire. All the groups in Appendix 1 confirmed their support.

Most participants (n = 145) opted to use the website to complete the questionnaire; the remaining 24 individuals requested paper copies. Of these paper copies, 15 were mailed to different groups for distribution to their members, six were handed out by the researcher directly, and three were sent to participants after they requested the survey be issued to them by mail. All paper copies included a letter introducing the study and the researcher (Appendix 2), an informed consent form (Appendix 3), the survey, and a postage-paid envelope. To assure participant anonymity, two postage-paid envelopes were provided: one for the research and one for the informed consent form. In order to protect the anonymity of respondents, both envelopes, one containing the questionnaires and the other containing the informed consent forms, were filed separately.

When a participant chose to answer the survey via the Internet, different steps were taken to protect anonymity and to ensure that the individual understood the purpose of the research and the nature of their involvement. First, the survey was publicized on the website: <www.makingadifference.ca>. This website is my counselling practice work website and even though other counselors are listed on this site, no other counselor listed on the website or working out of this practice was, or is, involved in the research or any other work with transgender people. Other than my committee, I am the only person with access to the survey results.

On the website, a direct link to the survey was created. Once respondents opened the link, they received the introduction letter (Appendix 2), followed by the informed consent form for the internet participation (Appendix 4). At this point, participants were advised that, owing to the nature of the Internet, confidentiality was limited; they were able to proceed to the survey (Appendix 5) only after they accepted the potential risk. If they disagreed, their participation was concluded.

Each web-based participant who agreed to complete the survey was then asked to create a user identification (user ID). At no time was the user's email address solicited. The user ID allowed for the correlation of the separate components of the survey to one respondent. Once a research participant completed and submitted a survey form, the web server created an email message containing the values from each field of the survey and sent it to the researcher. The email came from the server, *not* from the user. The only possible way for the email address of the user to be collected would be if the research participant specifically chose their email address to be their user ID. While this was not solicited in any way, it was also not prevented from a coding perspective. However, before providing the research participants access to the survey link on the website, the web server was tested and the reliability of the coding perspective was validated. A quick sampling of all submitted user IDs confirmed the futility of trying to match user IDs with specific individuals (Appendix 6).

As outlined in the informed consent form, there existed a possibility that the questions in the survey as well as in the face-to-face interview might contribute to

feelings of distress or anxiety. With this in mind, it was established in the beginning of the research that participants had the right to refuse to answer any questions, leave out complete sections in the questionnaire, or to withdraw from the research at any time.

Data collection was carried out over a period of six months, from December 2004 to May 2005. After the data had been collected, a message was posted on the website thanking all participants and informing them that, after the research was finished, the outcome of the research would be published on the website.

Upon completion of the study, questionnaires were given a code number. A coding manual and an abbreviated coding manual were created; data were then coded and entered into a database using SPSS, version 11.0. Hard copies as well as a computer copy of all questionnaire data were kept in a locked cabinet in my office.

Research Objectives

As discussed in Chapter 1, healthcare professionals encounter several difficulties when working with transgender clients. First, the current nomenclature, terminology, and diagnostic labeling of transgender clients leads to misdiagnosis and refusal of appropriate treatment (Denny, 2006). Therefore, the objectives of the quantitative aspect of the research were multiple. In the following, I will discuss the objectives in turn, listing the hypotheses I developed around each.

Clinicians have to be able to measure the failure or the success of counselling. One way to do this is through measuring QOL, self-confidence and stress level. However we need proper tools which are reliable to measure QOL, self-confidence

and stress in transgender clients. Therefore, it was important to identify and test a QOL tool and then investigate whether or not there were any differences between the fixed or fluid groups. Tests were also done for self-confidence, stress and counselling satisfaction. The objective of this research is to understand how relating to a transgender identity as either fixed or fluid can influence the way someone seeks and responds to services such as counselling. It also influences decisions on appropriate treatment modality and, ultimately, the failure or the success of treatment outcome.

In order to pursue these objectives, a variety of transgender identities, which are found under the transgender umbrella, had to be divided (see Table 1). Clustering the spectrum of transgender identities into two groups – fixed or fluid –was done to create a more inclusive typology for clinical use as well as for the basis of comparison. The transgender individuals who prefer the explicit category of either male or female according to the fixed gender binary were placed in the fixed category. Similarly, transgender individuals who prefer fluidity in how gender is experienced – as potentially flexible and on a continuum – were placed in the fluid category. This division permits a more in-depth understanding of the differences between transgender individuals and influences decision on treatment. Right treatment ultimately leads to better counselling experience and treatment outcome.

Diagnosis and treatment have to be evidence-based, therefore, it is essential to have tools available that are easy to use in clinical settings that can measure treatment outcome. QOL, self-confidence and stress are good indicators for

treatment outcome however we need reliable scales to measure this. The tools discussed in the following are not diagnostic tools, rather they are known for their high reliability and ease of use in providing clinicians with insight into the social and psychological functioning of clients. Knowing an individual's self-identity, fixed or fluid, QOL, self-confidence and stress-levels is crucial, as it affects what treatment modality will be deemed appropriate (i.e., harm reduction, client centered treatment, HRT, SRS). To measure the participants self-confidence Oakley's (1996, 1998) Self-Confidence Scale and for assessing stress level Cohen's (1994) Perceived Stress Scale (PSS) was used.

In this research, to measure QOL both the Memorial University of Newfoundland's Scale of Happiness (MUNSH) (Kozma, & Stones, 1980) and Bradley's Well-Being Scale (BWB) (Bradley, 1994) were tested in order to determine which would demonstrate higher reliability with the population under investigation. Since none of the scales was ever tested to establish reliability when measuring QOL of transgender people the first objective of the quantitative research was to find the QOL scale that demonstrated high reliability. First, a general comparison was made to assure that the two scales, the MUNSH and the BWB, were measuring a similar construct using Pearson's product–moment correlation.

Scale reliability of fixed and fluid transgender groups together, as well as between groups (fixed or fluid) were investigated using Cronbach's alpha coefficient (α). Reliability scores of previous studies of the MUNSH (Kozma, & Stones, 1980) and BWB (Bradley, 1994) will be presented in the instruments section of this chapter

as well as in the findings of Chapter 6. Reliability scores of the QOL scales for this particular research population will be presented in Chapter 6. The following are my hypotheses surrounding the second objective.

Hypotheses

Hypothesis 1a:

Alpha reliability of the BWB scale for the fixed and the fluid transgender groups, combined, will be poor, compared with previous reliability findings reported by McMillan, Bradley, Gibney, Russell-Jones, & Sönksen (2006).

Hypothesis 1b:

The alpha reliability of the BWB will be lower for the fixed transgender group than for the fluid transgender group, as it appears that more of the fluid transgender research participants stay married and also report higher incomes.

Hypothesis 2a:

Bradley's (BWB) scale is used to measure QOL in individuals with an illness. As transgenderism is not an illness, this scale may not be appropriate for measuring transgender individuals' QOL. Because the MUNSH was designed for use with a general population, it would be a more appropriate tool to measure the QOL of transgender people, and therefore achieve a better reliability score in comparison with the BWB scale.

Hypothesis 2b:

The alpha reliability of the MUNSH for fixed and fluid transgender groups combined will be below the general population's QOL. Previous reliability findings using the MUNSH, reported by Kozma and Stones (1980), are used in the comparison.

Hypothesis 2c:

The alpha reliability of the MUNSH will be lower for the fixed transgender group than for the fluid transgender group.

Research suggests that QOL is affected indirectly by changes in social support, e.g. belonging to a religious group, marital status, education, income and age (Kozma & Stones, 1980; George, Okun, & Landerman, 1985; Oakley, 1996; Ebersole & Hess, 1995). Therefore, the third objective was to investigate QOL group differences. The differences were investigated through the use of quantitative data and answering hypotheses related to the demographics of this population.

Hypothesis 3a:

Mean QOL scores will be lower for the fixed transgender group than the fluid transgender group.

Hypothesis 3b:

Mean QOL scores will not be significantly different among the preferred gender expression groups.

Hypothesis 3c:

Mean QOL scores and traditional religions (i.e., Roman Catholic, Anglican), are negatively correlated.

Hypothesis 3d:

Mean scores for QOL will be higher for individuals in a relationship (e.g., married, common-law, other) than for those who live alone.

Hypothesis 3e:

Mean QOL scores will be positively correlated with education for both transgender groups.

Hypothesis 3f:

Increased age will be positively correlated with QOL.

The fourth objective of the quantitative methods was to investigate transgender individuals' satisfaction with the counselling they received. Again, the focus was to find out whether there was a difference in levels of satisfaction between the fixed and fluid transgender groups. Previous research suggested that transgender people do not trust counselors (Lev, 2004; Meyer et al., 2001). However, previous research often investigated transsexuals, who are part of the fixed transgender group. In this research the difference between fixed and fluid transgender group was investigated. Establishing that there might be a difference between these two groups, as well as whether or not counselling has an impact on the transgender individuals' QOL, is important for clinical management.

Hypothesis 3g:

Mean QOL scores will not differ between those who receive counselling and those who do not.

Hypothesis 4:

The fixed transgender group will be more likely than the fluid transgender group to seek out counselling.

Hypothesis 4a:

The fixed transgender group will report higher counselling satisfaction than the fluid transgender group.

The fifth objective was to measure self-confidence. For measuring self-confidence, Oakley's (1996, 1998) self-confidence scale was used because it was successfully used with a wide variety of age groups (young adults and seniors). In addition to Oakley took into consideration the Canadian experience of a diverse and multicultural population when the scale was developed. Since this is a Canadian study I incorporated Canadian scales. Furthermore, Oakley's (1996, 1998) previous studies are used for comparison in this research. The reliability of Oakley's (1996, 1998) self-confidence scale is high, which suggests that it is robust across various populations. Furthermore, self-confidence was measured in relation with anxiety in a study by Eysenck and Eysenck (1985) which is an issue observed in transgender individuals (Bockting et al., 2006) and cannot be overlooked in treatment. The scales are explained in greater detail at a later point in this chapter.

Hypothesis 5:

Mean self-confidence scores of the fixed and the fluid transgender participants will be below previous findings in Oakley's research of self-confidence in the general population.

Hypothesis 5a:

Mean self-confidence scores will be lower for the fixed transgender group than for the fluid transgender group.

The sixth objective was to measure stress, in particular the difference in stress levels between the fixed or the fluid transgender group. Research suggested that QOL is influenced by stress; the higher an individual's stress levels, the lower their QOL (Lombardi et al., 2001; Bockting et al., 2005). To measure stress, Cohen's (1994) Perceived Stress Scale (PSS) was used. Not only is the scale easy to use in clinical settings but it also measures high reliability for the use with a wide range of age groups (see instrument section in this chapter).

Hypothesis 6:

Stress will be higher for the fixed transgender group than for the fluid transgender group.

The reasons for the hypotheses tested for *demographic* variables are multiple. Different hypotheses were established to compare the transgender population under investigation in this study with transgender groups investigated in previous research (Ebersole & Hess, 1995; Angello & Villegas, 2000; Nemoto et al., 2004; Gehring & Knudson, 2005). The question of income was compared with Statistics Canada's (2004) measurement of "low income cut-off" (LICO) for the overall Canadian population. Similarities as well as differences in the findings help clinicians to increase their knowledge of transgender people's demographic makeup and struggles.

The following hypotheses were tested for *demographic* variables:

1) The fixed transgender group will question their gender at an earlier *age* than the fluid transgender group.
2) Genetic females (FTM) will have a younger *age of questioning* than genetic males (MTF).
3) The fixed transgender group is less likely to report a heterosexual *sexual orientation* than the fluid transgender group.
4) The fixed transgender group is less likely to follow a traditional *religion* (i.e., Roman Catholic, Anglican) than the fluid transgender group.
5) The fixed transgender group is more likely to have a *marital status* of single than the fluid transgender group.
6) The fixed transgender group will have a lower *income* than the fluid transgender group.
7) The fixed transgender group is more likely to *be unemployed* than the fluid transgender group.
8) The fixed transgender group is more likely than the fluid transgender group to report living in *urban or suburban residential* vicinity than a rural community.

Instruments

The quantitative package distributed to participants contained two questionnaires specifically constructed for this research by the researcher (Appendix 5.1 and 5.2) and seven well known scales (Appendix 5.3a to 5.9). This was followed

by a series of questions to obtain personal demographic information (Appendix 5.10).

To answer the research questions and to test the above hypotheses, only the following scales were used: Gender-Related Behaviour Scale, the MUNSH, the BWB, Self-Confidence Scale, Perceived Stress Scale (PSS), and personal demographics (Appendix 5.1; 5.6; 5.7; 5.8; 5.9 and 5.10). The questionnaire included seven open-ended questions (Appendix 5.11) which were used in the qualitative analysis.

Since anonymity, and confidentiality are of the utmost importance for any research it has to be noted that the research was designed to provide the participant with complete control over what scale they wanted to fill out. Furthermore, anticipating that a wide variety of transgender individuals would respond, the questionnaire needed to include questions that might not be relevant for some of the population. For example, the Patterns of Transgender Behaviour Scale is only relevant to the cross-dresser/cross-gender participants. In addition, it was used to exclude the transvestic fetishists, but does not have any relevance to transsexuals. Therefore the participants needed to have control over what scale they felt was appropriate and consequently wanted to fill out.

Gender-Related Behaviour Scale

The Gender-Related Behaviour Scale instrument was created specifically for this research. This instrument was divided into three sections, with the breakdown as follows: 10 questions addressing childhood experiences (aged 1 to 10 years); 11

questions on experiences during puberty (aged 11 to 16 years); and 13 questions concentrating on individuals aged 17 years and older.

The questions were developed in the hope that they could strengthen the themes found in the analysis of the open-ended questions, as well as the face-to-face interviews. One of the goals of the qualitative research was to establish the role family, peers and social pressure plays in regards to gender dysphoria in transgender individuals. Some of the questions in the Gender-Related Behaviour Scale were used to substantiate the qualitative findings with quantitative data. Additional support for the qualitative data was found in the literature (Blanchard, 1994; Devor, 1994; Witten et al. 2001).

The questions were initially tested on a small sample of transgender individuals. The test group found the questions relevant to their experience and found that they easily understood the line of questioning. It also appeared that the test participants did not encounter any problems when responding to the questions. Even though in the reliability analysis the Gender-Related Behaviour Scale reached only a moderate reliability of alpha 0.51, I found that the broader goal of this particular questionnaire linking quantitative data (i.e., role of family, peers and social pressure in regards to rearing, gender dysphoria and QOL) and qualitative answers was achieved. The aforementioned line of questioning was especially important in establishing whether a link exists between rearing and feelings of shame, guilt, and anger about their transgender feelings and thoughts (see Appendix 5. 1).

Patterns of Transgender Behaviour Scale (PTBS)

The Patterns of Transgender Behaviour Scale (PTBS) was another instrument established for this particular study by the researcher (see Appendix 5. 2). The PTBS was made up of 12 questions. The questionnaire focused on cross-dressing behaviour in particular. It also included the causes, if any, for interrupting cross-dressing behaviour and at what age cross-dressing began. The aim of the PTBS questionnaire was to give cross-gender (CG) participants the opportunity to present their experience, and to investigate patterns of bingeing and purging of clothing, makeup, and accessories in CG behaviour, as well as to measure stress levels when the individual is not able to cross-dress. Even though the PTBS questionnaire was constructed for cross-dressers, it also included three questions (3, 7 and 11) intended to clearly differentiate between the cross-dresser and the transvestic fetishist and these three questions were used in the exclusion criteria.

The questions were developed from my counselling experience and from discussions with fellow clinicians, as well as feedback received from some CG individuals about which questions they found relevant to their experience.

Recalled Childhood Gender Identity Scale *(Zucker, 1991)*

The focus of this self-reporting Recalled Childhood Gender Identity Scale was to establish a clinical picture of gender-related behaviours of Gender Identity Disorder (GID) in childhood. This scale comprises two questionnaires: one for individuals who were female at birth and one for males at birth, each of which includes 23 questions. The instructions of the original author were included with the

questionnaire. However, some of these questions are formulated differently for females and males which make the use of the specific questionnaire female or male at birth imperative (see Appendix 5.3a male version, 5.3b female version). The participants were asked to describe their experience as a child, aged 12 years or younger. If their biological sex was male during their childhood, then they were requested to use the male version, if female during childhood, the female version.

The Recalled Childhood Gender Identity Scale has a measured reliability with a coefficient alpha of 0.79 for both male and female scales, which is high. However, in comparing the answers to the demographics, I realized that participants either did not read or misinterpreted the instructions, which were the instruction of the original author of the questionnaire, and filled out the wrong questionnaire. Males at birth filled out the female version (5.3b) which led to the exclusion of the scale in the final analysis.

Trauma Symptom Check List (TSC) *(Briere & Runtz, 1996)*

My decision to include the Trauma Symptom Check List was informed by my clinical experience, through which I found that many of my transgender clientele have experienced traumatic events. This 100-item scale is a standard in the assessment of numerous traumas, such as natural disasters, accidents, and emotional, physical, and sexual abuse (see Appendix 5.4). The measurement addresses questions on depression, avoidance, dissociation, anxiety, stress, and sexual and sleep problems.

Even though there is a shorter form (TSC-40) my committee at this time advised me to use the longer version (TSC-100). The administration of this self-report questionnaire is reliable but it appeared that many participants found this particular scale too time consuming and did not fill out this scale. Regrettably, this led to the exclusion of the scale for this particular research project.

Hogan-Finlay (1995) used the TSC-40, which is the short form of the TSC, with transsexual, transvestites, and a heterosexual control group, $N = 220$. The overall reliability of the TSC-40 in the Hogan-Finlay (1995) study was good. The Cronbach's alpha (α) in the subscales was: depression $\alpha = 0.75$, dissociation $\alpha = 0.74$, anxiety 0.77, post-traumatic stress $\alpha = 0.74$, sexual problems $\alpha = 0.63$, and sleep disturbance $\alpha = 0.74$ (Hogan-Finlay, 1995, p. 198).

Using a reliable trauma scale is important in the clinical setting. Bolin (1988), Feinbloom (1976), and Green (1987) found that transgender individuals are known to have coached each other to select appropriate responses on the Minnesota Multiphasic Personality Inventory (MMPI). As such, using a scale that is relatively unknown might be a means to establish trustworthy information on experiences of trauma and the establishment of clinical symptomatology of post-traumatic stress disorder (PTSD) as well as depression, anxiety and avoidance in this particular population. Transgender individuals mistrust the health professionals and see them often as gate-keepers (Lev, 2004; Ettner, 1999) which might be the cause for being selective in response to questions, which makes them vulnerable and ultimately can have an impact on treatment.

Bem Sex-Role Inventory (BSRI) *(Bem, 1978)*

One of the objectives of this study is to find out whether participants prefer the explicit category of either male or female, according to the gender binary, or if they prefer gender fluidity. Accordingly, I used the BSRI because the questions used in the questionnaire have both historically and cross-culturally represented gender binary assumptions of feminine and masculine. Bem (1978) found the following:

> First, largely as a result of historical accident, contemporary American culture has clustered heterogeneous attributes into two mutually exclusive categories, each category considered both more characteristic of and more desirable for female or males; these cultural expectations and prescriptions are well known by virtually all members of the culture. Secondly, individuals vary in the extent to which they use these cultural definitions as idealized standards of femininity and masculinity for evaluating their own personality and behaviour. In contrast, the androgynous individual is less attuned to these cultural definitions of femininity and masculinity and is less likely to regulate her or his behavior in accordance with them. (p.10)

The BSRI was designed to implement empirical research on psychological androgyny. The BSRI was issued under the name of a 'Self-Description Questionnaire' containing 60 personality characteristics to be ranked according to a scale ranging from 1 = 'Never or almost never true', to 7 = 'Always or almost always true' (see Appendix 5.5). The 60 personality characteristics are divided into 20 stereotypically feminine traits (for example, 'gentle', 'sensitive to the needs of others', 'love children'), 20 stereotypical masculine traits (for example, 'ambitious', 'assertive', 'dominant'), and 20 filler/social desirability questions (for example, 'happy', 'conceited', 'truthful'). The BSRI has the ability to rate whether an individual is high on feminine as well as masculine dimensions, indicating

'androgynous'; low on both dimensions, defined as 'undifferentiated'; or high on one but low on the other dimension, signifying either stereotypical feminine or masculine traits.

The psychometric analysis reported in the BSRI was tested on 340 females and 476 males, all undergraduate students in introductory psychology at Stanford University in 1978 (Bem, 1978). To estimate the internal consistency of the BSRI, the coefficient alpha was computed separately in both samples. For the femininity score: females, alpha 0.78; males, alpha 0.78. For the masculinity score: females, alpha 0.86; males, alpha 0.87. And, for the difference score (femininity minus masculinity): female, alpha 0.82; male, alpha 0.82. All scores are highly reliable.

However, the ratings on the social desirability items indicated that the so-called neutrality of about one-half of the desirability items cannot be considered as reliable (Walkup & Abbott, 1978). As a result, the social desirability items are only used as fillers.

QOL Scales

Research on QOL suggests that it remains relatively stable over the life span; however, this stability is only maintained until an individual reaches his/her early 70s (Kozma, Stones, & McNeil, 1991). Other research suggests that QOL is affected indirectly by changes in health, social support, marital status, and income (George, Okun, & Landerman, 1985). Oakley (1996) has also reported that the choice of response scale used in different questionnaires can influence results in the sense that

different populations may prefer one response scale over another; some individuals would complete one type of QOL scale but leave another blank.

As it was unclear which scale transgender individuals would prefer, two QOL measurements were included. It is important to note that the two QOL questionnaires selected have been used successfully with a variety of age groups. Previous research with transgender individuals has demonstrated that participants from a wide age range (from 17 to 88 years) of transgender people could be expected to partake in this study (Bullough & Bullough, 1997; Burnham, 1999; Angello & Villegas, 2000; Seidl, 2003). Furthermore, these two scales were used because they are considered to be reliable and valid measures of quality of life and well-being (Kozma & Stones, 1980; Kozma, Stones, & Kazarian, 1985).

However, neither of these QOL scales was previously tested for measuring the QOL of transgender people. Since I believe that transgenderism is a naturally occurring gender variation, rather than a serious health/mental health condition, I expected the BWB to show low reliability, and to be a poor indicator of transgender people's QOL. The reason for this assumption is that the BWB was tested and found reliable for assessing well-being in individuals suffering from serious health conditions (Bradley, 1994).

In contrast to this, is the MUNSH (Kozma & Stones, 1980), which shows high reliability when measuring the QOL of a healthy population. As I argue against approaching transgenderism as an illness, I expected the MUNSH to be highly reliable when measuring QOL in this particular population. The pressure the socially

constructed gender binary creates leads to: depression, anxiety, shame, and guilt which, in some cases, can cause distress and/or mental or physical illness. Since many individuals in this population experience discrimination (Lombardi et al., 2001) – which affects their QOL – it is speculated that transgender peoples QOL is below that of the non-transgender population. Following is a more detailed explanation of the two QOL scales including reliability scores from previous research.

Quality of Life – "MUNSH" (Kozma & Stones, 1980)

Kozma and Stones (1980) used the Affect Balance scale, the Life Satisfaction Index-Z, the Philadelphia Geriatric Centre scale, and 22 new items to develop a scale to measure happiness in the elderly. The Affect Balance scale, the Life Satisfaction Index-Z, the Philadelphia Geriatric Centre scale that Kozma and Stones (1980) used in the Memorial University of Newfoundland Scale of Happiness (MUNSH) was tested on 301 study participants. The 24-items that Kozma and Stones (1980) added to the MUNSH was tested on 297 study participants. Further test-retest reliability was obtained from 56 participants; the Cronbach's alpha indicated moderate reliability (0.70). Kozma and Stones (1980) found that the scale included all the attributes of performance that correspond to a scale that could be considered as a best model for measuring happiness. The MUNSH QOL uses a three-choice category response system: 'yes', 'no', 'don't know'. This scale explores both the perceived positive and negative aspects of a person's life, and yields an overall index of QOL

(see Appendix 5.6). Scores range from minus 24 to plus 24, where a high positive score indicates high QOL.

Kozma, Stones, & Kazarian (1985) investigated whether the MUNSH would retain its psychometric properties for groups significantly younger than it's previously standardization sample. They also examined whether the scale could effectively discriminate between community and clinical populations for both younger and older age groups. The researchers used 40 participants from the community and 117 new admissions to a psychiatric hospital. The results showed that the scale was not only highly reliable but also effective in discriminating between the community sample and the psychiatric population. The variance was attributed to the sensitivity of the scale to account for depression. Kozma et al.'s (1985) research findings are especially relevant to my hypothesis in that I consider transgenderism a naturally-occurring gender variance and not a disorder. Further, the MUNSH scale has been used in many studies with a variety of age and ethnic groups, and can, therefore, be considered well-suited to measuring the QOL of transgender individuals.

Quality of Life – Bradley-Well-Being (BWB) (Bradley, 1994)

Bradley's BWB was originally developed in 1982 for the World Health Organization with the aim of evaluating the psychological impact of diabetes. Its intent was to measure depression and anxiety while, at the same time, minimizing the somatic symptoms associated with a disease. The BWB consists of 22 questions that attest to the participant's feelings over the last few weeks on a four-point numerical scale, from 0 =

'Never' to 3 = 'All the time' (see Appendix 5.7). Minimum and maximum scores range from 0 to 66, where a higher score reflects higher levels of well-being or QOL.

The following are the guidelines Bradley (1994) provided to participants when using his QOL scale: "Please indicate how often have you have had each experience in **the past few weeks**, using the following scale". The instructions are especially important since individuals in the different transgender groups might experience very different levels of QOL at different stages in their life: i.e., transsexual after SRS experiences improved QOL (Rakic, 1996; Lawrence, 2003), whereas the QOL of someone without treatment opportunity might be very low.

Bradley (1994) found that the scale was also very useful for assessing well-being in individuals who suffer other serious health conditions. Through testing and re-testing, the BWB was found to have consistently high reliability and validity. By example, McMillan, Bradley, Gibney, Russell-Jones, & Sönksen, (2006) tested adult patients with growth hormone deficiency, with the results again confirming the high internal consistency and reliability (Cronbach's $\alpha = 0.96$, $N = 152$) of this scale. As previously stated, however, my position is that transgenderism is an example of natural human diversity and not a disorder. Accordingly, one of my hypotheses proposes that QOL scales designed for individuals with serious health issues will not prove reliable in measuring QOL among transgender persons. If this hypothesis is confirmed, the MUNSH should provide evidence of being a more successful measurement of QOL for this population than the BWB scale.

Self-Confidence Scale *(Oakley, 1996, 1998)*

Oakley's (1996) Self-Confidence Scale was used because it has been shown to be reliable (Cronbach's $\alpha = 0.79$), easy to self-administer, and is designed for and tested with a Canadian population. The researcher took into consideration the Canadian experience of a diverse and multicultural population when the scale was developed. Oakley (1996) identified that most self-confidence scales are designed specifically for use with teenagers. In contrast to this, Oakley (1996) developed a 12-item questionnaire suitable for use with all age groups and its results are able to provide a general sense of participant self-confidence. Responding to each statement, participating individuals rank their agreement or disagreement on a 5-point Likert scale (i.e., 5 = Strongly Agree, 4 = Slightly Agree, 3 = Neither Agree nor Disagree, 2 = Slightly Disagree, 1 = Strongly Disagree), with reverse scoring for negatively phrased items (see Appendix 5.8). A high score indicates high self-confidence. In this study, coding was adjusted as follows: +2 = Strongly Agree, 0 = Neither Agree nor Disagree, –2 = Strongly Disagree.

Oakley-McKeen (1996) reported normative data with 295 Canadian seniors aged 50 to 92 years, resulting in 23 as the lowest score, 60 as the highest, and an average score of 42.2. As previously mentioned, Cronbach's alpha was 0.79. Females were found to be slightly lower scoring in self-confidence than males, although the differences were not significant. Oakley's (1998) study examined 31 young adults and 51 seniors. She obtained self-confidence scores between 27 and 55 (mean = 40.57) for young adults, and scores between 32 and 55 (mean = 42.73) for

seniors. Measurements were obtained for groups, young adults and seniors, in the general population.

Previous research with different populations indicated that self-confidence and self-esteem are highly related (Oakley, 1996; Lorr & Wunderlich, 1986; Oakley, 1998). Oakley's (1998) research also indicated that self-confidence was not significantly related to age or gender.

Kozma et al. (1991) had obtained high correlation between self-confidence and QOL in his 1991 research. The high correlation between self-confidence and QOL of the Kozma et al. (1991) study prompted Oakley's (1998) decision to use her scale in combination with the MUNSH (Kozma & Stones, 1980) QOL scale in her 1998 study. The results indicated that both the MUNSH and Oakley (1996) Self-Confidence Scale are very compatible. The previously mentioned Oakley (1996) Self-Confidence Scale is highly reliability $\alpha = 0.79$. Bockting, Rosser, and Coleman (1999) reported that community involvement will increase transgender people's self-confidence, which is important in achieving a higher QOL. Taking all this into consideration, the logical choice was to use Oakley's scale to measure self-esteem in my research population.

Perceived Stress Scale (PSS) *(Cohen, 1994)*

The PSS is a widely used psychological instrument for measuring an individual's self-perception of his/her level of stress. This 10-item scale was used to measure the extent to which individuals perceive recent life circumstances as stressful, unpredictable, overloading, and uncontrollable. The items are easy to

follow and the questions are of a general nature and can be used with any population. Participants rated the 10 questions on a 5-point scale, from '0 = Never' to 4 = 'Very Often' (see Appendix 5.9). As evidence of validity, higher PSS scores were associated with, for example, greater vulnerability to stressful life-events-elicited depressive symptoms. PSS scores are obtained by reversing responses (that is, 0 = 4, 1 = 3, 2 = 2, 3 = 1, and 4 = 0) to the four positively stated items (that is, 4, 5, 7, and 8), and then summing across all items. Cohen (1994) reported his overall PSS scores as follows: male, n = 926 (mean = 12.1); female, n = 1406 (mean = 13.7); aged 18 to 29 years, n = 645 (mean = 14.2); aged 30 to 44 years, n = 750 (mean = 13.0); aged 45 to 54 years, n = 285 (mean = 12.6); aged 55 to 64 years, n = 282 (mean = 11.9); and aged 65 years and older n = 296 (mean = 12.0); and for other minorities (what constitutes minorities was not explained) n = 50 (mean = 14.1).

Personal Demographics

This section includes 19 demographic questions related to participants' age, chromosomal sex, anatomical sex, preferred gender expression, personal identity, ethnicity, racial background, religion, marital status, income, education, length of education (if they attended college or university), employment, sexual orientation, location of residence (province), type of area (i.e., rural, urban), citizenship, use of counselling services, and counselling satisfaction (see Appendix 5.10).

Open-Ended Questions

The open-ended questions were designed to elicit events and mutual themes among transgender people's experiences, as well as to collect information on what

figures (e.g., family, peers, and teacher's) instructed and reinforced appropriate gender behaviour in the participant's life. Appendix 5.11 provides a list of the seven open-ended questions included in the final part of the quantitative questionnaire. At the end of this section, participants had the opportunity to add their reflections and feedback on the research questions and organization. Of the two individuals who made use of this option, neither offered a new component or pointed to an oversight that had not been considered, rather the showed appreciation for providing them with the opportunity to talk about their experience.

Qualitative Methods

One of the goals of the qualitative research was to establish the role that family, peers and social pressures play in regards to gender dysphoria in transgender individuals. Some of the questions in the Gender-Related Behaviour Scale were used to substantiate the qualitative findings with quantitative data. Additional supports for the qualitative findings derived from the literature (i.e., Blanchard, 1994; Devor, 1994; Witten et al. 2001).

As I used a multimethod research design, face-to-face interviews was another means to validate previously found information. Transgender individuals often experience anxiety, depression, isolation, dissonance, anger, guilt, and shame (Israel & Tarver, 1997; Bockting, Huang, Ding, Robinson & Rosser, 2005), issues that affect an individual's QOL. The face-to-face interviews focused on life experiences, family dynamics and what consequences this had and still has on their QOL. Lewis and Ritchie (2003) found that using different sources of information gathering will

help both to confirm and to develop a better understanding of the phenomena under investigation.

Sample

A purposive sampling strategy was used to recruit participants for the section on quantitative research (for further explanation on purposive sampling refer to the segment on sampling in the quantitative section). Since the face-to-face interview participants already participated in the quantitative part of this research, it was known that the subject matter was appropriate for this group, which makes this kind of sampling a typical case sampling strategy (Patton, 2000). A case sampling strategy is a method that permits the selection of individuals (cases) who responded to another part of the research. An example of this would be a questionnaire which provides the researcher with knowledge of the overall pattern of response.

A total of 17 transgender individuals identified that they were interested in taking part in the qualitative section of this research. Nine individuals who had given permission to be contacted following survey completion were contacted via email to arrange an interview; another eight got in touch with me either by telephone or in person to do the same. All individuals who volunteered to take part in the individual, semi-structured, face-to-face interviews came from different locations throughout Canada.

Owing to limited funding, the final selection for these face-to-face interviews could only be completed in areas within a distance reasonably accessible by car for the researcher. Therefore, the final eleven face-to-face interview participants came

from the province of Ontario: five from Toronto and environs, and six from Ottawa and environs. Of these interview participants, seven identified themselves as 'Transgendered' (24/7 [living full-time] with HRT), three as 'Cross-dressers', and one as 'Transsexual' (pre-op).

Semi-Structured, Face-to-Face Interviews

The interview format was semi-structured to allow space for participants to tell their story and offer important personal insights about their lives as transgender individuals. The thirteen questions evolved from responses on the questionnaire, as well as from a collection of personal accounts and years of counselling experience with transgender individuals. The face-to-face interview questions, as well as the informed consent form for the interview participants, are included in Appendixes 7 and 8. The individual, in-depth face-to-face interviews were tape-recorded, transcribed verbatim, and coded to remove any identifying data from the transcripts. The tapes were destroyed after transcription.

The purpose of the qualitative part of the research was to find common experiences between transgender participants, as well as providing an explanation of how different issues (i.e., anxiety, depression, isolation) affect their QOL. As previously explained the findings were supported by the literature (i.e., Blanchard, 1994; Devor, 1994; Witten et al. 2001 Bockting et al., 2005). Therefore, the focus of the qualitative analysis concentrated on the identification of key themes. This was achieved through identifying feelings (i.e., shame, guilt) the individuals experienced and when they experienced them (i.e., childhood, puberty), or coping methods (i.e.,

day-dreaming, alcohol abuse). Spencer, Ritchie and O'Connor (2003) found that when using descriptive analysis, it is important to be sensitive and to use the individual's actual words. This is because the assigned meaning of the actual word forms the nucleus of the qualitative research.

Since a multimethod research design was used, some of the qualitative findings could be supported by the quantitative section of this particular research. According to Gaston and Marmar (1989) and Lewis and Ritchie (2003), multimethod research can be used to validate data from different sources in the same study (see Why Mixed Methods in this chapter).

Limitations:

Several limitations to this research project emerged. First, the survey was in English, which most likely caused the small percentage of transgender participants from Canada's French-speaking province of Quebec and officially bilingual province of New Brunswick (with 5.5% and 0.7% of participants, respectively) to take part in this research.

It was during the initial search for contacts (i.e., transgender groups to endorse the research) and data collection phase that I realized there were far fewer FTM groups, compared with MTF groups. Finding and convincing FTMs to participate in the research was very challenging. As a result, FTM participation was only 27.6%, which was low compared with the 62.8% of MTF participants.

Overall, it appears that a large number of participants are active members of support groups. However, since there was no question on how participants found out

about the study, the subject of what groups or organizations transgender people belong to could not be explored. Also, the study did not collect data from transgender/transsexual sex trade workers, and therefore it is recommended that further research be conducted in order to explore their needs. Paper copies of the survey were not distributed to, i.e., community centers, GLBT centres, or at transgender conferences which might have led to the exclusion of transgender individuals who do not have access to computers or are not part of an identifiable group. Finally, there was no measurement taken to determine how many people visited the website and looked at the survey but did not end up participating.

At this point, I am not certain as to how representative the group is that returned this particular survey. The participants might be extra vocal and/or they could be more victimized. Considering the limitations, the sample size, the selection of geographical locations, and the fact that only support groups were approached to promote the research, might have led to an imperfect measure. Nevertheless, it is hoped that the research increased social workers' and health care providers' understanding of transgenderism and transgender people's needs.

Chapter 6 Quantitative Findings

Overview

As indicated in the methodology, data for 24 of the 169 participants were eliminated from analyses for the following reasons: too much missing data ($n = 15$); chromosomal identity classification not provided ($n = 4$); or anatomical identity classification was not given ($n = 1$).

In addition, four individuals identified as transvestites and therefore did not meet selection criteria. For this particular research, individuals who self-categorized as transvestites were placed into the category of Transvestic Fetishism 302.3, which is found in the paraphilia section in the *DSM-IV-TR* (pp. 574–575). Therefore, if a participant indicated that s/he did not experience any gender dysphoria, they were excluded from this particular research. To assure correctness of my exclusion criteria, the participant's self-categorization was compared with their answers in section two of the Patterns of Transgender Behaviour Scale (PTBS) questionnaire, questions 5, 7, and 11, concerning transvestic behaviours such as: using clothing for sexual gratification. For more information on the exclusion criteria of the four transvestites see Chapter 1 and 5. This particular section of the questionnaire does not fit the fixed population; however, it addresses feelings and behaviours of some individuals in the fluid category, especially some of the cross-gender/cross-dresser participants.

Data for the remaining 145 participants were classified as either fixed or fluid transgender. As explained in Chapters 1 and 5, the fixed group prefers the explicit category of either male or female, according to the gender binary. Participants who were included in the fluid group prefer fluidity, in which gender is experienced as potentially flexible and on a continuum, which allows them to move back and forth between their female and male gender. The criteria for the fixed group was living full-time (24/7) in the opposite (to their natal) gender. A total of 89 participants fit the criteria for the fixed category; seven transgender (24/7 without hormone therapy), 20 transgender (24/7 with hormone therapy), 37 transsexual (pre-operative), and 25 transsexual (post-operative) were selected (see *Table 1* in Chapter 5).

The fluid population included 36 cross-dresser/cross-gender, five bi-gender, two gender-bender, one androgynous, 11 gender questioning, one drag king (gender questioning). Fifty-six ($n = 56$) participants fitted the criteria for this category (see *Table 1* in Chapter 5). Fluidity is viewed on a continuum; therefore, some of the participants now categorized in the fluid category might fit one day into the fixed group. However, at the time of the research, they were not living 24/7 in opposition to their natal gender and therefore they were categorized as fluid.

Creating a more inclusive typology for clinical use was achieved in this study by clustering the spectrum of transgender identities into two groups – fixed or fluid – for the basis of comparison. This division permits a more in-depth understanding of the differences within transgender individuals. For this research the key criteria was

the difference in transgender self-identity (fixed or fluid transgender groups) which was used in all of the analysis.

As stated previously, more research is done in the area of transgenderism, as well as in needs assessment including QOL. However, from a clinical perspective, there is not enough research being done that addresses QOL, self-confidence, stress, difference in counselling needs, as well as other differences between transgender individuals, that clearly adhere to the gender binary and individuals that prefer fluidity. Although equality and inclusion are important, from a clinical treatment perspective, clinicians have to know and consider the difference if they want to provide this diverse population with appropriate help in response to their transgender clients' inquiries.

I arrived at these particular hypotheses about this population through reading of the literature, examining other researchers' work, discussions with fellow clinicians, and listening to my clients during many years of clinical practice. As expressed in Chapter 1, my experience with this population comes from years of intensive work in my private practice, in which over 80% of my clients are transgender. Questions arose for which I could not find an answer or for which I found the answers unsatisfactory. Therefore, I decided to ask the following hypothetical questions, previously stated in Chapter 5, in the methodology section:

Hypotheses

In this research, to measure QOL both the Memorial University of Newfoundland's Scale of Happiness (MUNSH) (Kozma, & Stones, 1980) and

Bradley's Well-Being Scale (BWB) (Bradley, 1994) were tested in order to determine which would demonstrate higher reliability with the population under investigation. Since neither scale was ever tested to establish reliability when measuring QOL of transgender people in general or when split into the fixed or fluid category, the first objective of the quantitative research was to find the QOL scale that demonstrated high reliability. First, a general comparison was made to assure that the two scales, the MUNSH and the BWB, were measuring a similar construct using Pearson's product–moment correlation.

Secondly, it had to be established what scale would be more fitting to measure the QOL of the transgender population. Estimates of reliability were obtained for both scales based on Cronbach's alpha coefficient (α) for the entire sample, as well as for the fixed and fluid transgender groups separately.

The questions in the Bradley-Well-Being scale (BWB) are designed for people with illness; the questions are constructed to measure depression and anxiety and, at the same time, minimize the somatic symptoms associated with a disease. As it is designed to control for somatic symptoms of an illness, the scale is not a good fit for transgender people, because transgenderism is not an illness.

The Memorial University scale of happiness (MUNSH) was originally designed to measure happiness in an older population. It was later extended to the entire population, all age groups. The questions are designed for the general population and the scale does not focus on controlling illness; therefore, it is a better measurement for transgender people.

Research suggests that QOL is affected indirectly by changes in health, social support, marital status, and income (Kozma & Stones, 1980; George, Okun, & Landerman, 1985; Oakley, 1996). Therefore, several demographic variables were measured in regard to QOL.

Hypothesis 1a:

Alpha reliability of the BWB scale for the fixed and the fluid transgender groups, combined, will be poor, compared with previous reliability findings reported by McMillan, Bradley, Gibney, Russell-Jones, & Sönksen (2006).

Hypothesis 1b:

The alpha reliability of the BWB will be lower for the fixed transgender group than for the fluid transgender group, as it appears that more of the fluid transgender research participants stay married and also report higher incomes.

Hypothesis 2a:

Bradley's (BWB) scale is used to measure QOL in individuals with an illness. As transgenderism is not an illness, this scale may not be appropriate for measuring transgender individuals' QOL. Because the MUNSH was designed for use with a general population, it would be a more appropriate tool to measure the QOL of transgender people, and therefore achieve a better reliability score in comparison with the BWB scale.

Hypothesis 2b:

The alpha reliability of the MUNSH for fixed and fluid transgender groups combined will be below the general population's QOL. Previous reliability findings using the MUNSH, reported by Kozma and Stones (1980), are used in the comparison.

Hypothesis 2c:

The alpha reliability of the MUNSH will be lower for the fixed transgender group than for the fluid transgender group.

Hypothesis 3a:

Mean QOL scores will be lower for the fixed transgender group than the fluid transgender group.

Hypothesis 3b:

Mean QOL scores will not be significantly different among the preferred gender expression groups.

Hypothesis 3c:

Mean QOL scores and traditional religions (i.e., Roman Catholic, Anglican), are negatively correlated.

Hypothesis 3d:

Mean scores for QOL will be higher for individuals in a relationship (e.g., married, common-law, other) than for those who live alone.

Hypothesis 3e:

Mean QOL scores will be positively correlated with education for both transgender groups.

Hypothesis 3f:

Increased age will be positively correlated with QOL.

Hypothesis 3g:

Mean QOL scores will not differ between those who receive counselling and those who do not.

Hypothesis 4:

The fixed transgender group will be more likely than the fluid transgender group to seek out counselling.

Hypothesis 4a:

The fixed transgender group will report higher counselling satisfaction than the fluid transgender group.

Hypothesis 5:

Mean self-confidence scores of the fixed and the fluid transgender participants will be below previous findings in Oakley's research of self-confidence in the general population.

Hypothesis 5a:

Mean self-confidence scores will be lower for the fixed transgender group than for the fluid transgender group.

Hypothesis 6:

Stress will be higher for the fixed transgender group than for the fluid transgender group.

The following hypotheses were tested for *demographic* variables:

1) The fixed transgender group will question their gender at an earlier age than the fluid transgender group.
2) Genetic females (FTM) will have a younger age of questioning than genetic males (MTF).
3) The fixed transgender group is less likely to report a heterosexual *sexual orientation* than the fluid transgender group.
4) The fixed transgender group is less likely to follow a traditional *religion* (i.e., Roman Catholic, Anglican) than the fluid transgender group.
5) The fixed transgender group is more likely to have a *marital status* of single than the fluid transgender group.
6) The fixed transgender group will have a lower *income* than the fluid transgender group.
7) The fixed transgender group is more likely to be unemployed than the fluid transgender group.
8) The fixed transgender group is more likely than the fluid transgender group to report living in an urban or suburban residential vicinity than a rural community.

The hypotheses were tested with the use of SPSS, version 11.0. Many, different analyses were conducted using reliability tests, frequencies, descriptive, crosstabs, chi-square tests, *F* tests, one-way ANOVA or independent samples,

t–tests, and bivariate correlations—Pearson's product–moment correlation coefficient–*r*, mean, standard deviation, median, and range.

First the transgender self-identities were divided into 2 groups. It was important that these groups be open and inclusive, and this was achieved by clustering the spectrum of transgender identities into two groups – fixed or fluid. The fixed cluster includes transgender individuals who prefer the explicit category of either male or female within a gender binary, while the fluid group prefers a fluid interpretation, in which gender is experienced as potentially flexible and on a continuum. Table 1 (Chapter 5) shows the final breakdown of the transgender groups. After clustering transgender self-identities into two groups - fixed or fluid- these groups were then used as the key criterion in all of the analysis.

Second, a description of the demographic results is provided. Third, the Bradley well-being scale (BWB) and the MUNSH were tested for their reliability with the population in question. The scale that calculated higher reliability scores was used to finally test the remaining QOL questions in the hypotheses.

The instruments used for the quantitative analysis were Bradley's (BWB), the MUNSH, Oakley's Self-Confidence Scale, Cohen's Perceived Stress Scale (PSS), and some of the demographic data.

Demographic Results

Table 2 below provides a descriptive profile of transgender individuals that participated in this particular research, separately for fixed and fluid transgender groups, as well as the overall sample, for each demographic characteristic. The total

number of participants (*n*) within each level of each variable is provided along with the percentage (%) of the totals.

The total number (*N*) of participants within the variable was calculated and the numbers are provided at the end of each page, describing *Table 2* (see *note*).

Table 2: Descriptive profile of transgender individuals (fixed and fluid)

Characteristics	Fixed *n*	%	Fluid *n*	%	Total *n*	%
Age (years) [a]						
17-29	**17**	11.8	**8**	5.6	**25**	17.4
30-44	**32**	22.2	**21**	14.6	**53**	36.8
45-54	**23**	16.0	**18**	12.5	**41**	28.5
55-64	**13**	9.0	**4**	2.8	**17**	11.8
65+	**3**	2.1	**5**	3.5	**8**	5.6
Age of questioning [b]						
Age 1-5	**39**	28.7	**17**	12.5	**56**	41.2
Age 6-10	**24**	17.6	**15**	11.0	**39**	28.7
Age 11-15	**14**	10.3	**9**	6.6	**23**	16.9
Age 16-20	**4**	2.9	**2**	1.5	**6**	4.4
Age 21-25	**3**	2.2	**2**	1.5	**5**	3.7
Age 26-35	**2**	1.5	**2**	1.5	**4**	2.9
Age 36-up	**0**	0.0	**3**	2.2	**3**	2.2
Anatomical Sex [c]						
Male/Man	**53**	36.6	**55**	37.9	**108**	74.5
Female/Woman	**35**	24.1	**1**	0.7	**36**	24.8
Other	**1**	0.7	**0**	0.0	**1**	0.7
Both	**0**	0.0	**0**	0.0	**0**	0.0
Preferred Gender Expression [a]						
Male/Man	**21**	14.6	**19**	13.2	**40**	27.8
Female/Woman	**64**	44.4	**27**	18.8	**91**	63.2
Other	**2**	1.4	**3**	2.1	**5**	3.5
Both	**1**	0.7	**7**	4.9	**8**	5.6
Sexual Orientation [d]						
Gay	**22**	15.4	**2**	1.4	**24**	16.8
Bi-Sexual	**34**	23.8	**15**	10.5	**49**	34.3
Heterosexual	**14**	9.8	**23**	16.1	**37**	25.9
Asexual	**8**	5.6	**2**	1.4	**10**	7.0
Questioning	**9**	6.3	**14**	9.8	**23**	16.1

Note. [a]N=144; [b]N=136; [c]N=145; [d]N=143

Table 2: Descriptive profile of transgender individuals (fixed and fluid)

Characteristics	Fixed *n*	%	Fluid *n*	%	Total *n*	%
Ethnic background [d]						
English	**79**	55.2	**44**	30.8	**123**	86.0
French	**4**	2.8	**2**	1.4	**6**	4.2
Other	**6**	4.2	**8**	5.6	**14**	9.8
Racial background [a]						
Caucasian	**82**	56.9	**53**	36.8	**135**	93.8
Asian	**0**	0.0	**1**	0.7	**1**	0.7
Hispanic	**1**	0.7	**1**	0.7	**2**	1.4
Aboriginal	**4**	2.8	**1**	0.7	**5**	3.5
Other	**1**	0.7	**0**	0.0	**1**	0.7
Religion [d]						
Anglican	**7**	4.7	**10**	7.0	**17**	11.9
Buddhism	**1**	0.7	**0**	0.0	**1**	0.7
Roman Catholic	**11**	7.7	**11**	7.7	**22**	15.4
Protestant	**8**	5.6	**7**	4.9	**15**	10.5
Wicca	**6**	4.2	**0**	0.0	**6**	4.2
Agnostics	**10**	7.0	**8**	5.6	**18**	12.6
Atheism	**9**	6.3	**5**	3.5	**14**	9.8
Other	**11**	7.7	**4**	2.8	**15**	10.5
None	**26**	18.2	**9**	6.3	**35**	24.5
Marital status [c]						
Single	**40**	27.6	**15**	10.3	**55**	37.9
Married	**18**	12.4	**26**	17.9	**44**	30.3
Common law	**13**	9.0	**4**	2.8	**17**	11.7
Divorced	**10**	6.9	**5**	3.4	**15**	10.3
Separated	**4**	2.8	**3**	2.1	**7**	4.8
Widowed	**1**	0.7	**3**	2.1	**4**	2.8
Other	**3**	2.1	**0**	0.0	**3**	2.1

Note. [a]$N = 144$; [c]$N = 145$; [d]$N = 143$

Table 2: Descriptive profile of transgender individuals (fixed and fluid)

Characteristics	Fixed		Fluid		Total	
	n	%	*n*	%	*n*	%
Income [e]						
$ 5,000-$14,999	**22**	15.6	**7**	5.0	**29**	20.6
$15,000-$24,999	**18**	12.8	**6**	4.3	**24**	17.0
$25,000-$34,999	**6**	4.3	**5**	3.5	**11**	7.8
$35,000-$44,999	**8**	5.7	**6**	4.3	**14**	9.9
$45,000-$54,999	**8**	5.7	**8**	5.7	**16**	11.3
$55,000-$74,999	**8**	5.7	**12**	8.6	**20**	14.2
$75,000-$99,999	**11**	7.8	**6**	4.3	**17**	12.1
over $ 100,000	**5**	3.5	**5**	3.5	**10**	7.1
Education [a]						
Elementary school	**2**	1.4	**1**	0.7	**3**	2.1
High school	**19**	13.2	**6**	4.2	**25**	17.4
Some college	**32**	22.2	**19**	13.2	**51**	35.4
University, undergrad	**20**	13.9	**16**	11.1	**36**	25.0
University, masters	**13**	9.0	**10**	6.9	**23**	16.0
University, PhD	**2**	1.4	**3**	2.1	**5**	3.5
University, post-doc	**1**	0.7	**0**	0.0	**1**	0.7
Educational background, college/university, years [a]						
N/A	**57**	39.6	**36**	25.0	**93**	64.6
1 Year	**7**	4.9	**5**	3.5	**12**	8.3
2 Years	**13**	9.0	**8**	5.6	**21**	14.6
3 Years	**9**	6.3	**6**	4.2	**15**	10.4
4 Years	**3**	2.1	**0**	0.0	**3**	2.1
Employment [e]						
Employed	**43**	30.5	**32**	22.7	**75**	53.2
Self-Employed	**8**	5.7	**10**	7.1	**18**	12.8
Unemployed/Volunteer	**4**	2.8	**0**	0.0	**4**	2.8
Unemployed	**7**	5.0	**2**	1.4	**9**	6.4
Disability	**9**	6.4	**3**	2.1	**12**	8.5
Between jobs	**5**	3.5	**1**	0.7	**6**	4.3
Retired	**4**	2.8	**5**	3.5	**9**	6.4
Student	**5**	3.5	**3**	2.1	**8**	5.7

Note. [a]$N = 144$; [e]$N = 141$;

Table 2: Descriptive profile of transgender individuals (fixed and fluid)

Characteristics	Fixed *n*	Fixed %	Fluid *n*	Fluid %	Total *n*	Total %
Citizenship [d]						
Born in Canada	**71**	49.7	**29**	20.3	**100**	69.9
Canadian citizen by Naturalization	**3**	2.1	**9**	6.3	**12**	8.4
Landed immigrant	**0**	0.0	**1**	0.7	**1**	0.7
Permanent residence	**1**	0.7	**0**	0.0	**1**	0.7
Canadian residing Outside Canada	**0**	0.0	**1**	0.7	**1**	0.7
Student or work visa	**0**	0.0	**1**	0.7	**1**	0.7
Non-Canadian	**14**	9.8	**13**	9.1	**27**	18.9
Residential vicinity [d]						
Urban	**49**	34.3	**25**	17.5	**74**	51.7
Rural	**10**	7.0	**4**	2.8	**14**	9.8
Suburban	**29**	20.3	**26**	18.2	**55**	38.5
Residence [d]						
Alberta	**9**	6.3	**1**	0.7	**10**	7.0
British Columbia	**16**	11.2	**4**	2.8	**20**	14.0
Manitoba	**1**	0.7	**0**	0.0	**1**	0.7
New Brunswick	**1**	0.7	**0**	0.0	**1**	0.7
Northwest Territories	**0**	0.0	**1**	0.7	**1**	0.7
Nova Scotia	**1**	0.7	**3**	2.1	**4**	2.8
Ontario	**43**	30.1	**25**	17.5	**68**	47.6
Prince Edward Island	**1**	0.7	**0**	0.0	**1**	0.7
Quebec	**3**	2.1	**5**	3.5	**8**	5.6
Saskatchewan	**0**	0.0	**1**	0.7	**1**	0.7
Outside Canada	**13**	9.1	**15**	10.5	**28**	19.6

Note. [d]$N = 143$

Quality of Life (QOL)

First, a general comparison was made of the two QOL scales used in this study (i.e., Bradley's Well Being [BWB], and the MUNSH) to determine if one of the scales would be a better measurement for a transgender population. A statistically significant Pearson's product–moment correlation between the two scales ($r = 0.62$, $p = 000$), the MUNSH and Bradley's BWB, indicates that they are measuring a similar construct. As a result, one scale can be selected over the other based on its reliability. Estimates of reliability were obtained for both scales based on Cronbach's alpha coefficient (α) for the entire sample, as well as for the fixed and fluid transgender groups separately. Cronbach's alpha provides a measure of the internal consistency of the scale.

McMillan et al. (2006) tested the BWB on adult patients with growth hormone deficiency. This study confirmed the high internal consistency and reliability of this scale ($\alpha = 0.96$, $N = 152$, N of Items = 22). In comparison, the reliability of the BWB for the fixed and the fluid transgender groups combined was significantly lower ($\alpha = 0.40$, $N = 104$, N of Items = 22). Hypothesis 1a was confirmed in that alpha reliability of the BWB scale for the fixed and the fluid transgender groups combined was lower than previous reliability findings reported by McMillan et al. (2006).

Reliability was also unacceptably low for each transgender group ($\alpha = 0.33$ and $\alpha = 0.36$ for the fixed and fluid transgender groups, respectively). Reliability for the fixed group was slightly lower than the reliability for the fluid group; therefore, the first part of hypothesis 1b was confirmed.

The demographic characteristic of marital status of the participants of this research indicated that 34 of the fixed, compared with 30 of the fluid participants, were in a relationship (e.g., married, common law, other). Although the number is slightly higher, the comparison with individuals who identified as being alone (e.g., single, divorced, separated) was significantly higher in the fixed transgender group ($n = 55$), compared with the fluid transgender group ($n = 26$). The breakdown is shown in *Table 2*. Forty ($n = 40$) in the fixed, compared with 15 in the fluid transgender group, reported to be single, which supports the second part of hypothesis 1b.

Four participants, three in the fixed transgender group and one in the fluid transgender group, did not fill out the income category in the questionnaire ($N = 141$). The demographic results indicated that 46 from the fixed transgender group reported that their income was between $5,000 and $34,999. Angello and Villegas (2000) reported that most transgender individuals reported their income falling into the low- and middle-income category. In contrast to this, for the fluid transgender group, only 18 participants reported income in this category. Almost equal numbers reported incomes of $35,000 to $74,999 ($n = 24$ and $n = 26$ for the fixed and the fluid transgender group, respectively). The largest difference in income was found in the high-income category $75,000 to over $100,000. No research separating income for transgender individuals identified in the fluid category could be found, therefore, the latter part of the hypothesis is based on an assumption that the fluid transgender group would fall into a higher income category. Further, contrary to the assumptions,

16 of the fixed transgender participants, compared with 11 of the fluid transgender participants, identified within the high-income group (*Table 2*). For income, the second part of hypothesis 1b is only supported in the low-income category.

Hypothesis 2 was confirmed: Bradley's (BWB) scale appears to not be a reliable measurement for transgender individuals' QOL, in the fixed and fluid transgender groups, neither combined nor separated. Bradley's (BWB) scale is designed to measure depression and anxiety and, at the same time, to minimize the somatic problems associated with a disease, and the assumption is that transgenderism is not an illness.

In contrast to Bradley's scale ($\alpha = 0.40$, $N = 104$), the reliability coefficient for the MUNSH was high for the overall sample ($\alpha = 0.85$, $N = 102$) supporting hypothesis 2a, which states that the MUNSH will achieve a better reliability score in comparison with Bradley's (BWB) scale.

Kozma and Stones (1980) original study indicated moderate reliability of the scale ($\alpha = 0.70$, $N = 56$, N of Items = 24), which interestingly is lower than the findings of ($\alpha = 0.85$, $N = 102$, N of Items = 24) for the transgender participants. The reason for this difference might be that the original scale measured reliability with seniors, in contrast to the current study participants (fixed and fluid transgender groups), whose ages were very diverse (17 to 82 years). However, Kozma, Stones, & Kazarian (1985) used the scale with a more age-diverse population and found that the scale was not only highly reliable but also effective in discriminating between the community sample and the psychiatric population. Hypothesis 2b was refuted: the

alpha reliability measure of the MUNSH for the fixed and fluid transgender groups combined was significantly higher than a previous reliability measure reported by Kozma and Stone (1980).

Reliability was high for the fixed ($\alpha = 0.88$) and moderately high for the fluid ($\alpha = 0.75$) transgender categories. Not only was the reliability scale for the MUNSH higher in general but also it was significantly higher for the fixed group than for the fluid group.

Hypothesis 3 was also confirmed: the MUNSH indicated good reliability with the fixed and fluid transgender group combined, as well as measuring reliability for the groups separately. The MUNSH was tested to measure well-being in the entire population because transgender individuals should be accepted as part of the general population; therefore, the MUNSH should be a good measurement to evaluate transgender individuals' QOL.

Based on the findings, the MUNSH and Bradley's scale are measuring a similar construct, as well as the finding that the reliability measure of the MUNSH is better, the QOL data for BWB scale were eliminated and all subsequent analyses based on QOL were conducted using the QOL data from the MUNSH.

Correlation of Mean QOL Scores and Some Demographic Data

Hypothesis 3a assumed that the mean QOL scores would be lower for the fixed transgender group than the fluid transgender group. Contrary to prediction, the fixed transgender individuals had a slightly higher QOL than those who endorsed the fluid category.

Figure 3: Mean QOL by fixed and fluid transgender (TG) groups

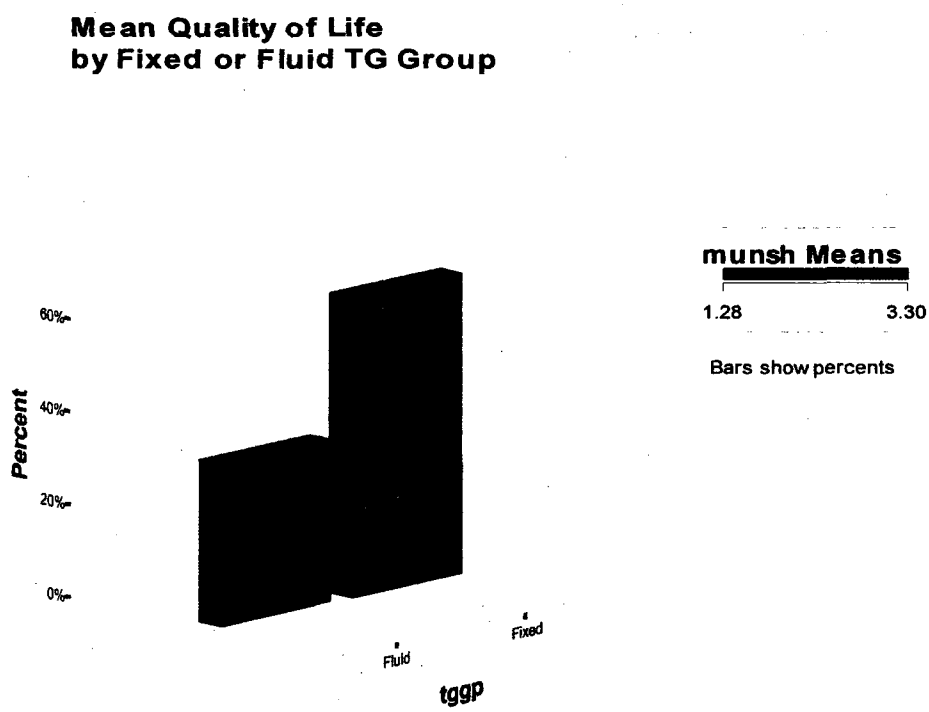


Figure 3 shows the MUNSH mean (M) difference in scores between fixed (M = 3.30) and fluid (M = 1.28) groups; however, the outcome was not statistically significant, t (100) = 1.448, p = .151. *Table 3* presents the distribution of QOL scores for both transgender groups and reveals that most scores (ranging from –13 to +14) fall predominantly around the 0 to 5 values. These values, by median (Mdn),

are much lower than expected for both groups (Mdn = 5.00 and Mdn = 0.50 for the fixed and fluid transgender groups, respectively), despite moderately high levels of scale reliability ($\alpha = 0.88$ and $\alpha = 0.75$ for the fixed and fluid transgender groups, respectively). For example, the overall median QOL score for the transgender participants in this particular study (Mdn = 3.00) is considerably lower than that obtained by Oakley (1996) who reported a median QOL score of 16.0 (range = –18 to +24). These findings suggest a lower QOL overall for transgender individuals.

Table 3 provides a summary of the descriptive measures, i.e., mean, standard deviation (SD), median, and range, for the dependent variable of the MUNSH QOL scale.

Table 3: QOL for transgender individuals (fixed and fluid)

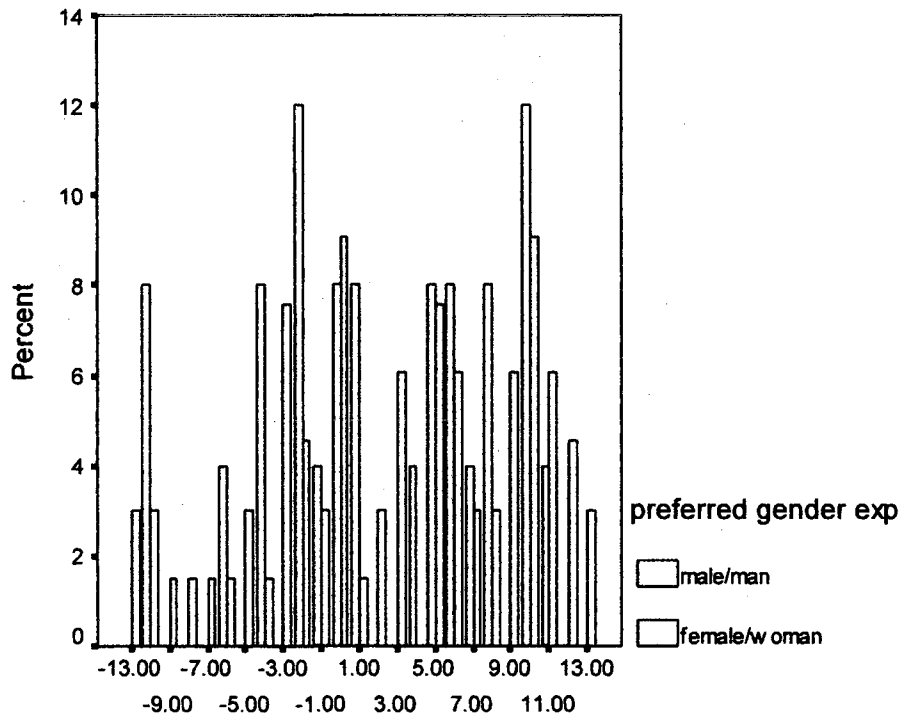
Characteristics	**Fixed**		**Fluid**		**Total**	
MUNSH [a]						
M (SD)	**3.30**	(6.57)	**1.28**	(7.07)	**2.59**	(6.79)
Mdn, range	**5.00**	–13 to 13	**0.50**	–13 to 14	**3.00**	–13 to 14

Note. [a]$N = 102$

To further understand the low QOL scores in the present study, further analyses were conducted for QOL and several demographic variables (Hypotheses 3b, 3c, 3d, 3e, 3f, 3g).

An omnibus *F* test was conducted to determine whether QOL differed for **preferred gender expression**; however, this analysis failed to reach significance, $F(3) = .953$, $p = .419$. As the inclusion of "other" or "both" groups might have suppressed the differences between male/man, compared with female/woman, a post hoc analysis was completed, data for "other" and "both" were removed, and the analysis was redone. The independent *t* test of the means (M = 1.96 for the fixed group, compared with M = 2.77 for the fluid group) failed to reach statistical significance, $t(89) = -.509$, $p = .612$ (see *Figure 4*). Lending support to hypothesis 3b which stated that the mean QOL scores will not be significantly different among the preferred gender expression groups.

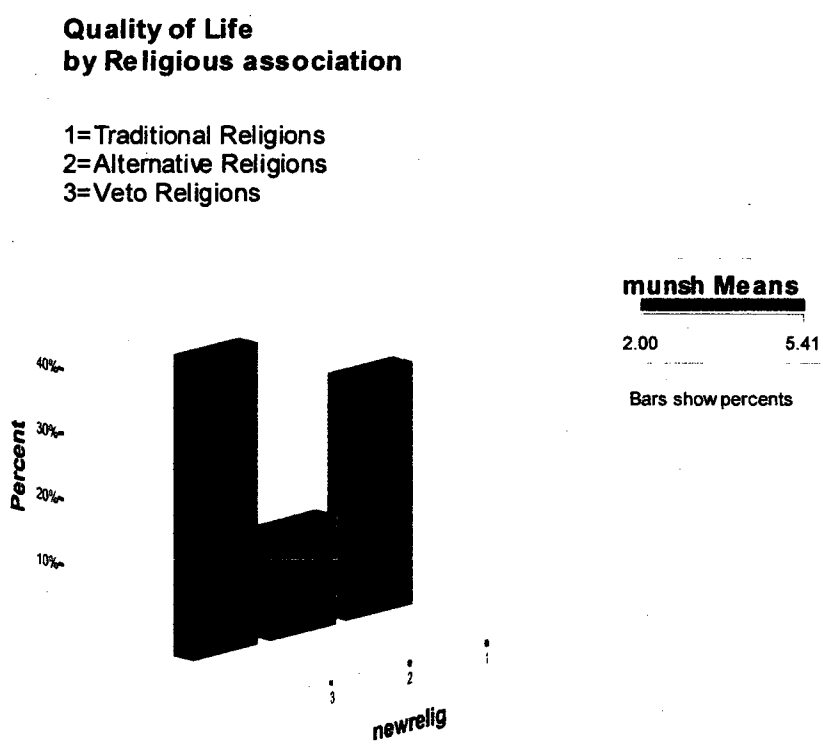
Figure 4: QOL by preferred gender expression (male/man or female/woman)



To test for a difference in QOL scores between those who endorsed traditional **religions** (M = 2.00), compared with non-traditional religions, represented as alternative and veto religions combined (M = 2.49), was in the expected direction (i.e., traditional would have lower QOL than non-traditional; hypothesis 3c).

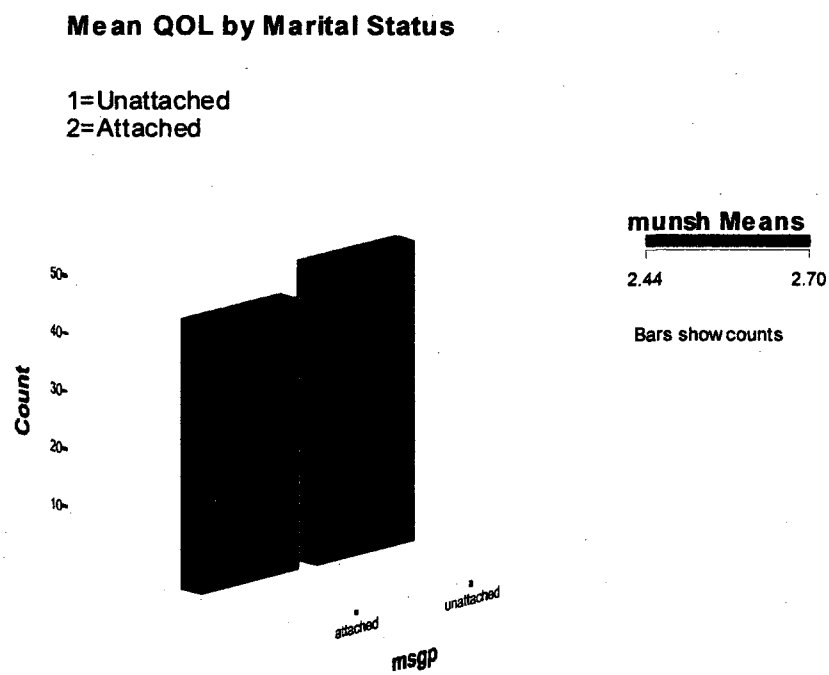
As shown in *Figure 5*, in which differences in traditional, alternative, and veto religions are compared (M = 2.00 to M = 5.41), participants who endorsed the alternative religions had a much higher QOL than the other two religious categories. The one-way ANOVA analysis failed to reach significance $t\ (100) = -.673$, $p = .503$

Figure 5: QOL by association with religious groups (traditional, alternative, veto)



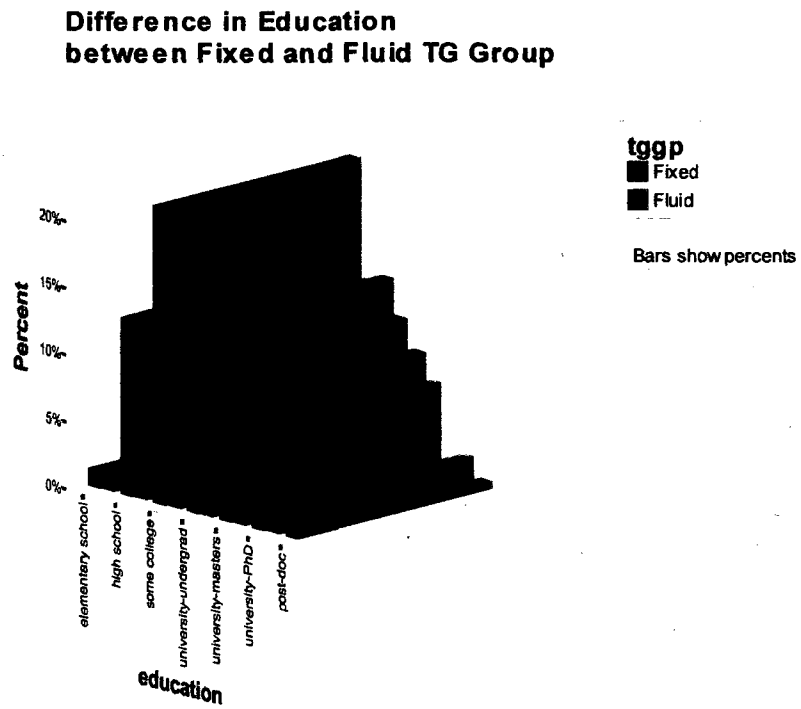
It was hypothesized that **marital status** would influence QOL; specifically, it was predicted that QOL would be higher for those who were in a relationship (i.e., married, common law), compared with individuals who were unattached, (i.e. single, divorced, widowed). A comparison of the means (M = 2.44 for unattached, compared with 2.70 for attached individuals), however, failed to yield a statistically significant result, t (97) = –.188, P = .851 (see *Figure 6*).

Figure 6: Mean QOL by marital status



In the area of **education**, the findings show that most participants had some college (35.4%) or undergraduate university (25.0%) education (see *Table 2* and *Figure 7).*

Figure 7: Differences in education by fixed and fluid transgender (TG) groups

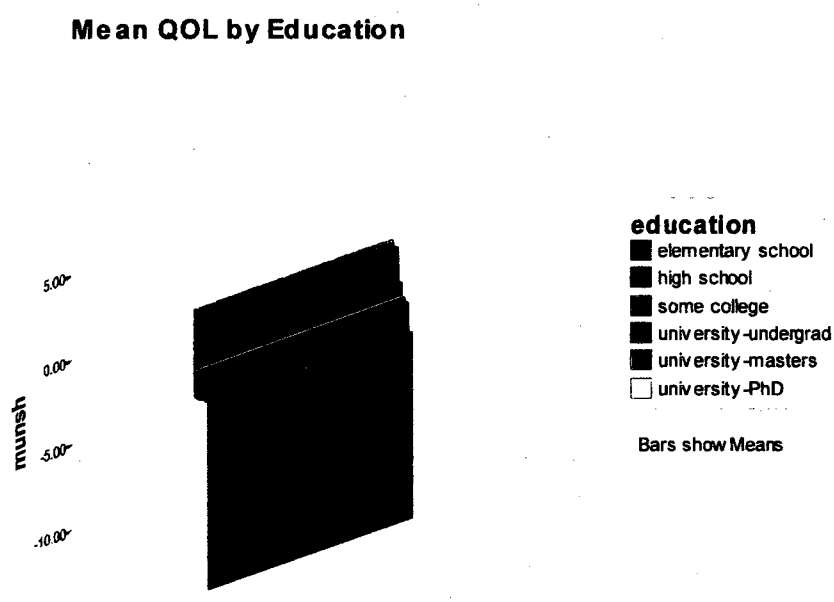


Fixed transgender individuals dominated elementary and high school only education levels, as well as college categories (36.8%), compared with fluid transgender individuals (18.1%). Also, within the transgender groups, individuals in the fixed group were more likely to attend undergraduate as well as graduate university (25.0%), compared with the fluid transgender group (20.1%). The 2 × 7 chi square test of the association between transgender group and education was not

statistically significant, χ^2 (6, N = 144) = 4.676, p = .586. Similarly, no difference within the fixed and fluid transgender groups was observed for official education levels. For example, 14.6% of individuals in the fixed and 14.5% of fluid transgender individuals completed two years of college or university. The two-year demarcation point was used as this was the most frequent category endorsed.

Figure 8 presents QOL scores for different **education** levels, and supports the hypothesis that QOL would be positively correlated with education, r = .22, p = .029. Higher education contributes to higher QOL (MUNSH mean –11.00 to 5.25).

Figure 8: Mean QOL by education



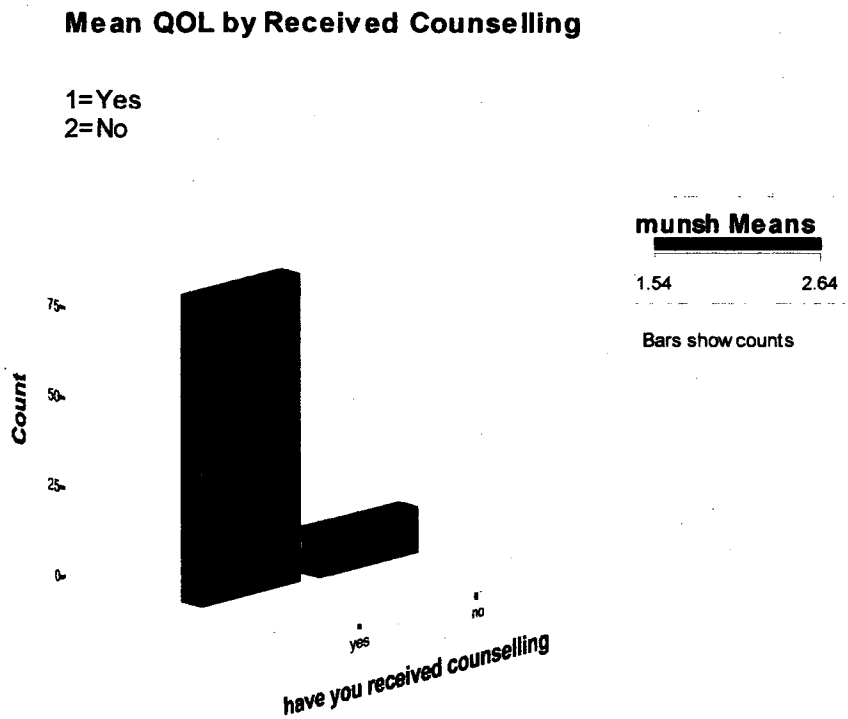
Age was significantly positively correlated with QOL, $r = .222$, $p = .025$, confirming the hypothesis 3f that older transgender adults would have a higher QOL than younger transgender adults. This finding is also consistent with previous research (c.f. Oakley, 1996). Therefore, age does not appear to be a contributing factor in the current research.

Inspection of *Table 2* reveals that the individuals who participated in this study varied along the **age** continuum, as expected. Most participants were between the ages of 30 and 54 ($n = 94$; 62.5%), with an overall mean age of 42.27 years (range = 17 to 82 years).

QOL and Counselling, Counselling Use and Satisfaction Rate

As predicted, no significant mean difference was noted in mean QOL scores between those who had **received counselling** (M = 1.54), compared with those who had not received counselling (M = 2.64, t (97) = –.547, p = .586), failed to reach statistical significance, however, confirming hypothesis 3g (see *Figure 9*).

Figure 9: Mean QOL by received counselling

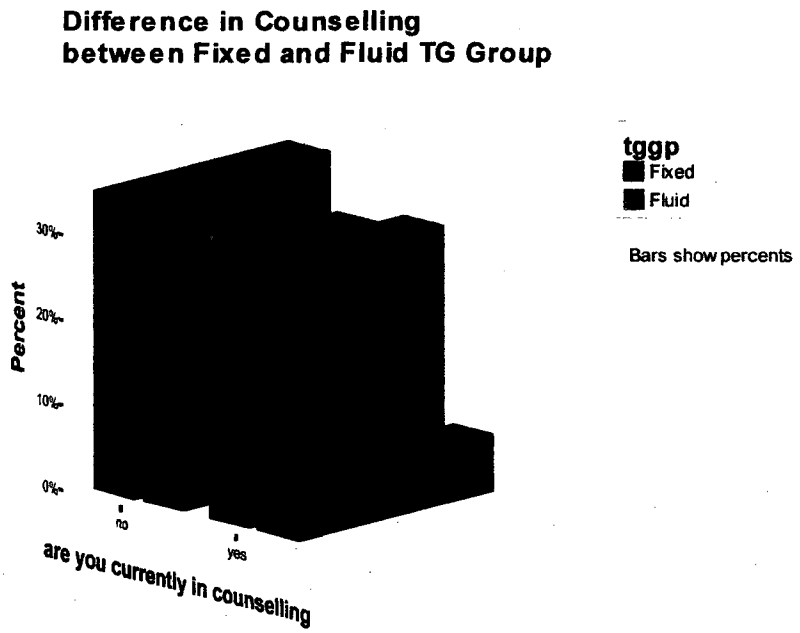


In this sample, a very high percent of individuals (80.0%) had **received counselling** (see *Table 4*) at some point in their lives. A 2 × 2 chi-square test indicated that the association between transgender group and counselling was statistically significant, χ^2 (1, N = 140) = 17.62, p = .000. The finding confirmed

hypothesis 4 that the fixed transgender group is more likely to receive counselling (57.1%), compared with fluid individuals (22.9%).

A further breakdown reveals that 90.9% of individuals within the fixed transgender group have received counselling. In comparison, only 61.5% of fluid transgender individuals have received counselling.

Figure 10: Differences in received counselling by fixed and fluid transgender groups



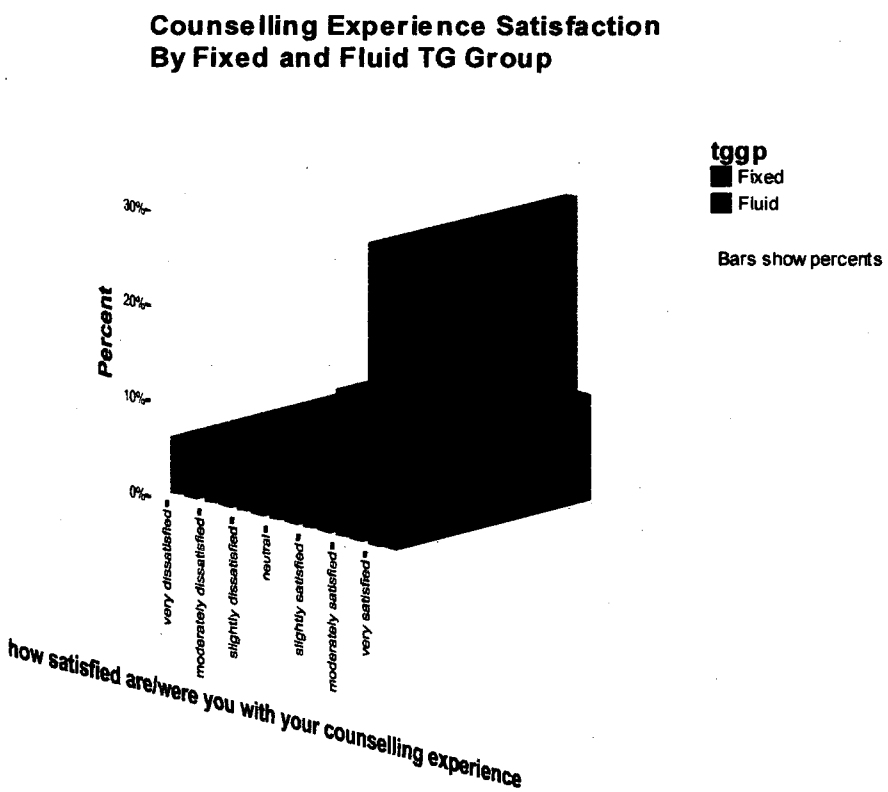
About one-third of participants were **currently in counselling** (36.6%). The test of the association between transgender group and being currently in counselling was statistically significant, χ^2 (1, N = 131) = 8.90, p = .003.

Similar to the findings for receiving counselling in the past, more fixed transgender participants were currently undergoing counselling (29.8% of entire sample), compared with only 6.9% of the entire sample of fluid individuals (see

Table 4). Within the fixed transgender group, 45.9% were equally likely to attend or not attend counselling. In contrast, only one in five in the fluid transgender group sought counselling (19.6%).

The results for **counselling satisfaction,** shown in *Table 4*, indicate that 42.7% of participants in this study were very satisfied, moderately satisfied (22.2%), or slightly satisfied (8.5%). Unfortunately, that means that one in four individuals (26.4%) were either neutral (8.5%), dissatisfied (5.1%), moderately dissatisfied, (3.4%) or very dissatisfied (9.4%) with the counselling they have received.

Figure 11: Differences in counselling satisfaction between the fixed and fluid transgender groups.



The association between transgender group and counselling satisfaction failed to reach statistical respectability, χ^2 (6, N = 117) = 5.795, p = .447. Further inspection of the data shown in *Figure 11* reveals that fixed individuals were slightly more likely (however, not statistically significant) to endorse the neutral or negative satisfaction categories (14.6%), compared with fluid transgender individuals (12.0%), refuting hypothesis 4a.

Table 4: Descriptive profile of transgender individuals (fixed and fluid) and counselling

Characteristics	Fixed		Fluid		Total	
	n	%	*n*	%	*n*	%
Received counselling [a]						
No	**8**	5.7	**20**	14.3	**28**	20.0
Yes	**80**	57.1	**32**	22.9	**112**	80.0
Currently in counselling [b]						
No	**46**	35.1	**37**	28.2	**83**	63.4
Yes	**39**	29.8	**9**	6.9	**48**	36.6
Counselling satisfaction [c]						
Very dissatisfied	**7**	6.0	**4**	3.4	**11**	9.4
Moderately dissatisfied	**3**	2.6	**1**	0.9	**4**	3.4
Slightly dissatisfied	**2**	1.7	**4**	3.4	**6**	5.1
Neutral	**5**	4.3	**5**	4.3	**10**	8.5
Slightly satisfied	**7**	6.0	**3**	2.6	**10**	8.5
Moderately satisfied	**18**	15.4	**8**	6.8	**26**	22.2
Very satisfied	**37**	31.6	**13**	11.1	**50**	42.7

Note.; [a]N = 140; [b]N = 131; [c]N = 117

Self-Confidence

The findings of hypotheses 5 and 5a, as shown in *Table 5*, indicate that the average **self-confidence** level for the entire sample (M = 38.7) is below the mean of 42.2 reported by Oakley (1996), which confirms hypothesis 5.

Contrary to expectation, however, no significant difference in self-confidence was observed between the fixed transgender group (M = 39.35), compared with fluid transgender individuals (M = 37.25), t (108) = 1.071, p = .287, refuting hypothesis 5a. On the other hand, the correlation between QOL and self-confidence was statistically significant (r = 0.60, p = 0.000), accounting for 36% of the variance; this result confirms construct validity between these two measures. Although overall QOL was considerably lower for the transgender groups in this study, interestingly the correlation between QOL and self-confidence was stronger than that obtained by Oakley (r = .48, p < .0001).

Table 5 provides a summary of the descriptive measures (i.e., mean, standard (SD) deviation, median, and range) for the dependent variable of self-confidence.

Table 5: Self-confidence for transgender individuals (fixed and fluid)

Characteristics	**Fixed**		**Fluid**		**Total**	
Confidence [a]						
M (SD)	**39.35**	(10.12)	**37.25**	(8.62)	**38.66**	(9.67)
Mdn, range	**42.50**	17 to 56	**36.00**	21 to 52	**40.00**	17 to 56

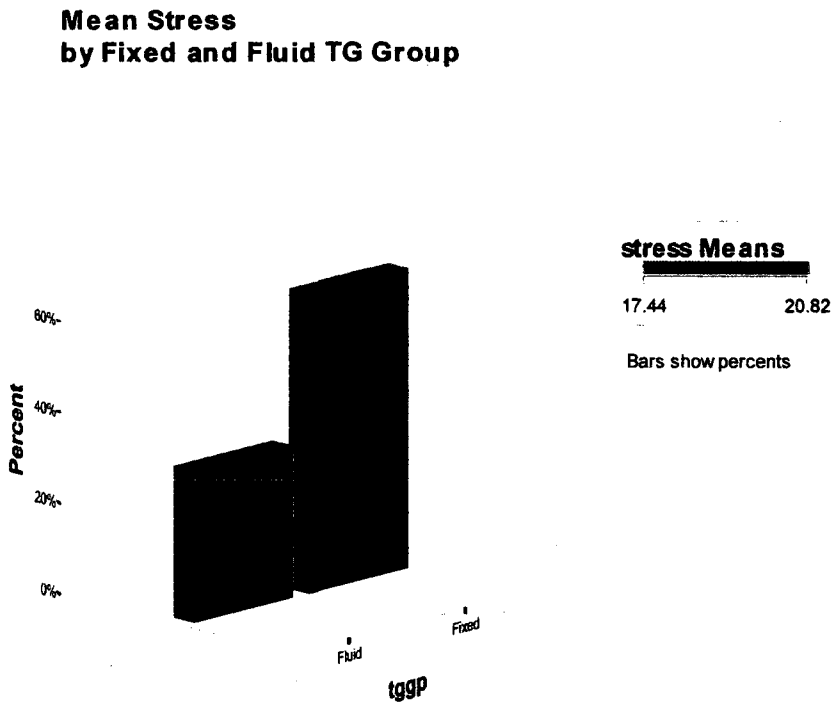
Note. [a]N = 110

Stress

Table 6 provides the means, medians, standard deviations, and range for the overall sample, as well as for the fixed and fluid transgender groups separately.

It was hypothesized that **stress** levels would be higher for the fixed, compared with the fluid transgender individual. For hypothesis 6, an independent *t* test confirmed that the mean difference between the fixed (M = 17.44) and fluid (M = 20.82) transgender groups was statistically significant, $t\ (111) = -3.065$, $p = .003$; however, this result was in the opposite direction, refuting hypothesis 6 (see *Figure 12*).

Figure 12: Mean stress by fixed and fluid Transgender (TG) groups



In addition, Pearson's product–moment correlation between stress and QOL was statistically significant, $r = -.578$, $p = .000$.

Table 6 provides a summary of the descriptive measures (i.e., mean, standard deviation (SD), median, and range) for the dependent variable of stress. It should be noted that both groups in fact have higher stress levels than those reported by Cohen (1994)—on average, the mean was 12.

Table 6: Stress for Transgender individuals (fixed and fluid)

Characteristics	**Fixed**		**Fluid**		**Total**	
Stress [a]						
M (SD)	**17.44**	(5.50)	**20.82**	(5.60)	**18.58**	(5.74)
Mdn, range	**18.00**	7 to 32	**21.00**	9 to 30	**19.00**	7 to 32

Note. [a] N = 113

Another important aspect worth mentioning is that the reliability for Cohen's PPS (1994) was moderately high ($\alpha = 0.71$, $N = 113$, N of Items = 10) for measuring stress in the fixed and the fluid TG groups combined.

Hypotheses Tested for the Demographic Variables

Hypotheses one to eight were tested for the demographic variables. *Table 2* also shows that the **age of questioning** for 86.8% individuals in this study was between 1 to 15 years of age (see *Table 2*). As this trend was noted for both groups, it was not surprising that the overall 2 × 7 chi-square test of association between fixed (n = 86) and fluid (n = 50) transgender groups, compared with age of questioning, failed to reach significance, χ^2 (6, N = 136) = 6.607, p = .359.

Figure 13: Age of questioning gender identity by fixed and fluid transgender groups

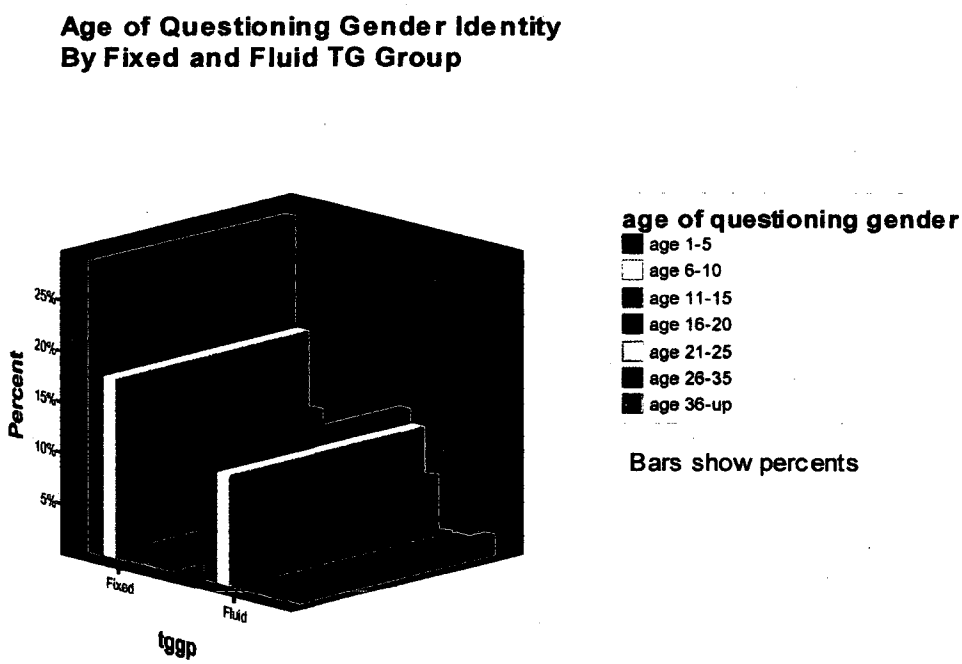
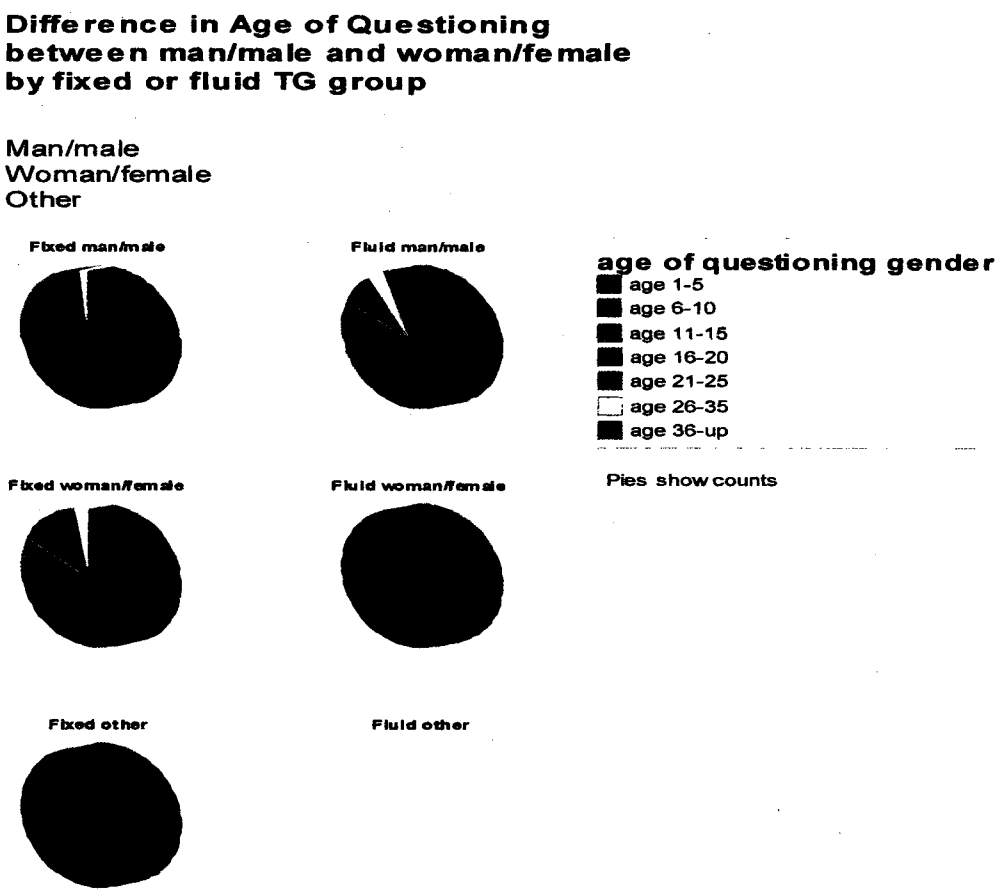


Figure 13 shows that the fixed transgender individuals were more likely to question their gender identity prior to age 5, compared with fluid transgender individuals; this finding, however, failed to reach significance; nevertheless, it confirmed the hypothesis.

Further analysis reveals that 52.94% of those born genetic female (FTM) were more likely to question their gender identity before the age of five, compared with 37.62% of those born anatomical male (MTF) (see *Figure 14*). However, this difference was not statistically significant, χ^2 (6, N = 135) = 7.714, p = .260.

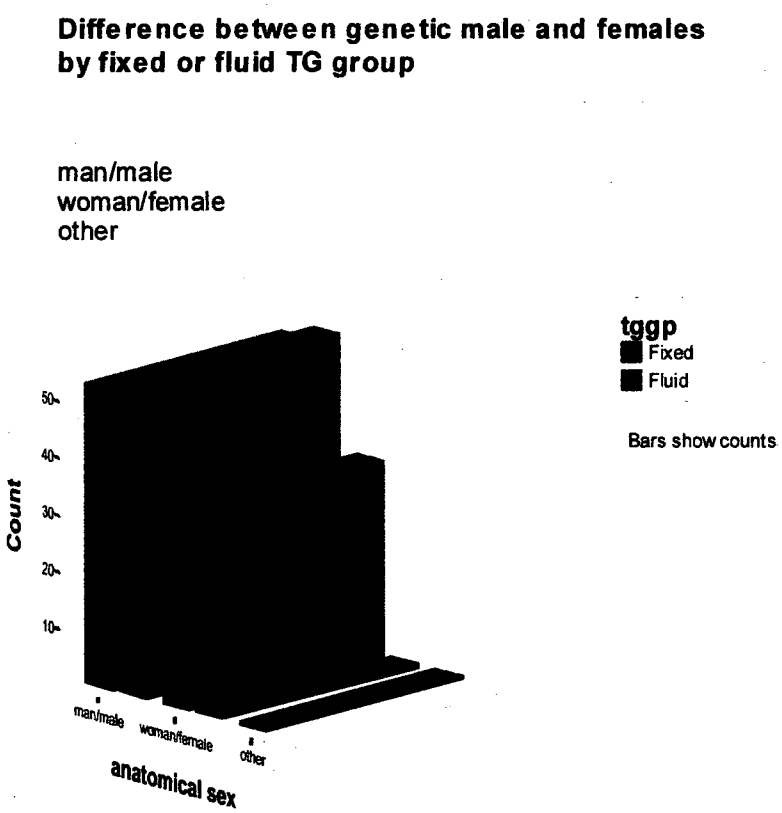
Figure 14: Differences in age of questioning by genetic sex



In comparison, the three-way chi-square test of association (transgender group × age of questioning × anatomical sex) reached significance, χ^2 (6, N = 136, 145, 145) = 135.353, 7.510, 123.159, p = .000, .006, .000). *Figure 14* shows the differences.

In terms of **genetic sex**, almost three-quarters of participants in this sample were born male (n = 108). The overall chi-square test of the association between the fixed and the fluid transgender group and genetic/anatomical sex was statistically significant, χ^2 (2, N = 145) = 27.04, p = .000.

Figure 15: Differences between genetic sex and by fixed and fluid Transgender (TG) groups



Although almost three-quarters of individuals reported male genetic sex (74.5%), the significant association is primarily due to the large transgender group difference for individuals born female; that is, the overwhelming majority within the female

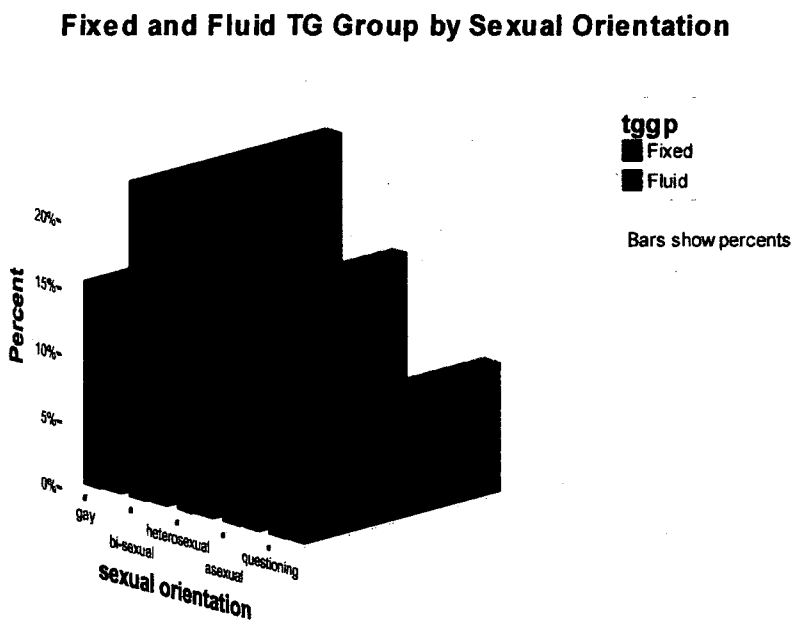
genetic sex (97.2%) category identified with the gender binary (fixed transgender), compared with only 2.8 % of female genetic sex participants identified as fluid.

Individuals identifying with male genetic sex are more evenly distributed in their choice between fixed (n = 53) and fluid (n = 55) transgender categories. Almost no one endorsed the other or both categories (.006%).

In contrast to genetic, anatomical sex, a higher percentage of participants identified with the female **preferred gender expression** category (63.2%), compared with the male preferred gender expression (27.8%). The preferred gender expression for female/woman was endorsed by almost one-half (44.4 %) of the entire sample in the fixed transgender group. The overall 2 × 4 chi-square test showed a significant association between transgender group and preferred gender expression, χ^2 (3, N = 144) = 13.394, p = .004. Similar to the findings for genetic/anatomical sex, a higher MTF participation, compared with FTM, was responsible for more female preferred gender expression, but the result clearly indicates a preference for the fixed transgender group (70.3%), compared with the fluid (29.7%). Again, few individuals endorsed other or both categories.

For **sexual orientation**, *Table 2* shows that one-third of transgender participants in this study are bisexual (34.3%), followed by heterosexual (25.9%), gay (16.8%), questioning (16.1%), and asexual (7.0%). The overall 2 × 5 chi-square test of transgender groups by sexual orientation was statistically significant, χ^2 (4, N = 143) = 25.383, p = .000. As can be seen in *Figure 16*, the fixed transgender individuals consisted primarily of bisexual, gay and asexual, and were less likely to identify as heterosexual, as predicted.

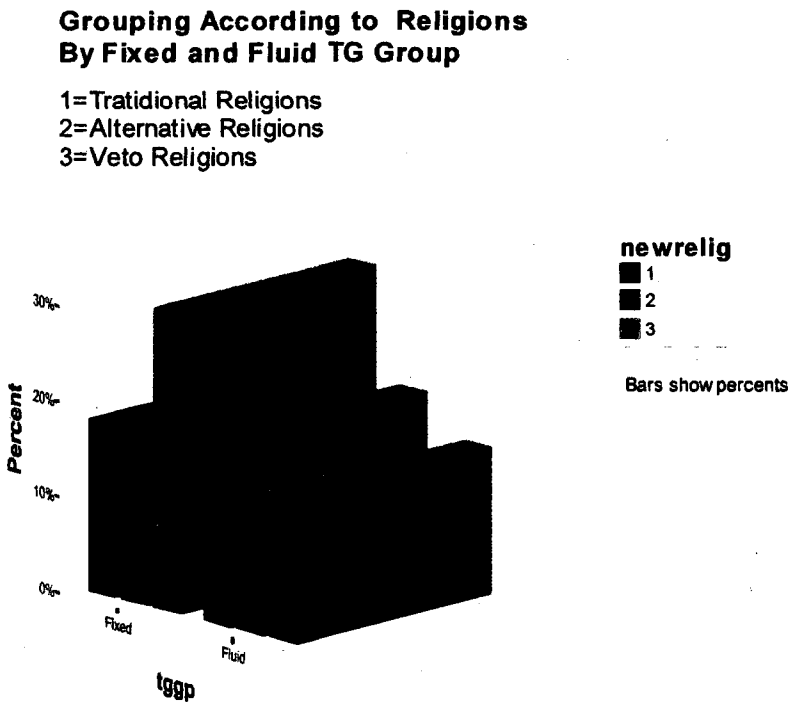
Figure 16: Sexual orientation by fixed and fluid Transgender (TG) groups



In the section addressing **ethnic background**, most participants, both in the fixed and in the fluid categories, were English-speaking (n = 123, 86.0%). Less than 15% (n = 20) of participants were French-speaking or were from other ethnicities (see *Table 2*). As a result, no significant transgender group differences were noted, χ^2 (2, N = 143) = 2.495, p = .287. Comparable results were noted when participants were asked to provide a **racial description**; most participants described themselves as Caucasian (93.8 %). Eighty-eight (n = 88) participants were in the fixed category and fifty-six (n = 56) were in the fluid transgender category. The overall 2 × 5 chi-square test of transgender group by racial background did not yield group differences, χ^2 (4, N = 144) = 3.070, p = .546 (see *Table 2*).

In terms of **religious faith,** overall, almost one-half of the entire sample (47.6%) endorsed veto religions (i.e., agnosticism, atheism, or none); another one-third (37.8%) identified with traditional beliefs (i.e., Roman Catholic, Anglican); and 15.4% self-identified with alternative religions (i.e., Buddhism and Wicca) see (*Figure 17*). Hypothesis 4 was confirmed; transgender individuals regarded as fixed are less likely to follow traditional religions.

Figure 17: Fixed and fluid Transgender (TG) groups according to traditional, alternative, and veto religions



It is also noteworthy that participants in the fluid transgender group were more likely to adhere to traditional religious beliefs (51.9%), compared with the fixed transgender group (48.1%) whereas, participants in the fixed transgender group

(50.6%) tended to endorse veto religions.

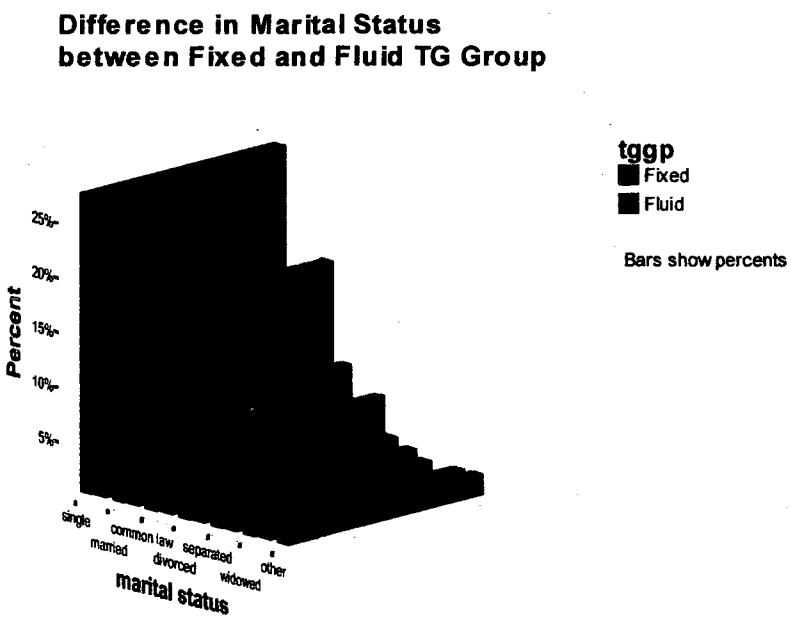
For example, when grouped according to traditional, alternative, and veto religions (see *Figure 17*), the 2 × 3 (transgender group × religion) chi-square test of association reached statistical significance, χ^2 (2, N = 143) = 8.842, p = .012. The largest group difference occurred within the alternative religion (i.e., Roman Catholic, Anglican) category, where 81.8% of individuals were in the fixed transgender group, compared with 18.2% in the fluid transgender group.

This finding provides support for the hypothesis that fixed transgender individuals would be less likely to follow traditional religions than fluid transgender individuals. Another striking finding was that of the largest number of individuals reporting no religious affiliation (24.5% of entire sample), three-quarters were in the fixed transgender group.

As hypothesized, fixed transgender individuals were more likely to report their **marital status** as single (27.6% of entire sample) and fluid individuals as married (17.9% of entire sample; see *Table 2* and *Figure 18*). The overall 2 × 7 chi-square test of the association indicates that the relation between transgender groups and marital status was statistically significant, χ^2 (6, N = 145) = 16.750, p = .010.

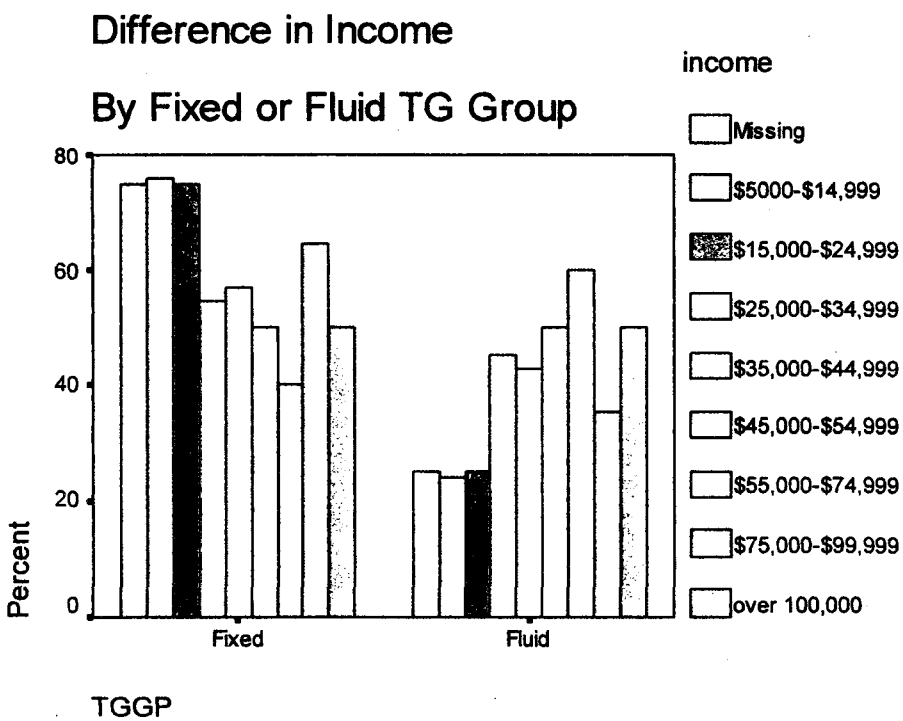
Several group differences were noted that likely contributed to this effect; that is, more common-law or divorced individuals tended to be of the fixed transgender category (76.5% and 66.7%, respectively), compared with the fluid transgender category, whereas in this particular research more fluid transgender individuals identified as being widowed (75.0%), compared with those in the fluid group (25.0%)—although the latter is based on a small sample size.

Figure 18: Differences in marital status by fixed and fluid transgender (TG) groups



Income levels are also shown in *Table 2*, and indicate that, generally, transgender individuals are distributed across all income levels. The overall 2 × 8 (not including missing data) chi-square test of transgender groups by income failed to reach significance, χ^2 (7, N = 141) = 10.077, p = .184.

Figure 19: Differences in income by fixed and fluid transgender (TG) groups

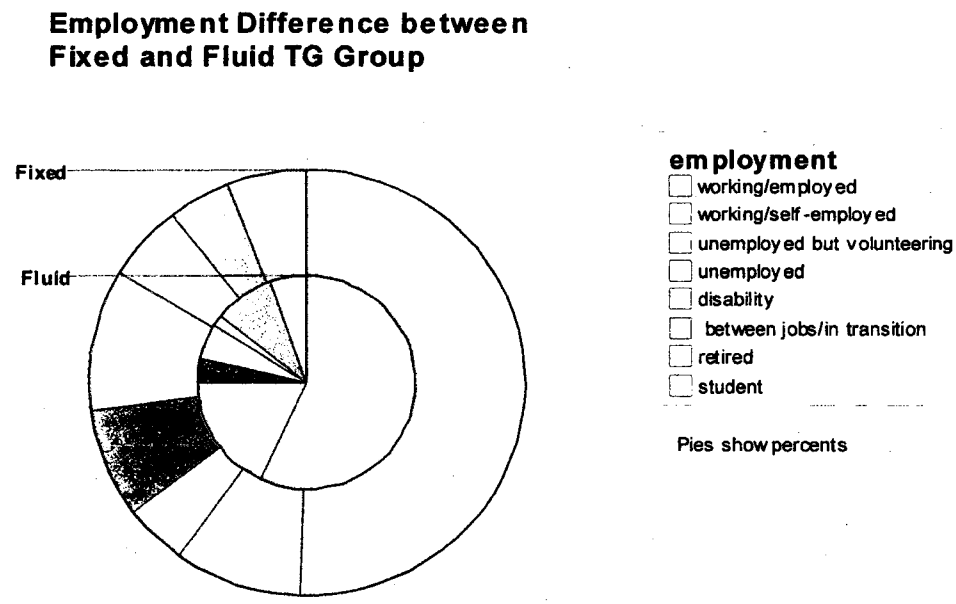


About three-quarters (75.9%) of individuals who earned less than $15,000 yearly (and 75.0% of those within the $15,000 to $24,999 range) were from the fixed gender binary. The absence of a significant finding might have occurred because of a bimodal distribution for the fixed transgender group (see *Figure 19*). Although participants in the fluid group were distributed across all income levels, they were slightly more likely to fall within the middle income categories than the fixed

transgender binary. *Figure 19* supports the hypothesis.

Overall **employment rates**, shown in *Table 2* and *Figure 20*, revealed that most participants were employed or self-employed (66.0%); no significant statistical association was observed between groups and employment rates, χ^2 (7, N = 141) = 9.321, p = .230. The fluid transgender people were slightly more likely to be self-employed (55.6%), compared with the fixed transgender group.

Figure 20: Employment differences by fixed and fluid Transgender (TG) groups



As predicted, of those individuals who were not currently working, individuals in the fixed transgender group were more likely to be unemployed (77.8%), on disability (75.0%), or between jobs (83.3%), compared with the fluid transgender group. This group difference, however, failed to reach statistical

significance. Hypothesis 7, which states that fixed transgender individuals are more likely to be unemployed, was not confirmed. As well, two-thirds of the fixed group was on disability, in contrast to one-third of the fluid transgender group.

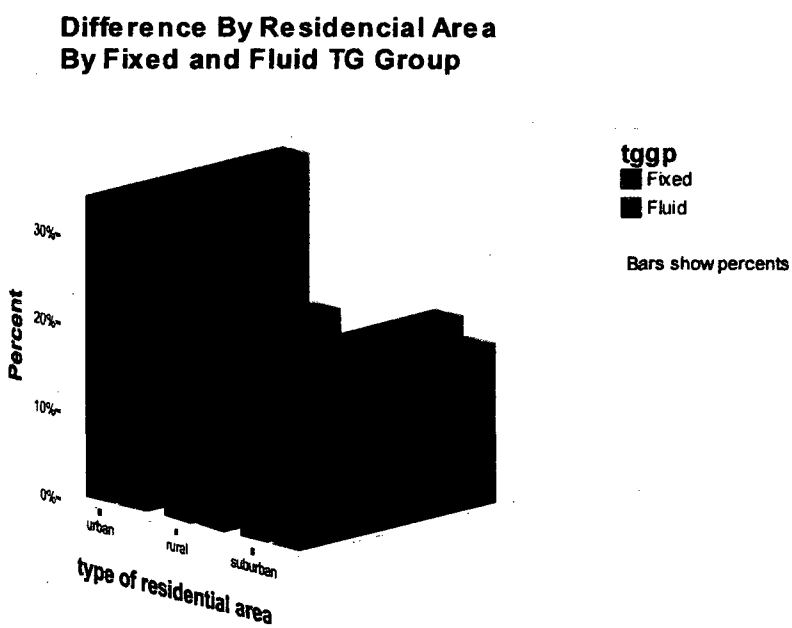
In response to questions about **citizenship**, 80.4% of respondents were either born in Canada, had Canadian citizenship, landed immigrant or permanent residence status, or were Canadians residing outside Canada. The remaining 19.6% of respondents indicated they were non-Canadians or visiting Canada on a student or work visa. The overall 2 × 7 chi-square test indicates that the association between transgender groups by citizenship reached statistical significance, χ^2 (6, N = 143) = 17.137, p = .009.

This result is due primarily to the high participation of Canadian citizens in the fixed transgender category (49.7%), compared with naturalized or landed immigrant Canadians who were more likely to identify themselves as fluid transgender. Individuals who indicated "other" citizenship were evenly distributed between the fixed (51.9%) and fluid (48.1%) groups.

Table 2 shows that the type of **residential vicinity** chosen as a place to settle was slightly larger for urban areas (51.7%), followed by suburban (38.5%) and rural (9.8%) areas.

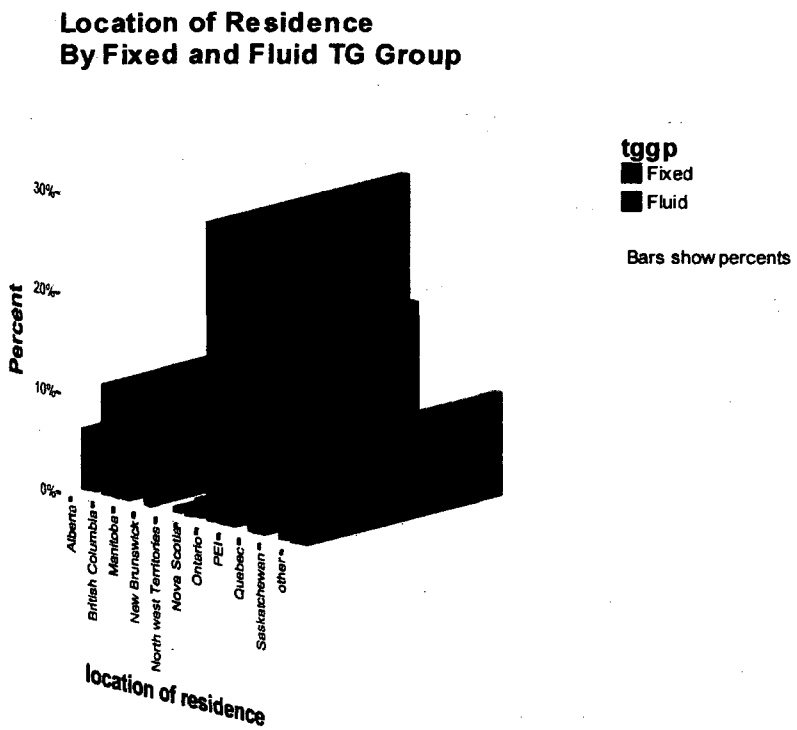
Although the 2 × 3 chi-square test of the association between transgender group and residential vicinity failed to reach significance, χ^2 (2, N = 143) = 3.067, p = .216, a slight trend is noted for fixed individuals to reside in urban areas (55.7%), compared with suburban areas (33.0%), as expected. Fluid transgender individuals were also equally likely to reside in urban areas (45.5%), compared with suburbia (47.3%). Contrary to expectation, most of the individuals residing in rural areas were of the fixed transgender group (71.4%), compared with the fluid transgender group (28.6%).

Figure 21: Differences in residential area by fixed and fluid transgender (TG) group



By location of **residence**, the largest category of participants in this study were Canadians who resided in Ontario (47.6%), followed by participants from outside Canada (19.6%). The overall 2 × 11 (transgender group × location) chi-square test of association was statistically significant, χ^2 (10, N = 143) = 18.370, p = .049.

Figure 22: Provincial location of residence by fixed and fluid transgender (TG) groups



Interestingly, *Figure 22* shows that fixed transgender individual are more likely to live in Ontario and in provinces to the west of Ontario (68.3%), particularly

British Columbia, compared with fluid transgender individuals who were more likely to reside in the provinces east of Ontario (57.1%), notably Quebec and Nova Scotia. The choice of province of residence for non-Canadians tends to be evenly split between the fixed and fluid transgender groups. A test of the association between the eastern (east of Ontario) and western provinces (including Ontario) approached statistical significance χ^2 $(1, N = 114) = 3.729, p = .053$.

Discussion of Quantitative Findings

I was well aware that it is not easy to find and convince transgender people to participate in research; therefore, a purposive sampling method was used. Study participants were recruited through approaching transgender support and discussion groups. This method in itself has some flaws as not all transgender individuals participate in groups. Whenever possible, comparison between the findings of this research and other research will be done throughout the discussion of the findings.

The goal of the research was to introduce an improved inclusiveness for the vast variety of transgender (TG) self-identities to be used in the clinical setting. This was achieved through clustering the spectrum of transgender identities into two groups – fixed or fluid. The fixed and fluid transgender groups were then used as the key criterion for investigating differences in quality of life (QOL), self-confidence, stress and counselling satisfaction. The key criterion was also used to investigate difference of several demographic variables.

Currah, Juang, and Minter (2006) acknowledge the problem with the binary sex/gender category and they viewed sex/gender on a continuum. Kenagy and

Bostwick (2005) found in their study that by grouping their participants into two discrete gender identity categories, MTFs and FTMs, they reinforced the gender binary. I fully agree with their concerns, because the MTF and FTM categories adhere to the socially constructed gender binary. In my study, I also chose two categories, the fixed and the fluid transgender groups, which, at first glance, might remind us of the binary. However, through clustering a variety of gender expression and self-identities into the fixed as well as the fluid transgender groups; I acknowledge the diversity of transgender people. The following is a reiteration of the groupings.

The groups under the transgender umbrella are very diverse and yet they do have important parallels with each other, which provided the possibility of ordering them into two main categories: (1) *fixed*—representing transgender individuals who clearly preferred identification with the gender binary, as either male or female. The fixed group includes transgender 24/7 (living in the opposite to their at-birth assigned sex, gender) without HRT, transgender 24/7 with HRT, as well as transsexuals pre-operative, transsexuals post-operative, and hermaphrodite/intersex (choosing either male or female), and (2) *fluid*—representing transgender individuals that favour openness and flexibility on the gender continuum. The latter group does not live full-time (24/7) in the opposite to their at-birth assigned sex/gender and includes the following: cross-dresser/cross-gender, bi-gender, gender-bender, androgynous, gender questioning, drag-king (gender-questioning). Subdividing the population is important; it might provide potential help in the identification,

classification, and explanation of severity level, considerations of their needs, and thereof, arising requirements for therapeutic interventions, such as counselling.

Despite the limitations and the differences in grouping, some of the findings complemented other research findings, especially in the demographic and QOL variables. As well, it gave understanding to clinical issues, which I and other clinicians experience in working with this particular clientele on a daily basis. First, the findings on the QOL scales will be discussed, followed by the participants QOL, self-confidence, stress level, and counselling experience. This section ends with a short discussion on some of the demographic findings.

QOL Scales and Results

In the clinical setting, using short scales measuring QOL, perceived stress, self-confidence, and other concerns are very helpful tools in understanding clients' lives and perceptions. These particular scales are not used as diagnostic tools, rather they allow for further questions, provide insight, present clinicians with greater understanding of transgender individuals' circumstances and day-to-day living, their past and present situation which is especially important because the concern with gender is only part of their issues, a fact that needs to be acknowledged in treatment.

Bradley's (1994) well being scale (BWB) as well as the Memorial University Scale of Happiness (MUNSH), (1980), were investigated. Both scales are very well known and in previous research (McMillan et al., 2006; Kozma & Stones, 1980; Kozma, Stones, & Kazarian, 1985), the MUNSH indicated moderate reliability with a Cronbach alpha of 0.70 whereas the BWB scale achieved a high Cronbach alpha of

0.96, when measuring QOL in previous studies.

Furthermore, a comparison of the BWB and the MUNSH indicates that they measure similar concepts. The findings showed that the BWB was not a good measure for transgender individuals' QOL. The reason might be that the BWB was constructed to measure depression and anxiety and, at the same time, minimize somatic problems association with a physical disease. It was assumed and confirmed that the BWB is not a good choice because transgenderism is not a physical disease nor is it a mental disorder.

In contrast to this is the MUNSH, which measures feelings in the last month as well as in general life experiences. This provides the clinician with a good, current, overall QOL measure, as well as some QOL feelings and perceptions from the transgender individual's past. It appears that the MUNSH may provide clinicians with a good reliable measure for transgender clients' QOL, and the 24-item scale is easy to use. It is imperative to acknowledge that the MUNSH is effective in discriminating between the general and the psychiatric population. This is important because transgenderism is not a mental illness. As already stated, the MUNSH is not a diagnostic tool; however, it can provide the service provider with information needed in a best practice approach.

As previously stated, there is an increase in literature on transgenderism; however, there is still a lack of QOL research concerning this population, a statement supported by Gail Knudson, a psychiatrist and well-known researcher and writer on transgender issues (Knudson, personal conversation November 16, 2007). Many of

the existing QOL investigations are linked with QOL in relation to SRS or other issues (i.e., HIV, needs assessments).

Similar to a study by Newfield et al. (2006), who compared FTMs with the non-transgendered population and found that the FTMs had a reduced QOL, this study found that the overall QOL for transgender participants was very low. In comparison with Oakley's QOL scores, she researched a general population sample, her research participants' population's median score was 16.0, transgender participants' median score was 3.0. Low QOL appears to be common in transgender people.

However, when gender dysphoria is resolved, QOL appears to improve. Several studies report on this improvement (Newfield et al., 2006; Rakic, 1996; Lawrence, 2003) reported that TS felt that their QOL improved after SRS or after starting HRT. The study by Newfield et al. (2006) is especially interesting as the researchers use an in-between comparison analysis that compared QOL of transgender individuals who received testosterone and chest-reconstruction surgery with those transgender individuals who did not receive testosterone or chest-reconstruction surgery, with the latter group demonstrating a significantly lower QOL. The current study also used an in-between comparison; the key criterion was the fixed and the fluid transgender groups. The findings indicated that there was a difference in QOL between these groups.

Because the fluid population does not seek out counselling the assumption was always that they (cross-gender people, fluid) have fewer issues; they have

employment, a higher income, better QOL, and less stress, as they switch back and forth in their gender, and therefore can enjoy their lives according to socially expected gender norms. Conversations with transgender individuals and clinicians (including personal conversations with clinicians and transgender people over several years, during 2000 to 2007) supported these assumptions. However, a comparison between the fixed and the fluid transgender groups showed that the fluid group had a lower QOL than the fixed transgender group. The difference was not significant as the QOL for both groups was extremely low. More investigation in this area is recommended, as well a need for changes in clinical treatment modalities for the fluid transgender group.

Self-Confidence

Most interestingly, although their QOL is low, the self-confidence scores of the transgender group were relatively high in comparison with other studies. The fluid transgender group reported slightly lower self-confidence than the fixed transgender group. Gehring & Knudson's (2005) study indicated that the participants felt lonely and isolated, but did not indicate suicidal ideations. Interestingly, they found low self-confidence, and the researchers further pointed out that the participant's experienced low anxiety.

In contrast to this the qualitative data of the current study identified high anxiety as a theme that strongly emerged. Oakley-McKeen and Petrusic (1995) and Eysenck and Eysenck (1985) reported that self-confidence could be inflated in highly anxious individuals. Transgender individuals often report anxiety, which supports

Oakley-McKeen as well as the Eysencks' assumptions. Anxiety may be directly related to gender issues as well as the fear that disclosing this secret might provoke anxiety (Bockting et al., 2006). Since transgender individuals learned over the years to hide their transgenderism, they might produce a self-confidence which appears high to the outsider but in reality is only a cover for self-protection.

Stress

With a severely low QOL, a high level of stress is to be expected. The results showed that there was a significant difference between the fixed and the fluid transgender groups. The fluid transgender group experiences higher stress than the fixed group. The impact that psychosocial stressors (i.e., harassment, violence, discrimination, employment issues, isolation, and depression) have on transgender individuals are well reported (Lombardi et al., 2001; Nemoto, Operario, Keatley & Villegas, 2004; Bockting et al., 2005, Bockting et al., 2006). Hiding their transgender or cross-gender feelings, finding friends with whom they can talk and express their feelings, self-acceptance, binging and purging of clothes, constantly questioning, "Where will this end?" all add to the stress this population experiences. Israel and Tarver (1997) reported that the stress transgender individuals experience is due to the widespread social stigma.

Keeping a secret causes isolation, which is another factor that might cause increased level of stress. For a long time, the individuals might have lacked the language to articulate their feelings of gender dysphoria. Bockting et al. (2006) expressed that long-time suppression of transgender feelings can lead to isolation and

loneliness. Belonging to a transgender group does not always provide relief; in a previous study Seidl (2003) found that 73.3% (n = 54) of transgender individuals who were members of a support group declared that they experienced severe isolation. It appears that transitioning and adhering to the socially accepted gender binary provides not only a higher QOL but also less stress. Transsexuals reported that their QOL improved after having SRS (Rakic, 1996; Lawrence, 2003).

The PSS indicated good reliability in measuring the stress of people experiencing transgenderism. Even though the PSS is not a diagnostic measurement yet, the scale might be a good tool to use in therapeutic treatment of this population.

Counselling

There are different treatment options for dealing with gender dysphoria and/or psychosocial issues affecting transgender individuals. Counselling is only one of the treatment options. Different therapeutic modalities may be used to help the transgender individuals dealing with their problems. Some transgender people see health care professionals as "gatekeepers," blocking their way of transition (Lev, 2004; Meyer et al., 2001). However, for some, counselling might be a very important aspect in normalizing, accepting, and dealing with transgenderism.

Kenagy (2005) also identified that receiving counselling for transgender people can create a challenge. In her study 7% identified that they had been refused counselling because of their transgenderism and 10% had been refused counselling for transgender related issues.

Previous research shows that 77.4% of transgender people in Ottawa and environs thought that therapist/health care professionals have no or minimal knowledge of transgenderism (Seidl, 2003). The reality is that the psychotherapeutic treatment for transgender individuals is still in its early stages. As well, the focus in transgender research and writings is often on TS, and very little is being done in the area of gender fluidity (Lev, 2004). Investigating the difference between fixed and fluid within transgender groups was important, because the two groups clearly have different needs. For fixed transgender people, therapy is often viewed as necessary in the process of obtaining the needed letters for HRT and SRS. Therefore, to seek counselling was more prevalent in the fixed transgender group, compared with the fluid transgender group.

Demographic Results

Demographic data is shown in *Table 2* and explained in the findings.

Gender Questioning:

It appeared that a higher percentage of the fixed transgender group questioned their gender between the ages of one and five years, compared with the fluid transgender group. Cook-Riley (1997) investigated age and gender identity and found that younger transgender individuals would identify as TS, while older transgender individuals would use cross-dresser as their self-description. However, the groups Cook-Riley (1997) used were only aged from 25 to 65 years and over. Nevertheless, Cook-Riley's (1997) study also points toward gender on spectrum in which coming out might happen at all levels of the spectrum.

White, Holman and Goldberg (2006) recognized that younger people, including young TS, who self-identify outside the gender binary and now use more gender fluid terms (such as pangender and gender-queer). Although ages for the current study ranged from 17 to 82 years, the mean age was 42.27, terms such as pangender and gender-queer were not included in the self-identification section and, in the section on "other," none of the participants self-identified with the aforementioned self-expressions or any other gender expressions.

Furthermore, comparing my current study with other studies; the study of Burnham (1999) had an age range of 19 to 67 years, with a mean age of 40.7; the study of Angello and Villegas (2000) had an age range of 28 to 73 years, giving a mean of 47.5. Neither of these studies mentioned White, Holman and Goldberg (2006) self-identification trends as an issue. The trend of new terminology should be observed and might need to be included in the demographics of self-identification in a follow-up study. Self-identification must also be taken into consideration in clinical management when working with transgender people. Therefore, clustering transgender expressions into fixed and fluid clusters provides not only openness and inclusiveness but allows it to continue to add new terminology.

Of notable interest is that FTMs question their sex–gender identity at an earlier age than MTFs; as well, the overwhelming majority, 97.2%, of FTMs preferred the gender binary (fixed). Whereas for the MTFs in the sample, the sex–gender identification for the fixed ($n = 53$) and fluid ($n = 55$) was evenly distributed.

Some of the FTMs expressed that their open upbringing allowed them to be tomboys and to freely associate with their sex and gender identity, "male/man." However, starting with puberty, they experience the enforcement of social gender norms, expectations, egoalience, and confirmation of their genetic/anatomical sex with menarche and breast development. At this time they are expected to publicly express their socially assigned sex and gender "female/woman." Feldman and Goldberg (2006) established that gender concerns can affect individuals of all ages. However, other research (Blanchard, 1994) confirmed that MTFs seek treatment for gender dysphoria during middle age whereas FTMs are typically younger.

Sexual Orientation

Concerning sexual orientation, more bisexual, gay, and asexual transgender individuals are found in the fixed transgender group, whereas more heterosexual individuals are found in the fluid transgender group. A higher ratio of the fixed transgender group (2:3) chose the category of asexuality, compared with the fluid transgender group. The overall results are comparable in relation to the Kinsey et al. (1948, 1953) scale of sexual orientation.

In the Xavier et al. (2005) study, 65% of participants identified as gay. In a further breakdown, only 1% of natal males used the self-identification of lesbian, whereas 45% of natal females used the term. For the current study, the term gay was chosen to be all encompassing (for gay males, gay females, and queer). Xavier et al. (2005) and Kenagy (2005) both had a category of "other," but did not specifically ask for asexuality. Furthermore, in the Kenagy (2005) study the majority, 84%, of

MTFs in contrast to 35% of the FTMs identified their sexual orientation as homosexual. Because asexual is not really addressed in transgender studies, it would be worthwhile to investigate this category more closely. Gender is established before sexual orientation and some of the participants identified as gender-questioning (fluid); therefore, they may still question their sexual orientation (16.1%) at the time the data for this particular study was collected.

Kenagy (2005) pointed out that the current concept of investigating sexual orientation does not work for this population since they might see male-to-male and female-to-female as different, since the physical characteristics might not be important. Question and proper explanation for sexual identity are crucial in research with transgender people.

Income

The issue of income can be placed into perspective through the Statistics Canada's (2004) measurement of "low income cut-off" (LICO) for the overall Canadian population: median income before taxes for Canadian families is $54,100; female lone-parent families, $27,700; and, the single person's income, $21,300 (Statistics Canada, 2004). The research data indicates that 28.4% of the fixed transgender group is below or within the low-income range. However, this is within the normal range of Statistic Canada's (2004) estimate of single Canadians (29.6%) living below the LICO.

For differences within the group, the fluid category comprised the slightly larger percentage of the middle-income category ($25,000 to $74,999). Angello and

Villegas (2000) reported in their study that almost equal numbers were found in the low- and middle-income categories. However, when comparing the fixed and the fluid transgender groups, the difference between the groups is large, with (75.9%) of the fixed transgender group is earning less than $15,000. This finding indicated how important a between group comparison was since the difference of income between groups might affect accessibility to counselling which furthermore might have an impact on the transgender individuals QOL.

Other studies such as: Lombardi et al., 2001; Goldberg, 2003; Nemoto et al., 2004, document a high poverty rate for transgender people, which is consistent with the findings of this study.

For employment some studies (Lombardi et al., 2001; Goldberg, 2003; Nemoto et al., 2004) report high unemployment among transgender people, while interestingly, more than one-half (53.2%) of the participants in my study identified as employed, which differs from the findings of the aforementioned studies.

Residence

As Canadian provinces provide different quantity and quality of services for transgender people, it was assumed that there might be a difference between percentage of fixed and fluid transgender individuals migrating to provinces with better provision of services. The country was divided into two parts, west, including Alberta, British Columbia (BC), Manitoba, Saskatchewan, Northwest Territories, and Ontario, and east, including Quebec, Nova Scotia, Prince Edward Island, and

New Brunswick. For this part of the analysis data for non-Canadian study participants were excluded.

More services are provided in the west, including Ontario, which might explain why a higher percentage of fixed transgender individuals are found living in these particular provinces. In the eastern provinces, finding appropriate service is difficult, which might explain why a higher percentage of the fluid transgender groups tend to be found more in the east. Transgender people who decide to start HRT or SRS might consider moving to the western provinces, for example, BC or Alberta, where SRS is paid for by the provincial government.

Whereas for the non-Canadian participants (e.g., Americans and Europeans), the split between fluid and fixed transgender group belonging was more equal. The only answer for this phenomenon might be, as stated, due to better services, and the reinstatement of SRS in some provinces (such as BC and Alberta).

Religion

Witten, Eyler, and Weigel, (2001) revealed that most transgender elderly do self-identify as being part of a traditional religion or as being highly spiritual. My clinical experience supports the view that spirituality becomes more important when people get older. Research on religion and spirituality confirms that it is important for feelings of belonging, dealing with depression, doubt, despair, and change; as well, it is important for QOL (Ebersole & Hess, 1995). The current research confirms that both the fixed and the fluid transgender groups seek out religious affiliations.

However, this research also indicated a significant difference in religious affiliations, in terms of which religious group they will join. A higher percentage of the fluid transgender group identified as members of traditional (i.e., Roman Catholic, Anglican) religions, whereas the fixed transgender group identified with veto (e.g., Agnosticism, Atheism, or none) religions.

The fixed transgender group adheres to the traditional norms and view of the gender binary; however, for religious institutions, the fixed transgender group does not adhere to the institutional expectations of gender. As explained in Chapter two, "A woman shall not wear anything that pertains to a man, nor shall a man put on a woman's garment, for all who do so are an abomination to the Lord your God" (Deuteronomy 22:50). Some, religious institutions go even further by openly condemning SRS. This might be one of the reasons why fixed transgender people feel more comfortable with alternative religions or avoid religious institutions altogether.

Interestingly, in terms of QOL, transgender individuals that choose alternative religions, such as Buddhism or Wicca, enjoy a higher QOL than transgender individuals who select veto or traditional religions. *Figure 5* shows the mean difference of QOL and religious affiliation (M = 2.00 to M = 5.41), indicating that transgender individuals choosing alternative religions have a higher QOL, with a mean of 5.41. A high percentage (31.5%) of transgender participants had no religious affiliation, which is higher than the Canadian standard reported by Statistics Canada

(2004), in which Canadians with no religious affiliation account for 16% of the overall Canadian population (Statistics Canada, 2004).

Marital Status

As for marital status, more individuals in the fixed transgender group declared themselves to be single, separated, or divorced (37.3%); in contrast, only 15.8% of the participants in the fluid transgender group were single, separated, or divorced. Surprisingly, it was found that marital status (married or common law) did not positively influence the QOL of the transgender participants.

Summary of quantitative findings

Even though the study had limitations, which are addressed in Chapter 5, important implications for changes in therapy can be drawn from this data. First the participants were grouped into two categories, the fixed and the fluid transgender group, which at the first glance might resample the gender binary. However, each group included a wide variety of gender diverse individuals.

As identified in the introduction, one of the problems is diagnostic typologies and according to the standardized diagnostic nosologies, clients have to be labelled. However, it is difficult to label clients if the diagnostic typologies are too narrow. Using two all inclusive groupings provides the therapist with the possibility to include a wider variety of people in the assessment and hopefully provides the client with the best diagnosis and help.

Another issue we encounter is the language which therapists use. This language might not be the same as the terminology of the clients which may be the

cause for misunderstandings, misdiagnosis and the termination of the professional relationship. Therefore, using a fixed and fluid transgender grouping in the assessment and treatment phase might be a very helpful method. Furthermore, the fixed and fluid grouping also provides room for considering gender on a continuum and consequently providing flexibility for change.

Second, the two QOL scales, the Bradley's (1994) well being scale (BWB) as well as the Memorial University Scale of Happiness (MUNSH), (1980) were investigated. It was established that the MUNSH provided a higher reliability in assessing QOL for transgender people. In the assessment process one of the problems is often that of time constraint (Lurie, 2005). Having a short reliable tool, such as the MUNSH, provides insight to the clients' QOL, which can help the therapist to pinpoint additional areas of requirements.

The reasons for time constraints can vary, some of them might be the clients' own time constraints due to their external health care insurance coverage, dollar amount available for therapy. Another might be the time constraint of the health care provider. Health care providers in community centers or employment assistance programs have only a limited number of sessions before referring the client out.

The next obstacle clients often come across is the availability of health care providers who are knowledgeable in transgender care. There are not enough health care providers, including social workers, who have knowledge on transgenderism. To address this problem changes to include transgenderism in the educational curriculum are needed. Recommendations for such changes are provided in

Chapter 8.

The quantitative findings suggest that both groups, the fixed as well as the fluid, experience low QOL. Fluid transgender individuals' QOL was slightly lower than the QOL of the fixed participants. Understanding family of origin is important since the individuals' upbringing, as well as the current relationship with family might have a severe impact on the transgender individuals' QOL. The family and peers (micro) as well as the larger social context (macro) have to be taken into consideration when working with this population. Past and current traumas can provide barriers. How socio-environmental issues affect the transgender individuals' development and QOL is further addressed in Chapter 7.

A sad reality is that even though more transgender people seek out counselling, they are not very satisfied with the services they receive. Other studies also identified that transgender people experience poor health care services (Kenagy & Bostwick, 2005; O'Hanlan, Cabaj, Schatz, Lock & Nemrow, 1997) and point out the need for education of service providers. Counselling service providers need to use a client centered treatment approach, which take client identified components into account and work within the realm of a harm reduction model (see Chapter 8).

Chapter 7

Qualitative Findings and Discussion

Overview

The quantitative section (Chapter 6) concentrated on the learned process of the socially constructed gender binary and the learning of gender norms and expectations. How each transgender individual is affected greatly depends on their main teachers and (or) influences. The effect that this learning has on the creation of a healthy self might limit an individual's true gender expression. During the different developmental phases, it might lead to psychosocial symptoms that affect transgender individuals' QOL life. The different themes that emerged from the participants' answers are shown in the context of the developmental phases.

Everyone may not be in agreement with the arguments connected with the quantitative findings. I will, however, discuss the findings in the context of my experience as a clinician working with transgender people for many years, the experience of other clinicians and observing clients as well as transgender friends. Over the years, I have built my opinions and assumptions; some of them are supported by other research, and some are based on clinical experience.

Supporting two different approaches (quantitative and qualitative) is difficult. However, quantitative findings that are in the extreme margins (i.e., extreme poor QOL) may be more easily understood through the themes that emerged from the qualitative data. As well, some of the qualitative answers will be supported by the quantitative findings of this research.

My introduction started by stating that the field of transgender studies is very young and that there are many disagreements as we struggle with different terminology, debate the concept of diversity, and contemplate clients' needs. Moreover, with growing interest in the field, different opinions continue to emerge. Nevertheless, although it is still a contentious issue, I believe in sex/gender as a continuum which is supported by Currah, Juang, and Minter (2006).

Recently however, sex/gender diversity seemingly reached greater acceptance. In the last decade we achieved some positive changes, such as: in Ontario, the Ministry of Transportation will change gender (M or F) on the driver's licences of transgender individuals who are on HRT only; before this policy change, gender adjustment on licences was done only after having SRS. My experience also shows that more employers, in the private sector, as well as in the federal (i.e., the Department of National Defence) and provincial government, will accept their transgender workers (during and after transition) and yet many health care professionals still struggle with acceptance of transgenderism, especially gender diversity (Kenagy, 2005).

I believe that one of the reasons might be that transgenderism and gender diversity are either only minimally, or not addressed at all in the educational curriculum of health care providers. Another important aspect is that there is not enough research on gender fluidity; regrettably, only a few clinicians have addressed this topic in the literature (Hart, 1984; Raj, 2000a; Zandvliet, 2000).

Findings and Discussion

The idea that the only way to establish a gender identity is through social learning/nurture, psychosocial factors, i.e. child rearing and cultural influences in child development, was challenged by La Vay (1991) and Zhou's (1995) research, which points to gender identity as innate/nature. The nature/nurture topic is still hotly debated. My belief is that both nature and nurture are contributing factors in transgender individuals' gender identity development. Our current knowledge suggests that many problems that transgender people experience (i.e., anxiety, depression, and dissociation) might be, in most cases, symptoms of nurture, in particular being raised in an environment that is dominated by a social structure that adheres to a gender binary. However, if and how much nature influences an individual's vulnerability to be affected by the dominant upbringing and therefore develop symptoms, such as anxiety, depression, and dissociation, we do not know.

A comparison could be made with posttraumatic stress disorder (PTSD). The prevalence for PTSD was established through community-based research, which revealed that a lifetime prevalence for PTSD was only 1% to 14%, whereas studies with at-risk populations (i.e., combat veterans and rape victims) indicated that high risk would increase the possibility of PTSD to 3% to 58% (*DSM-IV,* 1994). Using the example of PTSD, a comparison between the upbringing/development of children in general and the upbringing/development of people experiencing transgenderism may help us to understand transgender people's struggle as well as their low QOL. Posttraumatic reactions are described by Cole et al. (2000); however,

to my knowledge, there is no research available on effects of environmental factors (upbringing) that might intensify transgender people's vulnerability and increase the prevalence of PTSD, depression, and other symptoms.

In general, children experience identity struggles during their developmental stages (i.e., childhood and adolescence). A percentage of them might be affected by their identity struggles and upbringing. From this, many questions arise. Could transgender individuals be considered part of an at-risk population and as such a higher percentage might be affected by their gender-specific upbringing? As a result, could they be more prone to symptoms such as anxiety, depression, and dissociation? We still debate nature's influence on the development of transgenderism (genetic). We neither know whether nature is a contributing factor that so many transgender people experience symptoms (i.e., anxiety, depression, and dissociation) or if nurture is the only culprit. Further research is needed in this area to answer these questions.

Is Gender a Continuum or a Constant?

This question will continue to be asked as long we continue to ponder about transgenderism and view it as an infrequently occurring phenomenon, or as a medical or mental health condition. Developmentalists such as Kohlberg (1966), Kohlberg and Ulian (1974), and especially Money (1968, 1972, 1980) argued that gender is established by the age of three. However, the quantitative findings of this research point toward gender as a continuum; 41.2% questioned their gender between the ages of 1 and 5 years; 45.6% experienced gender incongruency during

the ages of 6 to 15 years; and 13.2% started questioning their gender identity after the age of 16 years (see *Table 2* in Chapter 6).

Angello and Villegas (2000) found that gender identity development, especially for the MTF is a continuum. One of the reasons might be, as Angello and Villegas (2000) reported in their study, that participants "either chose to, or on some occasions felt forced to, express themselves as either male or female and further perceived the feelings of such a melding as congruent, incongruent or in conflict" (p. 34).

The outcome of my research indicates that we may have to question that there is a fixed age when gender is fully established. Pointing toward the onset of gender incongruency can become an issue throughout an individual's lifespan. At this point it is important to reiterate that the participants' division into either the fixed or the fluid transgender group was done for this research only. An individual who in this study is currently considered fluid may one day choose the gender binary (fixed) and transition. I believe that including both the fixed and the fluid transgender groupings is a helpful tool for clinical management, the decision of treatment modalities that will fit an individual's needs rather than a medical diagnosis.

Furthermore, the current study indicated that FTMs appear to question their gender incongruency at an earlier age than MTFs. Burnham's (1999) research also indicated that FTMs question and resolve their gender identity issues at an earlier age. The majority of the FTM respondents in Burnham's (1999) research started cross-living in their thirties; in contrast to this, the MTF respondents' average age to

resolve gender identity issues was later, and they did not start cross-living until their forties or fifties.

One of the explanations why natal females express a greater "fluidity"/cross-gender appearance than natal males may be that they can more easily integrate into general society. For example, a "manly female" (Devor, 1997) might earn respect, whereas a feminized male might experience derision. One of the reasons why FTMs transition in their thirties might be that this is the age when the female body type generally becomes more feminine. Witten et al. (2001) established that female and male phenotypes get more similar as they age; therefore, it is easier for older MTF transgender individuals to pass. However, for the natal female, it gets harder to pass as male (without HRT) as they get older; typical female fat deposits and wider hips (to mention only a few changes) will bring higher awareness of the "wrong" gender to the individual.

The following are the qualitative findings that are presented and discussed within the developmental phases (i.e., childhood, adolescence, adulthood). Individuals' experiences and feelings are reported through the use of direct quotes. It is hoped that this may help in understanding transgenderism. I often hear, "I was too scared to talk about it" or "Nobody listens to me." The participants' stories allowed me, the researcher and clinician, as well as (it is hoped) the reader, to understand how social exclusion affects transgender people's lives, their well-being, their genuine gender expression (accepting the gender-binary, a cross-gender expression,

or any other alternative place on the diverse continuum of gender), and their self-identity formation.

Childhood

Examination of early memories of appropriate gender behaviour show that some transgender people learn/believe at an early age that something is wrong with them and that they do not fit in. The feeling of not fitting in accompanies many transgender individuals throughout their life, or until the gender incongruency is successfully corrected, or for cross-gender individuals, until a healthy balance is found. Participants expressed how they felt. Comments such as "I felt that my feelings were wrong" (MTF, TS post-op, fixed) are common. Others expressed self-hatred:

> I hated myself for a very long time for feeling the way that I did. I felt that I was really wrong. I would always wish to be a boy when I was younger and went to bed at night crying about it (FTM, TG without HRT, fixed).

> The very concept of transgenderism was not part of my world when I was growing up and I had no way of understanding what was happening to me. I didn't understand why I couldn't "fit in" (FTM, TS pre-op, fixed).

Early on we learn that gender is supposed to be an invariable feature; one's sex is either male or female, which, according to socially constructed norms, when adult, makes one a man or woman. Although it is still debatable, it could be argued that gender identity is established before birth (Sober & Imperato-McGinley, 2004; Playdon, 2002; La Vay, 1993; Jones, 2002). Others such as Money (1968, 1972, 1980) clearly argue that gender is learned. I did not find any research that found,

without doubt, that the development of gender identity is established before birth and continues throughout an individual's lifespan. Throughout the qualitative findings, nurture's influence on the development of **symptoms** will be discussed. However, this should not be misinterpreted as an indication that I believe that transgenderism is based on nurture only.

During the childhood developmental years, individuals (e.g., parents, grandparents, peers, teachers, and media) who have formative influences on the child's identity development enforce and reinforce primary information about appropriate gender behaviour, norms, and expectations. Gender roles are learned and they are the expected public expressions of an individual's assigned anatomical sex and gender. Participants reported that statements about gender-appropriate behaviour were announced in a loud and clear manner.

> As a child my parents would tell me "stop walking like that!" (Moving my hips.) Or sit me down for a talk when they discovered my stash of clothes (male, CD/CG, fluid).

> My parents and grandma pressured me by actually telling me that I needed to look and act like a lady. They would buy me clothes and accessories to make me live the part (FTM, TG with HRT, fixed).

> They sent me to psychiatrists to cure me of being Trans, which of course failed miserably (MTF, TS pre-op, fixed).

According to the participants' answers, the enforcement of traditional gender behaviour starts at home and continues to be reinforced by social institutions such as schools. Quantitative findings, which support the narrative accounts of increased pressure of appropriate-gender behaviour, are shown in *Table 7* (Traditional gender roles enforced at home). Only 5.5% of participants reported that they never

experienced enforcement of traditional gender roles in their home environment. In contrast to this 87.6% of participants reported between a slight to a great deal of traditional gender role enforcement in their home environment.

Table 7: Traditional gender roles enforced at home

		Frequency	Percent
Valid			
	Not at all	8	5.5
	A little/slightly	24	16.6
	Moderately	26	17.9
	A good deal	41	28.3
	A great deal	36	24.8
	Total	135	93.1
Missing		10	6.9
Total		145	100.0

Aside from socially expected behaviours, roles, and gender norms, families enforce their own rules and expectations on transgender individuals. Families often create expectations, which in some cases are culturally reinforced. For example, some families will use guilt to pressure their son, especially if he is their first or only son, to carry on the family name and traditions, to get married and have children, and to choose a career that meets the parent's expectations and provides them with increased social status. Study participants as well as clients with Latin (e.g., Spanish, Portuguese, and Italian) ethnic background often express that they struggle with these expectations.

> I was the only male and expected to carry the family name and succeed. I felt lots of pressure and expectations. The main tactic was high expectations (male, gender questioning, fluid).

For girls, dating and finding the right man, having children, and being like mom are the messages and expectations, which are often overtly or covertly implied, and produce great pressure. The following quote is an example of a covertly implied expectation for the female role that the individual should carry out.

> From about ages twelve to seventeen, I was supposed to be developing in the right direction, which meant growing up from being a tomboy into a feminine woman. The make-up, the clothes, the boyfriends and sex, the acting. I wanted to kill myself; I was severely depressed and practicing self-injury (FTM, TG with HRT, fixed).

Many children experience pressure at home. However, in addition to the normal pressures, a transgender individual also experiences gender incongruency, which creates the increased stress of adhering to traditional gender roles and can create symptoms such as anxiety, depression, guilt, and shame. The following narratives not only demonstrate the pressure tactics used by family and peers but also identify coping methods such as retreating and repressing transgender feelings or expressing anger, as the internal pain is overwhelming. Some examples show how gender issues and sexual orientation were, and often still are, seen as one and the same, creating not only confusion for the transgender individual but also providing additional grief. "Family pressure totally caused me to repress my transgenderism. I'll disown you if you turn out to be gay" (male, CD/CG, fluid).

> Family and peer pressures to be gender conformant were very strong. Shaming and derision, particularly in a group setting (family or peer) was the typical technique (MTF, TS pre-op, fixed).

> My family was not supportive of my inner being. I was forced to act as a hetero boy. I was feminine and at times beat for it by my father and brother. I grew up hating both of them and felt anger towards my

> mother for not defending me. Friends were harsh, schoolmates were vicious and working has always been hard (MTF, TG with HRT, fixed).

Along with entering school, there often comes a new group of peers and contacts with the outside world who further reinforce the gender binary with its norms and expectations. A staggering 89% reported that gender role behaviour was enforced in their school environment (see breakdown *Table 8*).

Table 8: Traditional gender roles enforced at school

		Frequency	Percent
Valid			
	Not at all	6	4.1
	A little/slightly	6	4.1
	Moderately	22	15.2
	A good deal	51	35.2
	A great deal	50	34.5
	Total	135	93.1
Missing		10	6.9
Total		145	100.0

In the school environment, several aspects played an important role in pressuring transgender individuals to conform. Some reported that their schools had gender-appropriate school uniforms, as well as gender-separated gym classes, cooking or sewing lessons for girls and woodworking or auto-mechanic classes for boys, creating expectations of gender-appropriate behaviours and gender-specific interests that only added to the individual's gender discomfort and dysphoria.

> Certainly this was very strongly reinforced in school and social environments where boys did "boy" things and vice versa. To indicate that I was questioning my gender or to do "girl" things would have been tantamount to social suicide (MTF, TS pre-op, fixed).

Traditional gender roles were not only enforced at home and at school but also by peers and friends; 88.2% of research participants expressed that they experienced a slight to a great deal of gender role enforcement (see breakdown *Table 9*). It appears that there is not much difference between traditional gender role enforcement at home, at school, or by peers.

Table 9: Traditional gender roles enforced by friends

		Frequency	Percent
Valid			
	Not at all	7	4.8
	A little/slightly	12	8.3
	Moderately	26	17.9
	A good deal	44	30.3
	A great deal	46	31.7
	Total	135	93.1
Missing		10	6.9
Total		145	100.0

Peer pressure was not only based on gender-appropriate dressing but also influenced dating, such as who do date, and expectations of heterosexual relationships and behaviour.

> There was some pressure to date, from peers mostly. ("What's wrong with you, with your looks you could have lots of girlfriends.") (MTF, TG with HRT, fixed).

> Absolutely! My upbringing could not have been any more socially accepted and gender specific according to my external male appearance and our cultural environment, and there was also the very clear message from my parents, teachers and peers that absolutely no deviation would or could be accepted. It was not uncommon to hear Mother say, "I would rather have my son in jail for murder or dead than to see him turn gay" (male, CD/CG, fluid).

As children move through childhood, they are exposed to gender stereotypes first learned at home and later influenced at school (Witt, 1997). A MTF participant stated that: "peer pressure played a very large role—especially in the schoolyards"

(MTF, TS post-op, fixed). Others confirmed that the peer pressure was not only provided and enforced through language but also that being a victim to physical violence was not uncommon.

> I was always told that was not the way boys acted by everyone. I was spanked and beat numerous times to quit acting and dressing like a sissy (male, CD/CG, fluid).

Children learn gender appropriateness through signifiers in early childhood. Signifiers include gender-specific clothing, toys, and language that are accompanied by guidelines from which the child learns about maleness or femaleness and, most importantly, to which category s/he should belong. Post-structuralists like Ferdinand de Saussure (1974) discussed the importance of signifiers (boys = blue, car, him; girls = pink, doll, her) and how the signified provides the meaning of the language and clarifies abstract concepts to the child (see Chapter 3).

Therefore, at a very young age, the child learns to refer to him/herself as boy or girl, but also what roles they should carry out. This notion might help to equip the individual with socially accepted rules, but it does not indicate their reality or explain their feelings of gender incongruency. Although they might not fully understand, transgender children feel that they are different and somehow they comprehend the necessity to act gender appropriately to protect themselves.

> When I started 1st grade. In a very short time, I learned that there were strict rules to living in the world. All of a sudden, my fertile imagination was frozen and replaced by deep shame—I would not be allowed to "pretend" I would grow up to be a boy (FTM, TS pre-op fixed).

Some young transgender boys might ask their parents if they can get a dress and wear tights, for instance, while transgender girls will ask if they will get a penis like their brother has. Such questions are indisputably common among transgender individuals during their childhood. Sadly, the answers that parents or caregivers provide are also very common. The following is a quote from a gender-fluid participant that expresses the child's internal feelings and understanding of the authentic-self:

> At four I figured I had a good reason to ask my mother for a dress, and as a consequence I was ridiculed by her, my father and my siblings. I was also frequently told by my parents that I had to be a 'hombre macho,' particularly my mother, so much so that sometimes I wonder whether there was something not quite right about me (male, CD/CG, fluid).

It appears that there is very little flexibility when it comes to wearing gender-appropriate clothing, to see the distinction one need only to go into a children's clothing store (e.g., Gap).

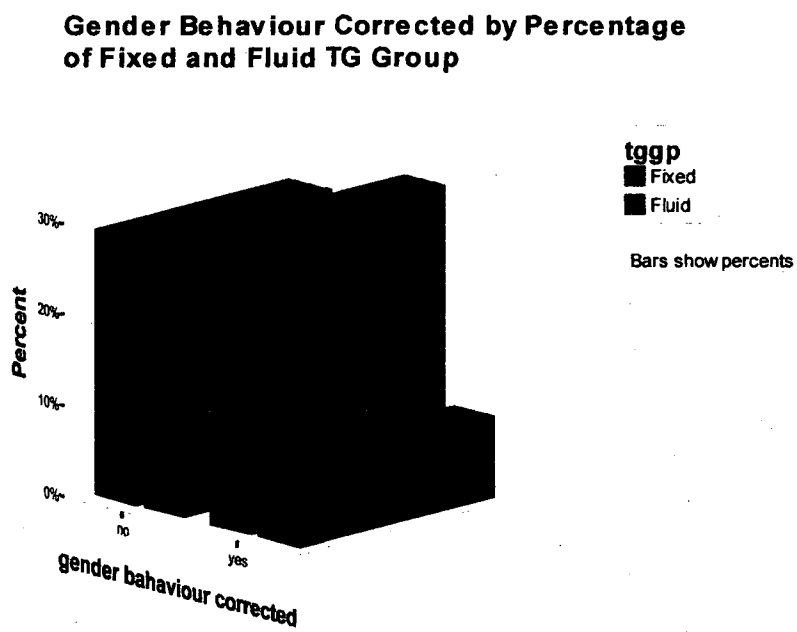
Table 10: Dressed in gender-appropriate clothing

		Frequency	Percent
Valid			
	Never	5	3.4
	Rarely	3	2.1
	Sometimes	7	4.8
	About half the time	1	0.7
	Often	8	5.5
	Very often	9	6.2
	Always	102	70.3
	Total	135	93.1
Missing		10	6.9
Total		145	100.0

Males/boys usually should wear darker, plain, or plaid colours. The colour pink for males is still viewed as inappropriate or, if a female/girls colour is used, there needs to be a cause, such as a pink golf shirt for men in support of breast cancer. A high number (70.3%) revealed that they were always dressed in gender-appropriate clothing, indicating that only some of the participants were experiencing flexibility when it came to choice in clothing (see *Table 10*).

Seemingly other commonalities to reinforce appropriate-gender behaviour are violence, coercion, and derision, and many of the narratives provided are sad evidence of some of the hardships transgender people endure.

Figure 23: *Gender behaviour corrected by percentage of fixed and fluid transgender (TG) group.*



The quantitative research results indicate that most reinforcement of gender behaviour correction was carried out by the family, followed by school and peers (see *Figure 23*).

> As a child, my dad and other family members used threats, coercion and violence to enforce gender roles (MTF, TS post-op, fixed).
>
> Mother threatened suicide to avoid dealing with my problems, when I was age 13 (FTM, TS pre-op, fixed).
>
> Totally; I learned from a very early age not to mess with gender. Generally ridicule or disgust were the tactics used (MTF, TS pre-op, fixed).
>
> At five years old, I was given the choice, obey and suffer to be a boy or spend the rest of my life in a rubber room (MTF, TG with HRT, fixed).
>
> So the toughest time was probably from about 5–8 years when I knew something was different about me, but not what (even then I was terrified of not being perceived as masculine) (MTF, TG with HRT, fixed).

For most people there is no question about sex and gender; it appears to be such an innate development; their phenotype of male or female does not conflict with social learning of gender behaviour (man or woman). Nevertheless, transgender individuals experience an enormous discomfort and incongruency between their physical sex (male or female), socially taught gender (man or woman), gender-appropriate behaviours, norms, and expectations, and their knowledge of self. Fixed as well as fluid transgender participants reported that they feared rejection and not fitting in, and that the feeling of belonging was important.

> It was understood that boys were boys and girls were girls and there was no middle of the road (male, CD/CG, fluid).

> Mother hated my long hair, said that only "sissies" had long hair, and would only buy very masculine stuff for me as a kid (MTF, TS pre-op, fixed).

During childhood, a child establishes many important developmental components that influence the individual's developmental achievement and processes at a specific time as well as throughout their lifespan. Examples of these components are trust, early and secure attachment, social competence, autonomy, feeling of mastery, self-determination, and healthy self-identity. Gender per se does not affect the aforementioned, but transgender individuals are significantly affected by the narrative process, the storytelling in the form of discourse. The story, the language used and the meaning, even hidden messages, have an implicit impact on the remembering mind (Siegel, 1999). "Stop acting like a girl," I've heard my father say so many times" (MTF, TS post-op, fixed). Through learning, many acquire the forced assumption of gender invariability, meaning that, according to social learning, gender is stable and based on physical sex and not on the innate knowledge of the true self.

For transgender children, the negative messages related through the narratives of gender-appropriate behaviour can affect a healthy transgender identity development and QOL. New messages normalizing transgenderism and validating their transgender feelings will help individuals to accept themselves.

> Childhood was tough because I feared rejection if my parents knew who I really was. I tried so hard to be a real boy. I prayed my dysphoria would be erased with puberty. Nope, it didn't (male, gender questioning, fluid).

> My father is not accepting of people who do not conform to what he considers normal (MTF, TS pre-op, fixed).

Entering school, some experienced not only mockery but also behavioural modification, including violence and physical punishment. Now physical punishment by teachers is prohibited and research shows that the most commonly offered hypotheses for disproportionate disciplining are based on gender, race, and socioeconomic status. Racially different and male students will suffer harsher punishment than students measured on socioeconomic status (Skibal et al., 2002). The punishment can include principal's office referrals, suspensions, and expulsions. There was no research found on rejection of gender norms and school punishment. However, transgender participants' reality indicates that rejection of gender norms was and still is punished in the school environment by either rejection, expulsion, or contempt.

> I was subjected to Behavioural Modification for two hours of every day at school. I was changed from a left-handed girl-thinking child to a right-handed boy-thinking person. Brainwashing to that extent is now illegal. I still suffer from the effects of such discipline and violence in my life (MTF, TG with HRT, fixed).

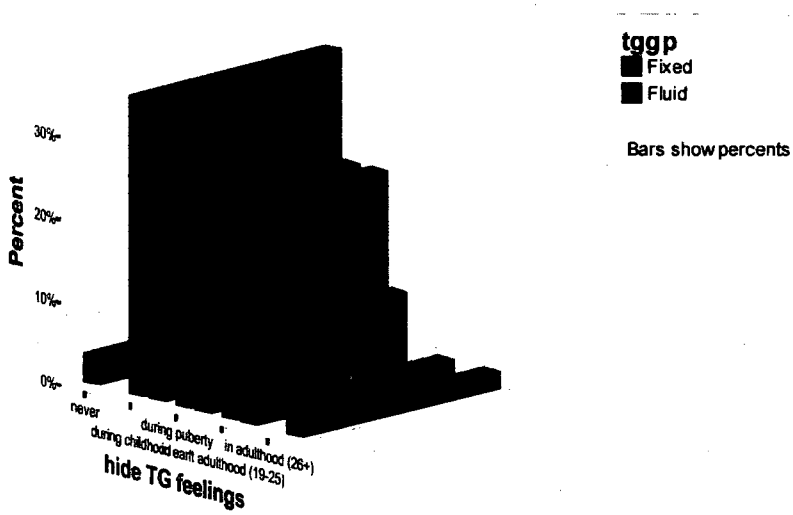
Childhood was difficult for many; yet, during this time, parents are more open to accept "cute" behaviours, especially in young children. When getting older (5+ years), gender-specific behaviour is enforced, especially for boys, and expectations of participating in rough play and in sports (not ballet or figure skating) are expected. In contrast, some girls are allowed to be tomboys, and excelling in sports brings pride to their parents; whereas a boy in a ballerina tutu and leotards would bring

shame.

> One day I ask my mother if I could get a ballerina outfit, she got very angry, told me that I was a boy and never talk about this again (MTF, TG with HRT, fixed).

As previously articulated, gender expression is learned at a young age but also throughout life. Participants indicate in their stories that they learned to hide their transgender feelings during early childhood. "At the age of 4 or 5 I was already hiding it" (male, CD/CG, fluid).

Figure 24: Learn to hide transgender (TG) feelings



A large number (55.2%) repressed their transgender feelings in childhood, 29.7% during adolescence, and hiding continued to decrease as people got older. Although hiding transgender feelings decreased with age, it appears that for many of the fluid participants hiding their transgender feelings and actions continued throughout life (see *Figure 24*).

> Pressure from family definitely played a big role, to dress like a girl (FTM, TS post-op, fixed).

> To be accepted by either girls or boys I was pressured to dress in a feminine manner (FTM, TG without HRT, fixed).

For many, hiding was, and continues to be, a way of self-preservation, a means to keep their family, their loved ones, their livelihood, their friends, and even the things they do not like but are accustomed to. "I just knew I wanted to be a boy" (FTM, TS pre-op, fixed).

> I hid in my thoughts. As a child I knew I was Bad! I borrowed clothes that were not mine. Bad! I turned my feeling inward and shitted on myself (metaphorically) (male, gender questioning, fluid).

It appears that being different (transgender) is not accepted and the knowledge of non-acceptance of difference comes from linguistic messages, signifiers, and actions that the transgender child hears as well as observes in their environment; "I felt expected to act as my birth gender; my mom used the bible against me for that" (MTF, TS pre-op, fixed). The messages of wrongdoing contradict with the transgender individuals' internal knowledge, innate messages that the body sends of the authentic sex and gender that the child feels is very powerful.

Adolescence

Many transgender individuals find that adolescence is especially difficult; above parental pressure, there is now increased peer pressure. Until puberty, some FTMs enjoy certain social freedom, tomboyish behaviour, androgynous dressing, choosing mostly boys as playmates; all of the aforementioned is accepted and provides them with a small amount of relief for their gender dysphoria. As puberty

sets in, parents realize "she is a girl" and they move quickly to correct the gender-inappropriate behaviour; no more boys as playmates, and more socializing with girls, going shopping, talks about family, children, and dating, all to emphasize some of the socially assumed feminine characteristics.

> As my body started to change, and gender differences became more understood among my peers, I found it harder to just be me and had to face the reality that people viewed me as a girl (FTM, TS post-op, fixed).

> Puberty and following years. My body betrayed me. I still believed that things would be okay, then my body sprouted breasts and started bleeding. I was horrified and everyone else acted like this was normal (FTM, TS pre-op, fixed).

> PUBERTY, PUBERTY, PUBERTY... my God!! The dreaded body transformations that are going in all the wrong directions; the pride my older sister and my peers were taking in those changes compared to my utter shame in them; the discomfort of locker rooms; the pressure to date; everyone around me learning to flirt and to use their feminine or masculine "powers"; the hormones raging; the shameful and unexplainable attractions to same sex friends; their discomfort when they would sense my attraction. Puberty is when I started having really black thoughts—never clearly defined—that could have led to suicide (FTM, TS pre-op, fixed).

Puberty is difficult both for FTMs and for MTFs. Hormones are raging, they are feeling sexual urges and finding relief either through masturbation, taking part in sexual play over the computer, or intercourse; however, at the same time, they are experiencing discomfort with their bodies, which leads to increased turmoil. "I was so confused, I knew something was wrong and I couldn't fix it" (MTF, TS post-op, fixed). The body's hormonal and emotional response after masturbation or intercourse conveys to the individual some satisfaction, which increases their

confusion, as it triggers further knowledge of the self to the self; they know that their body's appearance does not match their knowledge of self, but, at the same time, they are experiencing some pleasure.

Nathanson (1992) talked about innate affects, the negative (fear, distress, anger) and positive (joy, excitement, feeling good) affects and how these affects are inherently pleasant or unpleasant. Transgenderism, cross-dressing, sexual pleasure are inherently pleasant and yet there is the socially learned aspect that conveys to the individual that what they consider pleasant might be not acceptable, which then leads to shame, guilt, anger, fear, and anxiety (these symptoms will be addressed later in this section) as well as dissonance.

Freud (1905, 1915, 1917, 1962) believed that it was important to distinguish between fear and anxiety. If the source was known he called it fear, but when the source was unknown, fear becomes anxiety. Transgender people struggle with fear and anxiety. If they explored their true-self, cross-dressed, or expressed their opposite gender through behaviour (known source), they experienced fear of being "found out" by family or friends, or, if through not knowing about being transgender (unknown source) and feeling this great need to cross-dress, they experienced anxiety.

Transgender people might struggle for a long time with fear and anxiety. Past events (experienced by the individual often as traumatic) are written into their memory bank; a current trigger will check the memory bank to see if there is any previous experience, and, if a previous bad experience is found, fear or anxiety

follows. It takes a long time before transgender individual rewrite their memory bank and are able to overcome previously learned behaviour, which is often the known or unknown source of their fear and anxiety.

Not only FTMs struggle with puberty; MTFs also experience difficulties during this developmental phase. Male bodies also change, the voice deepens, and unwanted facial hair grows, and there are increased expectations to provide evidence of their maleness, through increased interest in females and masculine activities. Both for males and for females, puberty brings also an increase in hormones, which presents challenges such as increased libido and sexual urges, which were previously discussed.

> Puberty represented the toughest years for two reasons: my body betrayed me by becoming more masculine and revealing my libido in a way that was uncomfortable and secondly because socially I knew I was different, couldn't accept that difference but tried to fit in anyway (MTF, TS pre-op, fixed).

> 11–14. I knew I wanted to be female, it was lonely and really hard, and I felt at war with my body and with the world (MTF, TS pre-op, fixed).

> Puberty was very distressing on a more personal level, as my body kept changing in ways I despised. I wanted breasts, not facial hair, for one example. It's horrible to be trapped in a body that does the opposite of what you need it to. It's worse than any external prison could ever be (MTF, TS post-op, fixed).

Being interested in girls, but more in their clothing, and wanting to participate in girls' nights out, shopping, and girl talks made the MTF transgender adolescent a freak, an outsider, and led to increased isolation. Some of the FTMs as well as MTFs struggled with same-sex attraction, at first leading to increased confusion and then to

fear of being discovered and outed as gay. "If you were a boy and you wore something that had pink or purple, you were considered a fairy" (MTF, TG with HRT, fixed).

As transgender knowledge was, and still is, not common, many could not identify what was "wrong" with them and therefore some (especially FTMs) identified first with the lesbian community. They know that they do not really fit in and reject many characteristics of lesbian identity; however, "what other explanation was there?" (FTM, TG with HRT, fixed). Therefore, being gay was often the identity they first assumed. MTFs often feel a great attraction to females, yet some feel attracted to males, which not only caused greater confusion but it also intensified their fear of being branded as gay. This, in turn, subjected them to teasing, being called fakes, pansies, sissies, or homos. Often a parent's greatest fear, and cause for embarrassment, is to have a gay child.

> From derogatory language (fag, freak, and queer, weird, strange) that gender non-conformity meant rejection, abandonment, isolation. "Sissies" got beaten up (MTF, TG with HRT, fixed).

During puberty, the gender-appropriate upbringing is strongly enforced and encouraged: girls "have to be good" and boys are promiscuous; therefore, exhibiting the appropriate behaviour is the best way to show that they are "real" women and men, respectively. MTFs and FTMs reported that any refusal of performing gender-appropriate behaviour would lead to mockery, isolation, and violence, including emotional, physical, as well as sexual abuse, to punish the individual for not obeying the socially constructed, family- and peer-enforced gender rules.

> I discovered that the violence was so severe that I blocked out memories of it. They resurfaced. The worst to date was a memory of being raped by a male relative and being told, "I'll teach you what it's like to be a girl" (MTF, TS post-op, fixed).
>
> Physical violence, emotional abuse, shame, guilt, and disownment from both families (FTM, TG without HRT, fixed).

During adolescence, sexual behaviour and gender become intertwined, which further increases confusion. Gender is the first identity established in an individual, and sexual orientation follows. A male, whose true gender is female, interested in another male is considered—by society and, in the beginning, by themself—gay; however, the reality is that this individual is straight. This is very confusing, as society establishes sexual orientation on the physical/biological aspect of the individual's genitalia, instead of the "true-gendered-self" which comes from the individual's psyche, emotions, innate knowledge of self, and their blueprint in the brain (Jones, 2002).

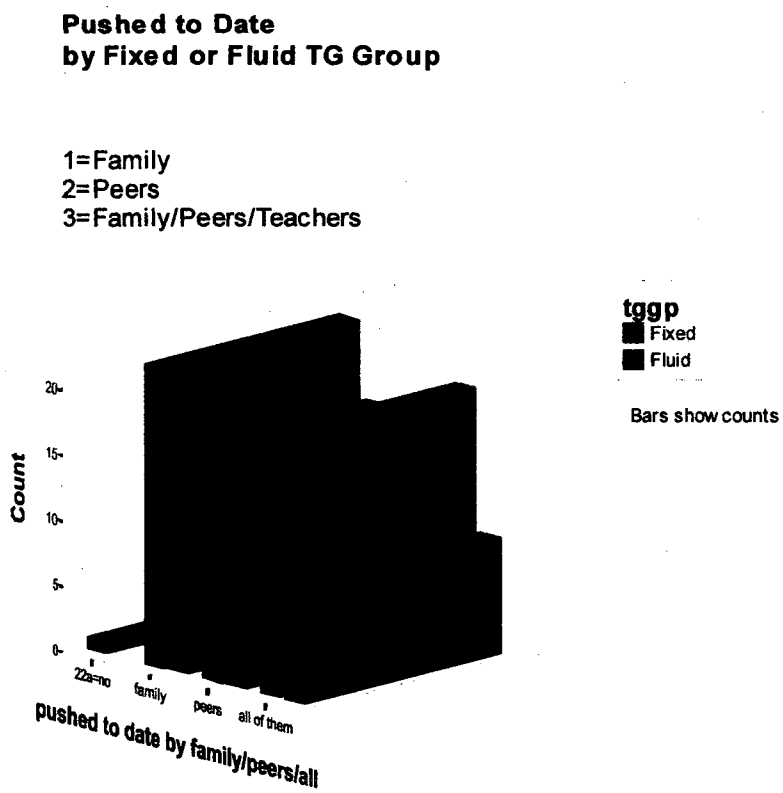
> I did have a "gender appropriate" upbringing. My father and friends constantly discouraged any iffy behaviour or clothing. I was encouraged to be promiscuous, constantly being introduced to young women. I was encouraged towards sports, cars, computers, and strongly discouraged from other interests. I was pushed into a lot of manual labour, in an attempt to "toughen me up" (MTF, TS pre-op, fixed).

Dating is clearly seen as a sign of normality, heterosexuality, and gender appropriateness. It appears that parents assume that they are the ones with the most to lose if their child does not conform to a traditional lifestyle (not having grandchildren and a daughter- or son-in-law). A lifestyle that the family is comfortable with and used to, including their entire home, work, and social

interactions, revolves around their constructed notion of normality, comfort, heterosexuality, and the gender binary.

> He would also always asked me, "When are you going to get a girlfriend?" or "Why don't you cut that hair and start looking like a man?" Some of my co-workers and so-called friends would joke around about me not having a girlfriend by saying things like "maybe he's a fag" or "he doesn't like girls, he must like guys" (MTF, TG with HRT, fixed).

Figure 25: Pushed to date by family/peers/teachers



Engagement, marriage, establishing the North American dream of house, cars, televisions, a white-picket fence, kids, and a cat or a dog provides evidence that the individual is an acceptable and respectable member of society. Understandably, what parent does not want this for their child? It becomes not only the parent's but also the

transgender individual's dream. The only difference is that in the transgender individual's dream they inhabit the body of their true gender self, which for many does not become reality for a long time, if ever.

Transgender individuals' stories reveal the intense pressure they receive from family, peers, and authoritarian bodies working in our social institutions (e.g., teachers), and the statistical data shown in *Figure 25* supports these stories.

Some hope that their transgender behaviour and thoughts will go away if they follow the family, peer, and social pressure to get married and have children. We need to understand that they truly love their partners and children, yet they love them from a MTF or FTM point of view. They might be able to suppress their feelings for a while, getting busy establishing a career and family; however, as soon as life slows down a bit and they get older, transgender feelings come back, and then they start to suffer in silence, or during their adult years, they can no longer suppress their transgenderism and self-identity and they seek help.

> I continued to repress the feelings, every time I purged my female clothing the dysphoria came back with a vengeance as if it wanted to let me know: you forgot about me, now you really suffer" (MTF, TS pre-op, fixed).

To cope with the external as well as the internal pressure, including abuse (external as well as self-inflicted), being belittled, experiencing difficulties in life, and low QOL, leads to the development of negative behaviours, such as self-injury (cutting) and alcohol and (or) drug abuse, which may further bring forward symptoms that either fall into the category of psychosomatic illnesses or mental disorders.

Surprisingly low, only slightly over one-half of the participants declared that they had a very difficult time during puberty; they could not express themselves, they felt lonely, and constantly had to watch their emotions and gender behaviour (see *Table 11)*. "A combination of trying to fit in and puberty-hell" (MTF, TG with HRT, fixed).

Table 11: Carefree puberty

		Frequency	Percent
Valid			
	Not at all	58	40.0
	Slightly	35	24.1
	Moderately	30	20.7
	Very	8	5.5
	Extremely	2	1.4
	Total	133	91.7
Missing		12	8.3
Total		145	100.0

Developing Symptoms of Secondary or Tertiary Mental Illnesses

Gender identity disorder (GID) is the primary diagnosis (Axis I) for the transgender individual; however, the impact of some of these negative treatments the transgender individual experiences are so severe that the individual often struggles with secondary and/or tertiary illnesses such as depression, anxiety, concurrent trauma, PTSD, panic disorder, personality disorder, eating disorders (Axis II), and physical illnesses, often psychosomatic, on Axis III, e.g., peptic ulcers, headache, hypertension.

We cannot forget the social, employment, and environmental aspects that affect the individual's well-being and QOL (Axis IV), and finally their global

assessment of functioning (GAF), considering psychological, social, and occupational function (Axis V). This all has to be taken into account when assessing transgender clients, for some the list is large. Some of the possible illnesses will be addressed in this section; however, foremost, this section will deal with some of the negative and positive coping methods individuals use to survive the social pressure and to cope with the feelings of gender dysphoria and the symptoms associated with secondary or tertiary mental illnesses.

Difficulty in concentrating leads to educational difficulties and transgender individuals are often labelled with a "learning disability" or Attention Deficit Disorder (ADD). However, one has to understand that transgender individuals are constantly concentrating on how to hide their feelings and thoughts about their gender incongruency, and therefore they use a reduced part of their brain to work on the task at hand. They constantly observe themselves to make sure that their behaviour fits their social gender assignment, an assignment that does not come easily or naturally to them. A lot of energy is involved in this, leaving little room for daily educational tasks or social functioning.

> Constantly watching myself, the need to observe others to make sure I did not make mistakes. If I relaxed for a minute, I would pay later for I was more afraid, for someone could see me acting in the wrong gender (MTF, TG with HRT, fixed).

> Yet, all of a sudden nothing made sense and I proceeded to bury that adherent part of my psyche very deep. It was promptly replaced by huge self-doubt. If I had been wrong about my very own identity, what else was I wrong about? I would have to check myself at every turn. That is when I was first aware that I was being "watched." And that is when I became a watcher

> myself—out of self-preservation. I also killed a part of me at that time (FTM, TS post-op, fixed).
>
> Currently, I feel guiltier that I continue to hide myself and often feel I am role-playing in the outside world (male, androgynous, fluid).

Daydreaming/Fantasizing

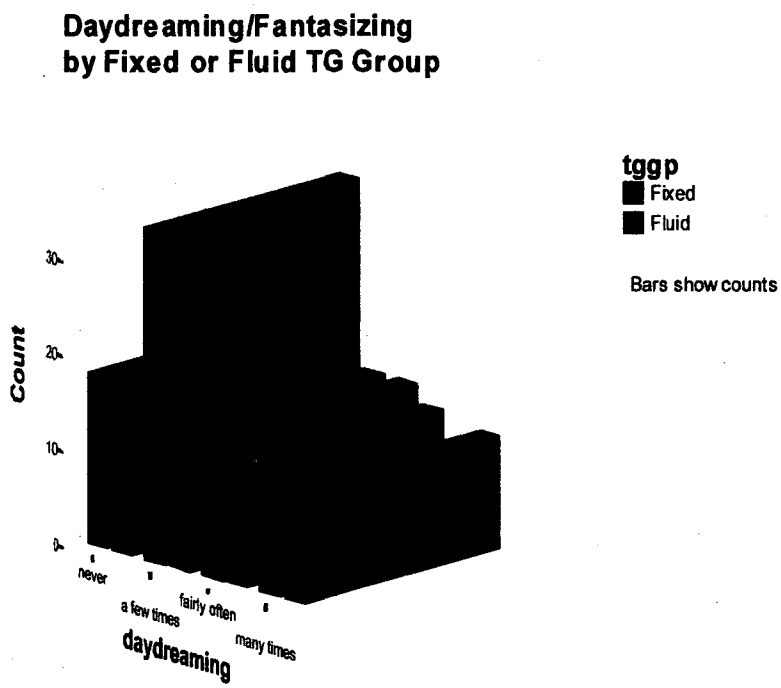
Daydreaming and fantasizing are often one of the coping methods transgender people use; it brings the individual some relief; however, at the same time, it also gets them into trouble. Examples of this at school may be not participating in class or missing what was said and then being used as a "showpiece of bad behaviour" to classmates; at home it may be lying about and insisting on their own beliefs; later in life, in relationships, it may manifest itself in becoming hermit-like, self-centred, or being uninterested in their partner and their issues. Daydreaming, living in a fantasy world, and observing their own behaviour can be elements of a great method for survival, for a while.

However, during the transition process, it can backfire. The transitioning transgender individual often goes back and uses the coping methods with which they feel most comfortable. Obsessively watching themselves to not give away their gender feelings can now turn into obsessively watching themselves to ensure that they do everything right in their true gender for people not to find out that they are transition, which then can inhibit emotional, spiritual, and developmental growth. Furthermore, it can be perceived as self-centredness or narcissism, which alienates others.

> I would withdraw for hours at a time in a world of imagination. I made up a whole concept of the world (incorporating reincarnation and karma) that would explain my shameful difference and turn it into "uniqueness." I needed to feel that there was a purpose, a "noblesse" even in my predicament. In trying to develop pride in my secret identity, I became a martyr of sorts in my own daydreams (FTM, TS pre-op, fixed).

As illustrated in *Figure 26*, daydreaming and fantasizing are part of a very commonly used coping strategy for transgender people.

Figure 26: Daydreaming/fantasizing



> I would not be allowed to "pretend" I would grow up to be a boy. This was certainly reinforced by teachers who were fairly rigid—down to the type of books a girl or a boy would be allowed to read. It was not unusual for a student to be made to stand up in front of the whole class and be admonished publicly for his/her own good (FTM, TS pre-op, fixed).

Alcohol and Drug Abuse

Alcohol and drug abuse are other frequently used coping methods for various reasons. For one, it is easily available, especially alcohol, which is available in almost every household and accessible to children at a very young age. Using addictive substances provides the escape from reality that transgender individuals might desire; it also presents them with some friends, as they now have something in common with alcoholics and other addicts who also live on the fringe of society.

Transgender individuals may feel the language of oppression, internalized as well as externalized transphobia, however, the individual often does not yet have the language (words) to describe their feelings. This can create turmoil, and for some the only way to stop this is to use. The individual knows that every form of addiction is considered "bad," and therefore it becomes another solution, to have a label that fits for the outside world and covers up what is really going on inside.

> However, from age 13 on, I began an escalating pattern of alcohol and drug abuse to deaden my feelings and unhappiness with who I was (forced to be) (MTF, TS pre-op, fixed).
>
> Yes, drink alcohol, smoke pot, chain-smoke cigarettes, and denial (MTF, TG with HRT, fixed).
>
> I did drugs and alcohol and altered my behaviour to be a tough guy (MTF, TS post-op, fixed).
>
> Unfortunately I turned to Heroin to deal with feelings of guilt and shame (MTF, TS pre-op, fixed).
>
> I suppose I turned to alcohol and drugs to deal with these feelings (MTF, TS pre-op, fixed).
>
> Yes, suppression, alcohol, self harm, it was like running away from real life to an escape world. (MTF, TS post-op, fixed).

> To deal with those feelings I drank really a lot, was angry, dressed like a punky Goth child, and slept with anything that moved (MTF, TS pre-op, fixed).

Treatment centres and programs are clearly established to help and service male, female, straight, gay male, lesbian, and bisexual people because they fall into the category of either male or female. Transgender people often do not fit into these categories, therefore, it is very difficult to find a place that even accepts them, never mind one that has a program that addresses the challenges that they face. Lombardi and Van Servellen (2000) observed that the "transgendered individual must navigate through a health-care system that is unable to comprehend let alone support transgendered individuals" (p. 293). Transgender individuals face the same type of issues when they try to find help for their alcohol and (or) drug abuse.

Furthermore, research of treatment centres and the experiences of transgender people provides further evidence of abuse and inappropriate behaviour by people running these facilities; for example, being forced to dress according to their biological gender, and to sleep in quarters and use the showers that are specific to their birth gender and not to their true gender identity (The Transgender Substance Abuse Treatment Policy Group of the San Francisco Lesbian, Gay, Bisexual, and Transgender Substance Abuse Task Force, 1995).

Bockting, Knudson, et al., (2006) identified that the question of substance abuse in the assessment stage is important and that the reasons why people abuse alcohol or drugs are different, both among individuals in the general population as well as among transgender individuals. Studies across North America suggest that

alcohol and drug use is a common problem among transgender people (Bockting, Hung, et al., 2005; Risser & Shelton, 2002; Xavier, 2000; Clements-Nolle et al., 1999;).

Abuse

Transgender individuals are often victims of physical, emotional, financial, or sexual violence. Devor (1994) reported on transgender individuals' experiences of childhood abuse and found that a total of 60% (n = 27) of the FTM participants (n = 45) reported physical, emotional, as well as sexual abuse. Furthermore, Devor (1994) pointed out long-term effects of child abuse include depression, alcohol and drug abuse, eating disorders, suicidal ideations, and often, sexual problems. However, it has to be clarified that not all transgender individuals have experienced physical or sexual abuse. Emotional abuse, however, appeared to be more common, especially for these particular research participants.

At this point, an important aspect for therapy with transgender individuals has to be identified. The abuse that the individual experienced (physical, emotional, and especially sexual abuse) has to be addressed from the experience and emotions of the true-self; meaning, for instance, if a FTM experienced rape or sexual abuse by a male, before transitioning, the abuse has to be worked out within a male-to-male sexual abuse perspective, not from a male-to-female one (for MTF, it would be the reverse). We have to remember that the most important part of sex/gender development, as well as trauma memory, is in the brain; memory is recorded in the

brain's memory bank and the brain works from the perspective of the true-sex/gender-self.

Transgender adults who have to leave their homes to survive abuse often end up on the streets. Shelters are not prepared to take in transgender people; the institution's excuse is often, "They still have male genitalia and we have to respect the feelings of the abused women we serve." This is understandable, but where does it leave transgender women? For transgender males it is the same. To survive and not become homeless, they frequently end up in the sex industry.

This research did not address these areas but instead acknowledges that it is a real issue requiring solutions and new policies, and therefore further research in this area is strongly recommended. For many transgender studies, the only significant research we have is American, and yet the reality is that in Canada the picture is different. However, when it comes to services for transgender individuals, Canada appears to be better than the United States, although it is far from being good.

Self-Harm

Self-harm and mutilations are some other forms of coping. To avoid feeling the intense anguish that emanates from their body and soul, for which the transgender individual often does not have the words to describe this state of absolute mystification (at this time the signifiers or the signified might not exist for them), they often use physical pain to cover their emotional pain. Israel and Tarver (1997) expressed that transgender individuals may direct their inner torment and

helplessness into a noticeable physical type that can involve cutting, burning, suicide attempts, or behaviours that cause self-injury or even lead to fatality.

> I wanted to make myself into a man inside because I knew I was a girl. I felt very ashamed and guilty about cross-dressing and said I'd rather kill myself than come out and accept my feelings (male, CD/CG, fluid).

Brown and Rounsley (1996) estimate that 17 to 20% of transgender individuals attempt suicide. Every year on Trans Day of Remembrance (November 20th) we remember transgender individuals who lost their life as a result of violent attacks caused by fear and hatred of transgendered people. Trans Day of Remembrance began in 1999 in San Francisco and now many cities throughout Canada participate in this event. It is sad to report that last year (2007) in North America, 30 transgender people's lives were ended through brutality; this does not include the victims we do not know about, who suffered and died in silence and isolation.

> Lots of self-hating self-talks. Also some physical mutilation and lots of fantasies of being tortured and humiliated. The list includes: being anonymous, trying to conform, hurting myself psychologically and physically, isolating, attempting to intellectualize my way out of my "weakness" (as I defined it) (MTF, TG with HRT, fixed).

> I started wanting to punish my body in order to release the tension. I realize now that I wanted to "will" my body to transform itself into a male body. The fact that I didn't understand why I was acting out didn't help—I felt humiliated by my behaviours as well as by my inability to make sense of them. I would punish my body by being involved in sports 7 days a week. Since there was dissociation between my mind and my body, I could sometimes push my body to the point of injury … I would deal with nervousness by carving out the skin inside my hand and under my feet (FTM, TS pre-op, fixed).

Exact numbers on how many transgender individuals will use self-harm owing to their gender dysphoria is not known. Gapka and Raj (2003) expressed that in the Sherbourne Health Centre in Toronto they see many transgender individuals and that self-harm and suicidal ideations are prevalent in the transgender community.

Shame

Over the course of an individual's life, social surroundings teach us a certain way of behaving; if we act inappropriately (according to our social conditioning and control) our own consciousness or awareness creates an emotional response that we may be on familiar terms with and recognize as shame. Shame has enormous influence on the individual; on the one hand, it reduces the positive affects of joy, excitement, and interest in life, while, on the other hand, it stimulates the negative affects of anxiety, depression, and in some cases, might lead to suicidal ideations. "Depression and anxiety may be directly related to gender issues" (Bockting, Knudson et al., 2006). Mathy (2002) found that the incidence of suicidal ideations and attempts are significantly higher in transgender people, compared with non-transgender people.

There are different facets of shame that transgender people experience and work with; I want to propose and address two of them: *internal* shame, recognized and, to a certain extent, controlled by not revealing their true feelings and behaviour; and *external* shame, which is divided into two parts: (a) Shame that is totally outside the individual's control; it is produced by their social environment and has an effect on their QOL and functioning in and with their environment (work, school, family,

peers); and (b) Shame that the transgender individual acknowledge and, in certain situations, might use in their favour.

Some individuals are constantly aware of their internal shame, as they are aware of their difference, which they know is socially unacceptable, and therefore they take control and constantly censor themselves. For example, in the beginning of therapy, the individual acts perfectly socially correct: very polite, censoring every expression of their emotional state, not showing their internal shame. They take control of what they want the other (therapist, friends, teachers, family) to notice and know about them. Through past experiences, they have developed an extensive lexicon of negative affects that have intensified their shame. Furthermore, they are aware and recognize what is or is not socially accepted. Therefore, showing their true selves and their internal shame would make the individual vulnerable.

However, if they are aware of their transgenderism and they come to be diagnosed with GID, they talk about their transgenderism in terms of expressing their external shame, shortcomings, and difficulties according to social expectations, the *DSM* (which is often misinterpreted), and (or) what they think the therapist wants and needs to hear, continuing to take control and censoring their internal state of shame. Since showing their true-self and difficulties they are afraid that their request for transitioning might be denied, since they do not fit the eligibility and readiness criteria.

Everyone experiences different categories of shame, depending on their own social environment, cultural, educational experience, and the developmental stage

that they are in. "Who we are is dependent on how we got to be us—each of us is the product of our development" (Nathanson, 1992). Throughout their development the transgender individual adds more and more experiences of shame to their repertoire; their shame shifts and intensifies.

Nonetheless, during transition, even though a transgender individual is an adult chronologically (e.g., age 40 years), they might have the developmental age of a teenager (e.g., age 16 years); therefore, their gender experience and awareness of shame will be different than that of the opposite gender adult. However, there are certain times when full awareness of shame will be present and the therapist has to be aware of this and help the individual to overcome their internal as well as their external shame.

In working through shame, we have to keep in mind that we can take charge of our awareness and how we deal with shame; what we cannot control is the environment that does the shaming. Shame can be addressed through openness in therapy, education on social conditioning, and normalizing transgenderism. In the interviews and open-ended questions, many discussed their feelings of shame and guilt, but it appeared that describing shame or guilt was a very difficult process for many; shame was mostly addressed with socially constructed words and not the affect, as the affect that shame creates might be too painful.

> Yes, there was. I am male gendered, female-bodied (but it is changing). I created a supra-feminine personae that dealt with the outside world and societal "female expectations" that were laid on me. While my male self suffered inside. I covered guilt and shame with my female character I had created (FTM, TG with HRT, fixed).

> I hid my feelings. Kept them inside. Eventually was suicidal over them. I suppressed my feelings to the point of emotion-lessness. Yes. I held my transgender feelings at a psychological "arm's length," not daring to examine them too closely or accept them as "mine," even inside my own mind (MTF, TS pre-op, fixed).
>
> Expect me to behave like a little "lady." That was the first feel I had of subtle pressure laced with shame. The biggest eye-openers, however, awaited me when I started 1st grade. In a very short time, I learned that there were strict rules to living in the world. All of a sudden, my fertile imagination was frozen and replaced by deep shame (FTM, TS pre-op, fixed).
>
> I believe that many Trans people are not honest about what they're going through, because they believe further treatment will be removed if they say the wrong things (MTF, TG with HRT, fixed).

Guilt

The more difficult issue is guilt; for many transgender people, this is a topic that is very difficult to talk about and even more difficult to eradicate. Shame and guilt are companions that love to travel together. Shame is produced through social conditioning, whereas guilt is produced by the individual themselves, they think and believe that by "simply being alive" the individual has taken on a role that carries the responsibility of appropriate gender expectations and behaviour in the family, peer, and social institutional structure, which I think clearly could be argued as a thought process that comes from socially learned expectations.

Meaning, we think that by simply existing we have to play a certain role in the lives of those around us, however insignificant it might be, and that we still pressure ourselves into playing these social roles. Over time, our social environment takes control, and through the reinforcement of appropriate gender behaviour and the continuing of shaming for inappropriate behaviour, transgender people feel guilty,

not for their behaviour but, "rather for who they are, being transgendered" and what this does to their family, peers, and co-workers.

> Of course! I was ashamed to be so different from everybody else. I felt ashamed and guilty about disappointing my family by looking the way I did and being resistant to conform. I was ashamed because I thought I was a lesbian, because I thought I was supposed to be a boy but I wasn't, and so my attraction to women made me queer (FTM, TG with HRT, fixed).

> Yes, there was significant guilt every time I allowed myself to express my true gender, be it [in] the form of wearing female clothing, playing with dolls, or playing with other little girls. I couldn't deal with it very well when I was young, the best I could do was just promise I'd never do it again (this approach did not work because I always did come back to these activities). The most disabling guilt actually came once I'd been forced to accept this part of myself as an adult. To accept meant that I'd been lying to my spouse and daughter after all of these years, that I'd let my parents down and that every interaction I had with the people I love while in male was a form of deception as well (MTF, TS pre-op, fixed).

> Family used shame, guilt and embarrassment (MTF, TS pre-op, fixed).

Adult

As in adolescence, adults also struggle to keep their transgender identity a secret; they often go out of their way to undertake dangerous jobs, such as joining the military or the police, some get married, get heavily involved in religious organizations, or have hobbies that are dangerous (diving, parachuting), all in the hope that this will cure them and make them a real man or woman. Diamond (1996) described that some transgender individuals felt strong pressure to pursue gender stereotypical activities, work, and relationships to fit in. Narratives of fixed as well

as fluid transgender individuals in this study confirmed Diamond's (1996) research findings.

> And to show the world I was a "real man" I did so many stupidly dangerous things that often I wonder how come I survived (male, CD/CG, fluid).
>
> Yes, there was always the RISK of public exposure, of losing family. I worked harder, attended church and studied the Bible for long hours. The Army was another escape avenue I tried (MTF, TS post-op, fixed).
>
> I was almost 40 years old. And on top of the shame and guilt I was absolutely convinced there could not possibly be other person in the world like me: a heterosexual genetic male wishing she was born female and needing to express her femininity (male, CD/CG, fluid).

Labelling and Stigmatization

To recognize objects, ideas, reasons, behaviours, and feelings we have to order them. This is accomplished by providing them with labels, and under these labels they are placed into our memory bank. Labels are socially constructed and they can be either positive or negative. The labels for gender emerge within the individual's current understanding of the gender self, according to the social structure they live in. The gender binary structure of being male or female might be the only one the child learns. Therefore, when the individual fails to adhere to the gender binary they create a negative self-image of being sick, deviant, not normal, and stigmatization occurs.

Goffman (1963) talked about stigma as "an undesired difference from what others anticipate" (p. 5). As the socially assigned gender does not come naturally to transgender individuals, they learn very quickly that their feelings of difference are

not acceptable. For many, playing the social role, and trying hard to go against what comes naturally to them, creates anxiety, discomfort, lowers their feelings of self-worth, induces feelings of failure, and decreases their self-esteem.

Consequently, many transgender individuals separate themselves from society, their peers, and family. Feelings of stigmatization become stronger as they mature; they become more aware of their "socially constructed shortcomings" and they add more and more negative labels to their feelings and behaviour. Self-stigmatization does not decrease until full acceptance of their transgender self is reached and they finally see themselves as normal and as a worthy part of the social structure.

> Yes, I was socialized in my birth sex. Hard to give examples of the behaviour enforcement, it was everywhere, mostly expected, not something to discuss. One little slip in speech, gestures, positioning and people were all over me. "Be a man!"(MTF, TS post-op, fixed).

> Family said, "Sex change is Blasphemy to God." Friends said, "You will be gone to us." Family said, "You can be any kind of woman you want to be." Lesbian community: Rejected me and my lesbian wife (FTM, TG with HRT, fixed).

> I always felt very guilty about being transgendered, though I did not know the word back then, because I was always told that men who desired to put on female garments were despicable perverts and also gays (male, CD/CG, fluid).

Anger

The constant negative messages—being a pervert, a freak, the shame, guilt, and self-blame for not transitioning earlier, or being too afraid to transition, being confused, the constant internal turmoil, and much more—can lead to anger. It is not

only anger against themselves, but also anger with the world; the inability to express their true selves earlier in life, or the suppressed emotions related to past abuse, can be the cause of the anger. Some transgender people express their anger in destructive ways, with the spectacle of a deserving (in-your-face) attitude, narcissistic behaviour (as previously explored, by means of using drugs, alcohol, and self-harm), or simply through picking fights with their family, friends, or even within the transgender community about their non-acceptance.

Others are able to use their anger in a constructive way, by getting involved in advocacy or focusing on sports, life changes, work, or education. Some will outgrow the anger through self-acceptance, transitioning, and some of the fluid transgender people will continue to cross-dress without guilt. Whereas others still, continue to struggle with feeling of unworthiness and may never be able to reach self-acceptance.

> My guilt and shame are more conscious now than when I was younger. I still don't feel entirely worthy (MTF, TG with HRT, fixed).

> My personal experience with transgenderism has included powerful feelings of shame and guilt. Usually I've dealt with these feelings by becoming angry with myself and people around me. I also denied and repressed my transgenderism (male, CD/CG, fluid).

> I've internalized the gender-conformity messages so well, that I'm my own worst enemy now (MTF, TG with HRT, fixed)

Gapka and Raj (2003) reported in their study that anger and frustration are commonly experienced by transgender people. They often also experience a great deal of stress; the cause might be financial instability, low income, housing issues,

unemployment, or problems with family. Clinicians are often afraid to prescribe testosterone if an FTM presents with anger issues; however, clinical experience, my own as well as the experience of Diane Watson (psychiatrist), indicates that most FTMs feel more stress-free after starting testosterone.

Body Awareness/Discomfort

Constant correction of their inappropriate gender behaviour increases transgender people's discomfort, and it also makes them more aware of the socially perfect picture of masculinity and femininity. "The cultural norms of femininity and masculinity include strong cultural messages about what 'real' men and 'real' women should look like as well as norms related to attractiveness" (Bockting et al., 2006, p. 61). This awareness becomes an issue, especially in terms of how they see their body. Before transition, their body is often viewed as a "cancer" that betrayed them. After transition, for some, body image might continue to be an issue as the body still does not represent the learned image of masculine or feminine body perfection.

MTF transgender individuals often swing the pendulum from *hyper-masculine,* in the hope of not being discovered, to *hyper-feminine,* to convince themselves (regarding their perception of femininity) that they are now passable. Going to either extreme is done in the hope of fitting into the socially constructed image of the gender binary. (For FTM individuals it is the other way around; however, in this population, this observable fact is seen less frequently.) During transitioning, or for cross-gender in female mode, it takes time until they find their

self-identity and accept their body image without social pressure of body perfection.

Table 12 shows transgender people's awareness and concerns with their body image.

Table 12: Body awareness/discomfort

		Frequency	Percent
Valid			
	Never	5	3.4
	A little	6	4.1
	Sometimes	27	18.6
	Most of the time	43	29.7
	All of the time	42	29.0
	Total	123	84.8
Missing		22	15.2
Total		145	100.0

> My body is rather large and masculine, and gives me a lot of discomfort in its lack of inherent physical femininity (MTF, TS pre-op, fixed).
>
> Desperately wish I had a more feminine (and in general, better looking) face and voice. A smaller, less masculine body (shoulders, hands, feet) would be very, very nice too (male, CD/CG, fluid).
>
> I wish I was taller and had bigger hands more than anything. I'm slowly dealing with my very small phallus (HRT has helped a great deal). More than anything I want my vagina to close up, though a more average phallus would be very much so appreciated (FTM, TS pre-op, fixed).
>
> My body is a source of great discomfort for me, and I feel greatly alienated from it. This has reduced for me with time somewhat, through the benefits of hormone therapy, and some cosmetic surgical procedures. My genitals continue to be a source of great emotional and psychological discomfort, and generate social and legal stresses and restrictions upon me (MTF, TS pre-op, fixed).
>
> My body always bothers me. I always wish that my breasts were bigger and my "buttocks" were more feminine and my hips were a little wider (MTF, TG with HRT, fixed).
>
> I have lived with both for 50 years. I'm not sure if I have ever truly accepted it or not. I have always wished that I had only the female

> personae, and it is becoming increasingly frustrating to continue this way (male, CG/CD, fluid).

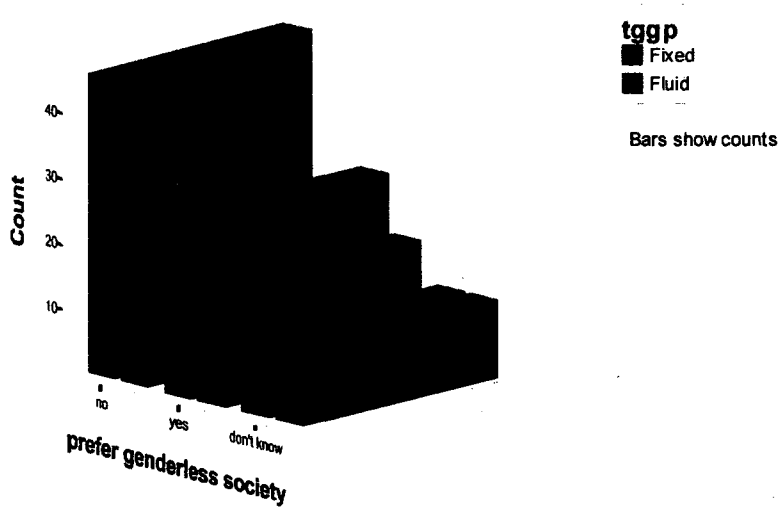
Usually the body parts or characteristics that transgender people have the most issues with are: voice (high, feminine; low, masculine), hands (small, feminine; large, masculine), breasts (feminine), not having a uterus, penis (to have one and also one which fits the socially expected size), and facial hair (to express maleness or no facial hair for femaleness); these are only some of the socially constructed female or male characteristics. Facial hair is often mentioned as the most important obstacle for the MTF transgender individual. The five o'clock shadow might be easy to cover in the morning; however, after 8 hours, it is very visible and might cause problems for employment.

Eating disorders are also a common issue that can be related to body image. In FTMs, anorexia keeps the individual more androgynous looking and it also might help to minimize breast mass and can prevent menstruation. However, eating disorders can appear both in FTMs as well as in MTFs (Gapka & Raj, 2003; Winston, Acharya, Chaudhuri, & Fellowes, 2004; Bockting et al., 2006).

Experiencing all the pressure, feeling constantly ashamed, guilty, and angry, and being marginalized by society becomes overwhelming and leads to isolation; therefore, many transgender individuals try very hard to fit in. Eating disorders can develop into an obsessive-compulsive behaviour that may counteract stress. Fitting in comes with a high price, as they are giving up their own knowledge of self and adapting to gender stereotypes of being male or female.

Questions related to preferring a genderless society are often difficult for transgender individuals to answer. It appears to depend on where they are in their transitioning; age is an issue, but also being cross-gender; acceptance of both personas is important for cross-gender people, and yet, passing and fitting in is also important, which complicates the issue. On the one hand, they need the gender binary for acceptance and reformation of their female persona (if they are biological males), but on the other hand, they need the freedom for their gender expression and therefore they need gender fluidity.

Figure 27: Would you prefer a genderless society?



For example, in a MTF transition it is difficult for many to understand that they do not need to erase all their good male characteristics to become female; however, it is complicated to find the right balance. Upbringing, culture, and social learning all play an important part in self-acceptance and the importance of fitting into a fixed gender binary or choosing a more open, fluid gender.

Although some expressed that both genders are needed, many of the survey participants preferred the gender binary.

> I live full time as male but have come to realize that my masculinity ought not to be formulated through negating the feminine. I am comfortable living as an effeminate male (FTM, TS post-op, fixed).

Many endorse gender stereotypes because all their life they have experienced taunting, name-calling, and violence. As a result, they have internalized the gender-conformity messages so well that they are their own worst enemy concerning gender openness. Even in the transgender community, gender fluid people are not always accepted, which leads to further exclusion. One of the reasons why for some transgender individuals seeking acceptance within the gender binary is so important might be that, since they had to hide their true selves for so long, to be accepted within the binary is essential for their well-being. In this research only a small percentage (16.6%) will search for complete gender openness.

> Friends and family and school (when I grew up); a gender appropriate upbringing was always enforced in one way or another. Even a little while ago, my mother noticed that I was tweezing my eyebrows and she said "Stop! You're doing that so much that it's starting to look girly, women are only supposed to do that." I felt like saying "Yeah, and your point is?" Now I feel that I'm in an even deeper hole of repression. I feel like I'm trapped (MTF, TG with HRT, fixed).

> My upbringing was gender appropriate and behaviour was reinforced mostly by my peers. Our gym classes were split into boys and girls (MTF, TS pre-op, fixed).
>
> I have lived a cross life since '96 both accepted as a boy and a girl in mainstream. It is a complicated balance (male, Bi-gender, fluid).

White, Holman and Goldberg (2006) referenced the Amsterdam team (de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006) and their recommendations based on their experience with transgender youth presenting gender fluidity. The Amsterdam team expressed that "the normal developmental process of adolescence often involves experimentations relating to identity and self-expression, caution is indicated if an adolescent presents seeking partial change" (de Vries et al., 2006, p. 88).

However, it may be difficult to impart caution as today's youth have easy access to the Internet and, therefore, easy access to hormones online. In working with youth, the first principle for the clinician should be harm reduction and finding a balance of integrating fluidity.

My experience is that more youth are coming out and seeking gender fluidity in the form of bi-gender or androgynous expression; whereas adults might seek gender fluidity in the form of cross-gender identity and with this the behaviour of cross-dressing.

Gender Behaviour Corrected

A particularly disturbing finding was that the majority of participants indicated that gender-appropriate behaviour was enforced by their family, using any means that they thought would help to drill gender-appropriate behaviour and expression into the child, adolescent, or adult.

> I felt expected to act as my birth gender. My mom used the Bible against me (MTF, TS pre-op, fixed).

> Can't you just live like this and be happy? Don't ever fucking talk to me about that again! I'll give you money if you'll just wait a couple more years (MTF, TS pre-op, fixed).

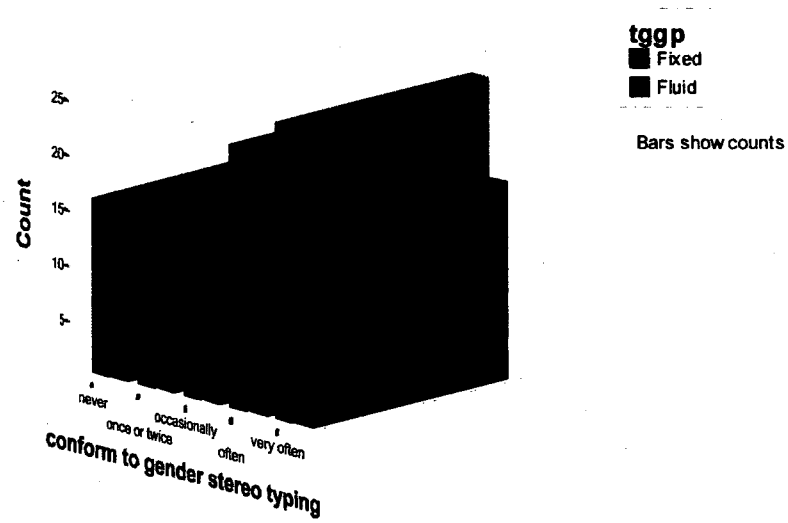
Families used fear, threats of disownment, physical, emotional, sexual violence, shame, guilt, financial pressure, coercion tactics, and religion against the transgender individual. In many cases, the constant family, social, and peer pressure worked for a long time; the individual started to repress their feelings, binging and purging of clothing, fears of being found out, fear of marriage breakdowns, fear of losing their children; feeling so constantly ashamed and guilty that over time their self-esteem and self-worth became very low, and often they began using alcohol, drugs, and self-harm to cope with the constant stress.

> I spent most of my adolescence terrified that I would be found out. Did whatever was necessary to ensure this never happened (male, CD/CG, fluid).

> Only in my mature years did I understand it and discuss [it] with my wife. Threats about separation, financial were used (MTF, TS post-op, fixed).

> My family looked upon it as sinful. Cross-dressing was prohibited in the Bible (male, bi-gender, fluid).

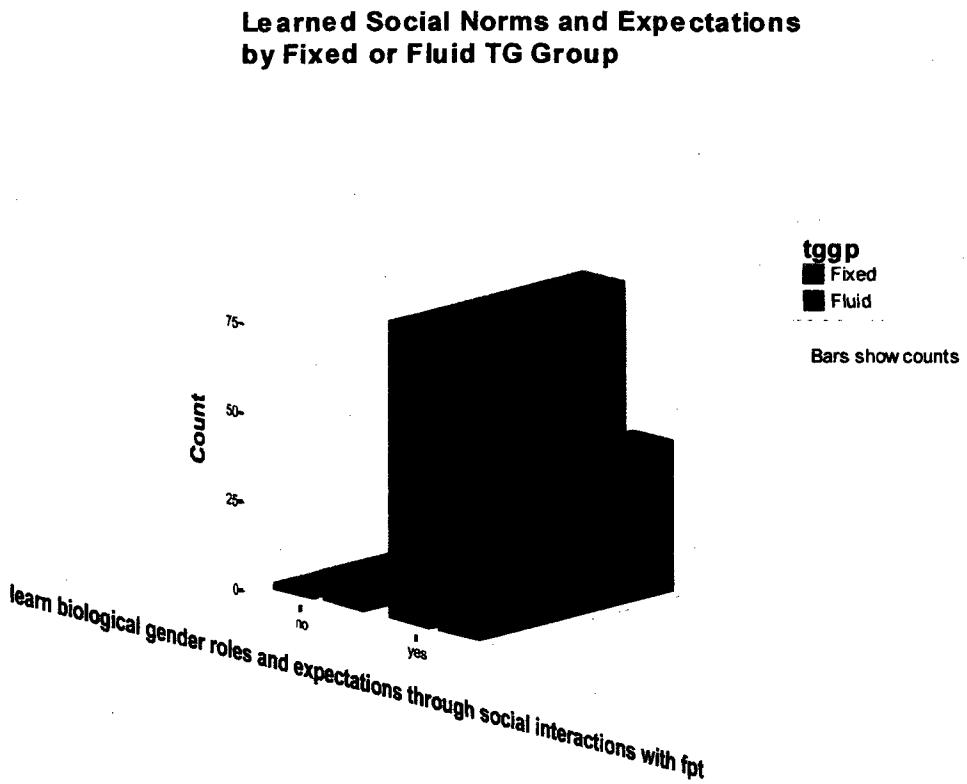
Figure 28: Conform to gender stereotyping



Some aspects of gender behaviour appear to be innate and come very easily; some transgender individuals stated that being their true gender-self came naturally to them but that acting according to their biological gender was difficult and felt unnatural.

Lorber (1991) views gender as a complete product of social learning. Some aspects of the gender binary and gender norms are socially constructed, but, we cannot dismiss the impact that hormones play on the individual's brain.

Figure 29: Learning social roles and behaviour through social interaction



Understanding the biological cause for transgenderism (LaVay, 1991, 1993) might help transgender individuals, as well as the therapists, to comprehend why some experience gender incongruency in childhood, others during adolescence, or even later in adulthood, but also why severity of gender dissonance increases over their lifespan.

Certain early behaviours appear to be spontaneous expressions of innate gender identity, before socially censured learning modifies behaviour. Some examples of this include sitting to urinate (MTF), spontaneous play, and attachments

to parents and role models. As previously stated, research on the biological aspects of transgenderism is in its infancy.

Summary

Different themes emerged in analyzing the qualitative findings. The following is only a short explanation of how the themes are affecting QOL, self-confidence, and stress. According to the qualitative data, the different combinations of expressed maleness and femaleness are influenced by the social environment, child rearing, and peers. Participants identified in their stories that behaving and using mannerisms in the "true-self" comes very easily and feels natural. However, in therapy we have to deal with reality—the individual's reality, the pressure used to learn the socially accepted behaviours and gender norms, and the reality of gender dissonance that transgender individuals experience on a day-to-day basis.

The majority of participants indicated in their life stories that the main pressure for gender-appropriate behaviour came from their families, who used any means necessary to gain control and force them into socially accepted gender norms and expectations. Over time, many try to adapt out of fear of losing their families, friends, and (or) employment. Coping methods, such as daydreaming and fantasizing, help and are clearly effective tools for survival. Later, when these tools are not enough, alcohol, drug abuse, and self-harm are added.

Therapists need to use a harm reduction and client centered model that includes client identified issues in the counselling process (see Chapter 8). The impact that the enforcement of socially accepted gender behaviour had on the

individual must be addressed. Myth and misconceptions have to be deconstructed before a healthier view of the transgender self can be established.

The upbringing and constant social barriers influence the individuals QOL and stress level. As well, it is believed that the distorted perception of the self and others comes from the constant feelings of shame and guilt as it was identified by many transgender participants. Therapists need to work with the internal as well as external transphobia which has severe implications on the success of counselling.
As previously stated, clients' own use of different terminology and healthcare providers' diagnostic typologies which might be in accordance with the standardized diagnostic nosologies might differ, and this difference might lead to misdiagnosis and the utilization of wrong treatment modalities.

The information gathered through this research hopefully provides the service provider with greater insight to the issues transgender people experience. As well it will help to bring changes in the service provision, to see transgenderism as part of a greater gender continuum rather than as a pathology.

Chapter 8

On the Road to Inclusion

Future Research Considerations

Despite the research limitations, interesting findings and new ideas have emerged, making it apparent that this topic could easily become one's life work. More research is required, especially in the following areas:

1) Research to establish a rating scale to measure severity levels of gender dysphoria.

Severity level is an indication of distress. Knowing severity levels in the fixed transgender group might help the clinician when assisting transgender clients in the process of moving through the multifaceted trajectories of gender transition. At the same time, the severity level in the fluid might be an indicator of internal, self-acceptance and/or external acceptance or non-acceptance, QOL and feelings of safety.

2) Research on validating instruments for cross-cultural applications.

Diagnostic and assessment tools should be tested by clinicians for their validity and reliability. This is especially important for the Canadian transgender populations which occupy a multicultural society in Canada.

3) Needs assessments pertaining to the racial diversity of transgender people.

Canada is multicultural yet, in my experience, First Nation people, Black Canadians or Hispanic transgender people's needs are not well known. I can only speak to Ottawa where there is no support group for multicultural transgender people

and my clientele often testify that they feel misunderstood and left out by the transgender community. A needs assessment with these groups would help clinicians to understand their specific needs and develop resources accordingly.

4) Research on transgender identity development and the influence of socially constructed gender norms with a comparison group of people who do not experience any gender discomfort.

The current research indicates that transgender peoples' QOL is extremely low and that family, peers and teachers negatively influenced transgender children's identity development. Therefore it would be interesting to examine whether or not child rearing in general has a negative impact on identity development and/or if it is the feeling of being 'different' that makes transgender individuals a target.

5) Research on the difference between sexual orientation and gender identity: comparing gay, lesbian, bisexual, and transgender people.

Prince (1997) found that the incorrect use of language, leads to misinformation and confusion such as: that sex and gender are one and the same and that much damage has been done by confusing the two. Even health care professionals still assume that transgenderism and homosexuality are the same. Therefore, research that investigates the specific differences between the two might help people to better comprehend the different needs these populations have.

6) Research between the paid and non-paid HRT, SRS, and therapy among and within Canadian provinces and whether or not a difference in QOL exists between transgender people from the different Canadian provinces.

Even though " 'health care in Canada is considered universal': under the terms of the Canada Health Act, all Canadian citizens and landed immigrants are entitled to receive medically necessary care. Medical care is supposed to be available to everyone, often for moral and ethical reasons, and in Canada, it is considered to be a 'universal,' accessible health care program" (Government of Canada, 2007). However, transgender people experience how the so-called entitlement to receive medically necessary care varies in the different provinces in Canada. Since some of the provinces have paid SRS, the question remains, does knowing this influence the QOL of the transgender population in these provinces, or not?

7) Research on legislative changes in human rights, transgender rights, and differences between countries in this regard.

Alec Casanova-Ferrer (2005) found the following: In 1989, The European Parliament approved a Resolution on the discrimination of transgender people and requested that the National Health Services of the different states be responsible for transgender care (i.e., HRT, SRS). However, the question still remains unanswered as to how many countries have taken the resolution seriously and incorporated transgender care into their National Health Services.

8) Survey of healthcare providers' attitudes towards and knowledge about transgenderism.

Previous research shows that 77.4% of transgender people in Ottawa and environs thought that therapist/health care professionals have no or minimal knowledge of transgenderism (Seidl, 2003).

Lev (2004) and Meyer et. al., (2001) found that transgender people did not trust counselors. The current research confirmed that in the area of counselling satisfaction both groups, the fixed and the fluid, expressed dissatisfaction. More research in this area is still needed. Seidl's 2003 study found that health care providers lacking knowledge of transgenderism was one of the concerns identified. Recommendations on how to structure transgender knowledge into the social work curricula are included in this chapter.

Goldberg (2006) suggested a framework for training clinicians working in the community setting. Clinicians in the community settings are often the first line of professional support for many transgender clients. However, most of the training, professional meetings, seminars and/or conferences focus on the fixed transgender group, the individuals who transition by means of HRT and SRS, thus excluding the fluid transgender people.

These aforementioned areas represent only some of the possibilities for future research; each will elicit more questions, but hopefully also a greater understanding of transgenderism.

Transgender individuals seeking help often encounter great difficulties when locating health care professionals who are knowledgeable in the area of transgenderism. The following are recommendations that should be included in the curricula of health care and social work professional education in order to raise awareness and increase knowledge of transgenderism.

Recommendations

To reach a paradigm shift and make changes in the therapeutic modalities, amendments in the professional education of social workers, therapists, medical doctors, and health care professionals in general are needed. A course should be created for health care professionals and social workers where they can be formally educated in the area of transgenderism. Basic knowledge on transgenderism has to be taught at the undergraduate level; at this level, issues of social change, principles of human rights and social justice, advocacy, and the micro and macro issues of people in their environments should be addressed.

At the graduate level, a course on advanced transgender issues has to be given, including concrete assessment, evaluation, and counselling techniques, as well as knowledge of the *Diagnostic Statistical Manual of Mental Disorders* (*DSM-IV-TR*, 2000), which provides a comprehensive listing of the diagnostic criteria for hundreds of mental disorders, including GID.

The Harry Benjamin Standards of Care should also be taught, using version six which is available online (http://www.wpath.org). In order to ensure and encourage advancement in the area of transgenderism, changes to the curricula and academic material need to be made. In addition, universities Canada-wide must adapt their courses accordingly. Doing so will properly prepare social workers and other health care professionals to deal with transgender clients.

As the research findings have demonstrated, a large percentage of transgender people fall into the low-income category and therefore working with a gender

specialist in private practice is not a viable option. As a result, community centre social workers must be properly educated in the area of transgenderism because they are often a transgender individual's first and only line of support.

Many transgender people deal with alcohol or drug addiction; therefore, addiction counselors must also be included in transgender education. Alcohol and drugs are often used as coping methods; therefore, it is important to evaluate the client thoroughly, to know about their gender struggles, and to avoid assigning the client with a diagnostic label that may be found difficult to change in the future. Most importantly, the client's success in reaching his/her therapeutic goal may depend on their counselor's knowledge of transgenderism.

Some transgender clients might experience concomitant mental health conditions such as anxiety disorder, major depressive disorder, panic disorder, eating disorder, personality disorder, obsessive–compulsive disorder, and/or other mental health issues. These issues are often the result of growing up with the secret of being transgender and experiencing shame, guilt, and internalized as well as externalized transphobia which often leads to mental health disorders. Transgender clients need clinicians who look at the larger picture.

> What comes first, the chicken or the egg?; mental health issue or gender issue? We might never know the answer to these questions, but we should always put the well-being of the client first, and therefore help the transgender individual cope during a difficult transitioning process, which in some cases might be combined with mental health issues. (Seidl, 2006, p. 200).

Building a team with a psychiatrist who is transgender-friendly is important, because some transgender clients might need medication before they are able to address and accept their GID.

Therapists cannot forget to include the family, partners, spouses, children, friends, co-workers, and employers in the transition process or in accepting cross-gender living in order to guarantee successful treatment outcome and increased QOL for transgender individuals. This includes knowledge of family dynamics, couple counselling, sex education, employment rights, and human rights issues, which also should be covered in transgender education.

In addition, significance should be placed on individual counselling, group therapy, and discussion groups for transgender clients, as well as for their partners. The discussion groups should be facilitated by a gender specialist and co-facilitated by a transgender individual. Individual counselling should be structured to address the needs of the participants, while the discussion groups should include education and address sexual intimacy in transgender relationships.

Transgenderism is not a new issue; however, the non-pathologicalization of transgenderism is a new paradigm, creating the need for an improved and more positive education to guarantee appropriate support and service delivery to transgender individuals. Education not only increases knowledge but also creates awareness and ultimately transgender education will show the way to greater acceptance and inclusion, instead of continued ignorance and transgender exclusion. Finally it is hoped that through education, health care providers will use a

terminology that is more inclusive and will enhance service delivery to transgender individuals. Improved transgender care should include treatment modalities that are based on harm reduction and a best practice approach.

Social work, mental health, and medicine have undergone significant transformations in the past quarter-century. There is more openness, empathy, and in medicine, great surgical advances, and yet there is still a lack of understanding with regard to transgenderism. This lack clearly appears to be due to deficiency in knowledge on the issue, misunderstanding of the importance and positive aspect of classification, lack of funding for proper health care (i.e., therapy, SRS, and HRT), and generally due to our own upbringing within cultures that adhere to the dominant socially constructed gender binary.

Although transgender individuals have very different upbringings and experiences, there are some commonalities. We cannot overlook important elements related to the social vulnerability among the fixed as well as the fluid transgender groups: the lack of social support and understanding, lack of institutional assistance, such as help with counselling, medical care, SRS, and HRT. In addition, respectful treatment should include courteous language and inclusive terminology.

Closing Summary

As previously stated, the variety of medical as well as self-identified transgender categories are often very confusing for clients as well as for clinicians. In order to provide our clients with the appropriate help and to avoid misdiagnosis and refusal of treatment, a more inclusive typology is required. Clustering a variety

of transgender groups into two groups – fixed or fluid – creates a more inclusive typology for clinical use, and leaves room to add on new emerging self-identifications.

Even though the fixed group adheres to masculine and feminine according to the gender binary, it allows openness since altering the sex and taking hormones are not requirements. The only condition is to live 24/7 (full-time) in the opposite of their birth assigned gender. In contrast, the fluid group needs to be able to express and live part-time in both their feminine and masculine gender expressions, or be totally androgynous and capable of switching their gender self-identity and expression in seconds. Since I consider gender to be on a continuum, the fluid group might one day continue and need the help of a clinician to transition. Therefore, it is important that the clinician maintain an open mind and not see this as a phase or mental health issue.

In the clinical setting, there is an increased focus on accountability, and consequently, diagnosis and treatment has to be evidence-based. For that reason, we need proper tools that are reliable and easy to use in clinical settings. Since either transitioning or even accepting fluidity often takes a long time, being able to use QOL, self-confidence or the Perceived Stress Scale to measure client's progress is helpful, especially when the client feels discouraged. The measurement can also provide clinicians with insight to the client's recent distress or impairment in social, occupational or other important areas of functioning. It is known that the Self-Confidence Scale and the MUNSH work well together. Both scales are highly

reliable tools and, therefore, should be used in the clinical setting when working with transgender clients.

Several themes emerged from the open-ended questions and interviews; experiencing shame, guilt, anger, violence, and abuse were prevalent. For example: a FTM transgender client experienced sexual abuse during childhood, at the time of the abuse he was still living in the birth assigned gender, however in his mind he perceived himself as being a boy, therefore the clinician has to address the sexual abuse from a male victim perspective.

Another example some FTM might experience anger. Many clinicians would jump to the assumption that the anger is caused by the testosterone or if the individual expresses issues with anger in the assessment phase clinicians are often afraid to prescribe testosterone. However, testosterone does not cause the anger some FTM might experience. The clinician has to address past and current traumatic events, social as well as daily living situations rather than decreasing testosterone.

The fluid population also experiences difficulties in social, occupational and other important areas of functioning. We often see obsessive-compulsive behaviours, bingeing and purging of clothing which have to be addressed. In some cases treatment incorporating Spironolactone might be helpful under the direct supervision of a psychiatrist.

Finding the right treatment modality is a challenge that can be solved by means of clustering the spectrum of transgender identities into two groups – fixed or fluid. As previously stated, using a harm reduction and client-centered treatment

approach is strongly recommended when working with transgender people.

The term 'Harm Reduction" is very well known and has been applied to needle exchange and a variety of other practices aimed at reducing physical and mental harm related to drug use (Cho, 2002). One of the principles of harm reduction is to provide the needed services. In the transgender context providing services is important, however, the services have to be user-friendly social services rather than those user-hostile social control institutions. Harm reduction can affirm the individual's knowledge of their self-identity and increase their QOL. This research clearly demonstrated that the fixed and the fluid transgender individuals have an extremely low QOL and change in treatment modalities should be considered necessary.

Bockting et al. (2006) recommended beginning treatment with the issue that most negatively impacts the client's quality of life. For many transgender people the feelings of exclusion, being isolated and socially stigmatized, are some of the issues that negatively impact their QOL (Witten et. al., 2001). Another issue is that many transgender people avoid treatment since they know that they might not fit into the rigid frame of the current eligibility and readiness criteria. As identified in this research and supported by Lev (2004) transgender people do not trust the health care professionals, they see clinicians as gate keepers and are dissatisfied with the treatment they receive.

Rather than isolating transgender people, treatment has to change, whereby clinicians must concentrate on listening to the client's needs, acknowledge that the

rigid criteria's do not work for many of the fixed and especially do not work for the fluid transgender group. Using a harm reduction model means integrating them or re-integrating them into the work force, the general community and providing them with the appropriate services. This will empower transgender clients and increase their QOL.

Furthermore, services (i.e., counselling, HRT, SRS, chest-reconstruction) have to be covered by our health care system. A cost-benefit analysis could be used to establish that the individual harm and overall public costs of unemployment and mental health care could be minimized if we provide this population with the appropriate help.

The division of clustering a variety of transgender groups into two groups – fixed or fluid – created a more inclusive typology for clinical use and will also work with a harm reduction and client centered service delivery model. Such a model not only takes a variety of transgender self-identities and gender expressions into consideration but also acknowledges that each individual has different needs. This particular typology of clustering a variety of gender identities into two groups – fixed or fluid –can influence the way someone seeks and responds to services such as counselling. We are on the road to inclusion yet we have to recognize that we still have a long journey ahead of us.

Note to Page 28

Endnotes

[1] "Intersexuality" replaced the term "hermaphroditism". Intersex is a group of conditions where there is a discrepancy between the external and the internal genitals (testes and ovaries). Intersex grouping is divided in several categories such as: 46, XX, most commonly known in this category is the congenital adrenal hyperplasia, 46, XY intersex or complex or undetermined intersex. Hermaphroditism is an older term which cam from joining the names of a Greek god and goddess, Hermes and Aphrodite. This term was also divided into different categories: true hermaphrodite or pseudohermaphrodite. (Medline Plus, 2007).

Since these writings deal with the historical as well as the current context, the term intersex/hermaphrodite will be used interchangeably.

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Appendix 1: Transgender Groups in Canada

Transgender Social & Support Groups throughout Canada:

Alberta

Edmonton Transgender Support Line
Phone: (780) 488-3234

Illusions Social Club
P.O. Box 2000
Calgary, Alberta T2C-1B4 Canada
Phone: (403) 486-9661
http://www.geocities.com/WestHollywood/Village/5276

Illusions Social Club II
Box 1852
Edmonton, AB, T5K 2P2
Phone (780) 488-3234
Contact Shae Guerin
Email: illusionssocialclub@yahoogroups.com
Website: www.tic.ab.ca/~shae

Edmonton Transgendered Society
Edmonton Transgender Support Line
Phone: 780-488-3234
www.egret.mybravenet.com

Phi Sigma, Tri-Ess Chapter
Box 81115, 755 Lake Bonavista Dr. S.E.
Calgary, Alberta T2C-1B4 Canada
Phone: (403) 271-6247
E-mail: flannerj@cadvision.com

Serenity
Box 81115, 755 Lake Bonavista Dr. SE
Calgary, Alberta T2J 7C9 Canada
Phone: (403) 281-6426
E-mail: jaki@tgforum.com

OUTreach (Edmonton)
Box 75, Students Union Building, University of Alberta
Edmonton, AB, T6G 2J7
E-Mail: outreach@gpu.srv.ualberta.ca
Web: www.ualberta.ca/~outreach/

Pflag Edmonton
(780) 944-1394 vb 3524
E-Mail: pflag@freenet.edmonton.ab.ca
Web: www.freenet.edmonton.ab.ca/glcce/pflag.htm

True Spirit North
(780) 405-4314
E-Mail: truespiritnorth@shaw.ca
Web: http://www.members.shaw.ca/truespiritnorth

British Columbia

BC FTM Network
P.O. Box 10,
1895 Commercial Drive
Vancouver, BC, V5N 4A6
Phone: (604) 862-1321
E-mail: bcftmnet@hotmail.com

Cornbury Society
PO Box 3745,
Vancouver, BC, V3B 1Z1
Phone: (604) 862-1321
E-mail: cornbury@telus.net
http://www.cornbury.org

Kootenays TG Support Group
P.O. Box 270
Rossland, British Columbia V0G 1Y0 Canada
Phone: (250) 362-5701
E-mail: jrasku@armispiansystems.rossland.bc.ca

Trans/Action
C/O 620 - 1033 Davie Street
Vancouver, BC, V6E 1M7
Phone: (604) 687-8752
E-mail: bfindlay@imag.net

Zenith Foundation
Box 46, 8415 Granville St.
Vancouver, British Columbia V6P 4Z9 Canada
Phone: (604) 261-1695
E-mail: zenithfoundation@hotmail.com
http://www.GenderWeb.org/~zenith

Dream Girls
P.O. Box 535, Kamloops, BC, V2C 5L7.

East Kootenay Gay and Lesbian Organization (Cranbrook)
Box 21023 Cranbrook Mall Postal Outlet
Cranbrook, BC, V1C 6K5
(250) 489-5939
E-Mail: dcattonnmawson@cyberlink.bc.ca

FTM Etc.
Vancouver BC FTM Peer Support/Discussion Group
Meets the 3rd Sunday of each month from 1pm to 4pm.
Contact:
Devon M: (604) 255-2313
Lukas W: (604) 254-7292
E-Mail: BCFTMNetwork@Off-GridSolutions.ca

PFLAG Vancouver
P.O. Box 30075, 8602 Granville Street
Vancouver, BC, V6P 5A0
(604) 263-0378
E-Mail: betew@intergate.bc.ca

Pinkline (Victoria)
(250) 920-6121

Trans Alliance Society
C/O 294 - 3495 Cambie Street
Vancouver, BC, V5Z 4R2
(604) 684-9872 Xtn 2044
E-Mail: info@transalliancesociety.org
Web: www.transalliancesociety.org

Transcend
PO Box 8673
Victoria, BC, V8X 3S2
(250) 413-3220
E-Mail: transcend@islandnet.com
Web: www.islandnet.com/transcend/

UVic Pride (Victoria)
Student Union Building, University of Victoria
P.O. Box 3035, Victoria, BC, V8W 3P3
Open 11:00am to 6:00pm
(250) 472-4393
E-Mail: pride@uvss.uvic.ca
Web: http://uvss.uvic.ca/~pride/

Youthquest gay, lesbian, bisexual, and transgendered youth to age 18.
#200 - 2540 Shaughnessy St., Port Coquitlam, BC
(604) 944-6293
E-Mail: youthquest@mail.org
Web: www.geocities.com/WestHollywood/9992/

Zenith Foundation - Victoria Chapter
Ste 303, 955 Cooke St,
Victoria, BC, V8V 3Z1
(250) 384-4635

Manitoba

Masquerade
E-mail Robin at: robin_z37@hotmail.com
Web: http://winnipegcrossdressers.homestead.com/

Winnipeg Transgender Support Group
1-222 Osborne St South
@Confusion Corner
Winnipeg, MB, R3L 1Z3
Phone: (204) 284-5208
E-mail wtsg@mts.net
Website: www.transgemdercafe.com

Prairie Rose Gender Club
PO Box 23 Grp 4 RR1, Dugald, MB, R0E 0K0
Phone: (204) 257-2759

Gays and Lesbians of Brandon and Elsewhere (Brandon)
Box 22039, Brandon, MB, R7A 6Y9
(204) 727-GAYS (4297)

New Brunswick

SAINT JOHN RAINBOW ALLIANCE
email: rb_alliance@hotmail.com
website: http://hello.to/pride_saint_john/

NB GAY ALLIANCE
Art Vautour
email: artgenea@nbnet.nb.ca
phone: 863-1888

MONCTON TRANSGENDER SUPPORT GROUP ~
Eldon Hay 536-0599
email: eldonhay@nb.sympatico.ca

SPECTRUM ~ A social and support group for students, staff and faculty at UNB and STU in Fredericton.
Meets every Wednesday at 7pm at Tilley 28 (downstairs Arts Common Room)
wesite: http://wwwunb.ca/spectrum

CATALYST ~ LGBT & supporters at Mt Allison,
C/o Donna Sutton, Counsellor
Mount Allison University
Sackville, NB, E0A 3C0
(506) 364 2357 or (506) 364-2255,
fax (506) 364-2263,
email: dsutton@MTA.ca or ktrotter@mta.ca

New Foundland

Lesbian/Gay/Bisexual/Transgender Support and Info Line
(St. John's)
P.O. Box 6221, St. John's, NF, A1C 6J9
Phone: (709) 753-4297
Tues and Thurs, 7:00-10:00pm
E-mail: ngale@geocities.com
www.geocities.com/WestHollywood/4291

LBGT-MUN (Memorial University, St. John's)
(709) 737-7619
Room UC-6022, 6th floor, New University Centre
E-Mail: lbgtmun@plato.ucs.mun.ca
Web: www.mun.ca/lbgt/

Nova Scotia

Atlantic Transgender (ATG)
Halifax, Nova Scotia, Canada
E-mail: atggrp@geocities.com
http://geocities.com/westhollywood/7557

Gender Expressions Atlantic
E-Mail: gender_expressions@hotmail.com
Web: www.geocities.com/gender_expressions/

ValleyPRIDE (Kentville)
E-Mail: mike.giffin@ns.sympatico.ca,
Web: www.geocities.com/WestHollywood/Heights/2377/

Ontario

Algonquin Pride (Ottawa)
C/O Algonquin College, C-151-1375 Woodroffe Ave,
Nepean, ON, K2G 1V8
727-GRAD (4723) extension 7711
E-Mail: pride@algonquincollege.com
Web: http://www.algonquincollege.com/prid

Canadian CrossDressers Club
161 Gerrard Street East,
Toronto, Ontario, Canada M5A 2E4
Phone: (416) 921-6112 (24 hours per day)
Fax: (416) 964-8824
E-mail: info@wildside.org
http://www.wildside..

Carleton University GLBT centre (Ottawa)
c/o 401 Unicentre Building, Carleton University Ottawa, ON,
K1S 5B6
(613) 520-3723
E-Mail: glbt@carleton.ca
Web: www.carleton.ca/glbt

Consultation and Counselling Practice
Toronto, Ontario, Canada
Maxine Petersen-Lee, M.A., C. Psych. Assoc.
Phone: 416-994-1376
E-mail: counsell@istar.ca

Chrysalis
349A George St. N, Suite 206
Peterborough, Ontario K9H 3P9 Canada
E-mail: chrysalistg@yahoo.ca
http://www.angelfire.com/ok3/chrysalistg/index.html

COLAGE - Toronto chapter
Support and advocacy organization for daughters and sons
of lesbian, gay, bisexual and transgender parents..
Sheri Zernentsch
(416) 928-0513
E-Mail: sheri@interlog.com
Web: www.colage.org

Durham Youth Triangle (Oshawa)
E-Mail: dty@geocities.com
Web: www.geocities.com/WestHollywood/Village/6880/

Fabulous Youth of Halton
(905) 469 -1859
E-Mail: fabyouth@home.com
Web: www.go.to/fabyouth

Free to be Me Youth Group (Belleville)
For gay, lesbian, bi-sexual, transgendered and
their supportive friends, between the ages of 18-28.
(613) 962-5860

Gay, Lesbian, Bisexual and Transgendered Youth Group of Halton
Meetings are held in Burlington for youth up to 24 years old
on the first Thursday of each month.
(800) 563-6919 Ext. 50.

Female to Male Transexual/Transgendered Peer-Support Group
519 Church Street Community Centre
Toronto, ON, M4Y 2C9
Phone: (416) 392-6878
E-mail: jamesm.brown@utoronto.ca
Contact: James Brown

Gender Metaphor
P.O. Box 27097
Ottawa, Ontario K1J 9L9
E-mail: gender-metaphor@ottawa.com
http://www.geocities.com/gender_metaphor

Gender Metaphor
829 NorW Road Suite 715
Kingston, ON, K7P 2N3
Contact Michelle Renee
Website: www.geocities.com/WestHollywood/3190

Gender Mosaic
P.O. Box 7421
Vanier, Ontario K1L-8E4 Canada
Phone: (819) 770-1945
E-mail: gender_mosaic@geocities.com
Website: www.geocities.com/gender_mosaic

GLBTQ Youth Group (Cornwall)
A support and social group for youth aged 25 and under serving Cornwall and the surrounding area. It meets once a week in the evening.
(613) 874-2289 or Toll Free 1-888-886-4715
E-Mail: pmacrae@datacom.ca

Global - Gays, Lesbians or Bisexuals at Laurier (Waterloo)
E-Mail: 00global@mach1.wlu.ca
Web: www.wlu.ca/~wwwclubs/www/global.html

Haldimand and Norfolk GLBT Website
E-Mail: halnorglbt@aol.com
Web: www.geocities.com/halnorglbt/

Hamilton Transsexual Support Group (FTM-MTF)
135 Rebecca Street
Hamilton, ON, L8R 1B9
Phone: (905) 528-0854
E-mail: janet@interlynx.net

Lesbian Gay Bi Youth Line (Ontario-wide)
P.O. Box 62, Station F, Toronto, ON, M4Y 2L4
(416) 962-YOUTH Toll Free: 1-800-268-YOUTH
Daily, 3:00 pm to 11:00 pm
E-Mail: lgbline@iComm.ca
Web: www.iComm.ca/lgbline

LGBT Youth Drop-in (Scarborough)
A support group for lesbian, gay, bisexual and transgendered students in Scarborough and surrounding areas.
The group meets Mondays at 4:00.
Call Bonnie Simpson (416) 438-3697 Ext. 600.

Kingston Lesbian Gay Bi Trans-identified Association
C/o 51 Queen's Crescent
Kingston, ON, K7L 3N6
Email: klgbta@hotmail.com
Phone: (613) 533 2960
Fax: (613) 533 2712

MEAL-TRANS
519 Church St.
Toronto, Ontario M4Y 3C9 Canada
Phone: (416) 392-6878, ext.104
E-mail: mealtran@519.icomm.ca
http://www.gaytoronto.com/519

Ontario Female to Male Network
378-532 Montreal Rd.
Ottawa, Ontario K1K 4R4 Canada
Phone: (613) 798-9552
Fax: (613) 728-8054
E-mail: onftm@cyberus.ca

Ontario Female to Male Network E-mail list
Web: groups.yahoo.com/group/ONFTM

Ottawa Female To Male monthly meeting. For information see
Web: http:ca.geocities.com/ottawaftm/

Ottawa TS Support Group
E-mail: ts-ottawa@canada.com
Support group for transitioning transsexuals.
http://www.geocities.com/tsottawa

Ottawa Youth Services Bureau
1338 1/2 Wellington Street
Ottawa, ON, K1Y 3B7
(613) 729-1000
Email: headoffice@ysb.on.ca
Web: www.ysb.on.ca

OUTline
(519) 836-4550
Sunday - Thursday, 7:00pm to 10:00pm
Friday and Saturday 6:00pm to 9:00pm
E-Mail: outline@uoguelph.ca
Web: www.uoguelph.ca/~outline/

Pflag Ottawa
381 Lefebvre Way, Orleans, ON, KlE 2W5
Diana or Dennis Stimson (613) 834-9880
Meets every second Wednesday at 7:30pm
E-Mail: ddstimson@rogers.com
Web: www.gaycanada.com/pflag-ottawa

Pflag Toronto
115 Simpson Avenue, Toronto, ON, M4K 1A1
(416) 406-6378
E-Mail: toronto@pflag.ca
Web: www.pflag.ca/Toronto.html

Pride@LU (Sudbury)
(705) 673-6506
E-Mail: pridelu@geocities.com
Web: www.geocities.com/WestHollywood/3859

Rainbow Action for Youth Network (Simcoe-Muskoka)
An association of LGBT adults and youth as well
as health, education and social service providers
offering support to LGBT Youth. Meetings are held monthly.
Anita Bol (705) 435-5734

Rainbow Youth Coalition (Ottawa)
A network of social service workers, health care providers,
teachers, youth and parents working together on
behalf of LGBTQ youth.
(613) 237-XTRA Ext. 2105

Reflections (Niagara Region)
A Transgender Support Group in the Niagara Region.
E-Mail: gurrlmail@yahoo.com
Web: www.geocities.com/gurrlmail/reflections.html

Peterborough TG Support
Contact Shari Warfield
Phone: (705) 748-6711, Voice mail #43
Fax (705) 748-2577

Soffa Support Group
519 Church Street Community Centre
Toronto, ON, M4Y 2C9
Phone (416) 392-6878

S.O.S. Club (for partners of TS's)
519 Church St.
Toronto, Ontario M4Y 2C9 Canada
Phone: (416)-392-6874
E-mail: sosclub@idirect.ca
http://webhome.idirect.com/~players
This is a new social & support group, based in Toronto, to help the
partners of transsexual persons. The group meets on a monthly basis.

Supporting our Youth Trans Fusion Group
300-65 Wellesley St East
Toronto, ON, M4Y 1G7
E-mail: coordinator@soytoronto.org
Phone: (416) 924 2100
Contact: Elisa Hatton
Website: www.soytoronto.org

TG Station London
Transgender support group.
E-Mail: michelle@mdoll.com
Web: www.tgstation.org

The Rainbow Classroom Network
An Ontario Organization formed to inform, support and mobilize people working to create Rainbow (GLBT) supportive classrooms.
7th Floor, Ontario Institute for Studies in Education
252 Bloor St. West, Toronto, ON, M5S 1V6
E-Mail: lmoser@total.net
Web: www.dezines.com/rainbow/index.htm

Toronto Scouting - 129th group
The world's first openly gay, lesbian, bisexual, transgendered and transsexual scouting group.
Bonte Minnema, Chair
(416) 935-0272
E-Mail: bonte@clo.com
Web: www.queerscouts.org/

Toronto Transition Support
C/O The 519 Church St. Community Centre
519 Church Street, Toronto, ON, M4Y 2C9

TransEqual
609-165 Ontario St
St Catherines, ON, L2R 5K4
Phone: (905) 688-1309
Contact: Laura Blake

Transformations
333 Sherbourne St
Toronto, ON, M5A 2S5
Contact: Rupert Raj
Phone: (416) 324 4174
E-mail:rraj@sherbourne.on.ca
Contact LeeAndra Miller
E-mail: leeandra@city.org
Phone: (416) 924 2100

Transgender Canada
1902-400 Slater Street
Ottawa, ON, K1R 7S7
Phone (work) (613) 729 1088
Phone (home) (613) 236-9110
Contact Jan Hobbs
Email: ethics@magma.ca

Transgendered, Bi-Sexual, Lesbian, & Gay Alliance of York
C449 Student Centre, York University, 4900 Keele Street
North York, ON, M3J 1P3
Phone: (416) 736-2100 x20494
E-mail: tblgay@yorku.ca

Trans Peoples Political Action Network (TPPAN)
Phone: (613) 594-5756
E-mail: flundie@engsoc.carleton.ca

Transition Support Group TV/TS
C/o 519 Church St Community Centre
Toronto, ON, M4Y 2C9
E-mail: shadsmith@hotmail.com
Phone: (416) 923 0717
Contact: Shadmith Manzo

Trans Youth Toronto
519 Church Street Community Centre
Toronto, ON, M4Y 2C9
Phone: (416) 392-6878
Contact Gavin Downie
Email: mealtran@the519.org

Two Spirited People of First Nations (Toronto)
(416) 944-9300

University of Ottawa
GLBTQ Pride Centre
85 University Ave, University Centre, Room 215 E
Ottawa, ON, K1N 6N5
(613) 562-5800 x3161
Fax: (613) 562-5343
E-Mail: uopride@uottawa.ca
Web: www.uottawa.ca/student/glbtq/

Transsexual Menace - Toronto
E-mail: sarah@interlog.com
www.interlog.com/~sarah/menace.htm

Xpressions
P.O. Box 223, Station A
Toronto, Ontario M5W 1B2 Canada
Phone: (416) 410-6949
Contact Miggi Gilbert
E-mail: xpressions@xpressions.org
http://www.Xpressions.org

PRINCE EDWARD ISLAND:

Gay, Lesbian, Bi, and Transgendered Community Support
(Charlottetown)
53 Grafton Street, Charlottetown, PE, C1A 1K8
Phone: (902) 892-4163 E-mail: mark.smith@isn.net

ABEGWEIT RAINBOW COLLECTIVE

Tel. 894-5776 or 1-877-380-5776 (toll free accross PEI)
email: arc@altavista.com

QUEBEC

Action Santé:
Travesti(e)s et Transsexuel(le)s du Quebec - ASTT(e)Q
Cactus, 1250 rue Sanguinet
Montreal, QB, H2X 3E7
Phone (514) 890-7016
Information, Resources, Support and Workshops for the Montreal area
Pager (514) 851-7674

Club MET
4113 Dorion St.
Montreal, Quebec H2K-3B8 Canada
Social TG group.

FTM International
5495 Trans Island
Montreal, QC, H3W 3A7
Phone: (514) 830-6740
Fax: (240) 597 6495
Contact: Dave Altrows

Travestis Montreal
E-mail: mac@mlink.net
www.mlink.net/~mac/tvm.html

ASTT(e)Q
Action Sante: Travesti(e)s et Transsexuel(le)s du Quebec
Information, Resources, Support and Workshops
for the Montreal area
c/o CACTUS, 1626 Saint-Hubert
Montreal, QC, H2L 3Z3
Pager (514) 890-7015

Gay Line Montreal
PO Box 384, Succ. H, Montreal, QC, H3G 2L1
(514) 866-5090 Toll Free: 1-888-505-1010 in QC
7pm to 11pm

FACT Quebec
PO Box 293, 5858 Cote de Neiges Blvd,
Montreal, QC, H3S 2S6

Le Spectre (Montreal)
(514) 528-1700
Contact Michelle de Ville.

Lesbian, Bisexual, Gay, and Transgendered Students
of McGill University (Montreal)
3480 McTavish Street, Room 429, Montreal, QC, H3A 1X9
(514) 398-6822
E-Mail: lbgtm@vub.mcgill.ca
Web: ssmu.mcgill.ca/lbgtm

Premier Contact - Outouais
Une Organisation qui offre des Services et du Support
et plus encore! Pour les personnes Transsexuelles, la
communaut Transgenre et la population qui veut en savoir plus, sur qui sont les personnes Transgenres.
Jose-Chantale Hubert - Coordonatrice
(819) 777-1441
Email: premiercontact@videotron.ca
Web: sites.netscape.net/premiercontact95/

Transgenre Montreal
Web: www.transgenre-montreal.com/

SASKATCHEWAN

Gays and Lesbians at U of S (Saskatoon)
Box 369 RPO, University, Saskatoon, SK, S7N 4J8
(306) 966-6615
E-Mail: glus.mail@usask.ca
Web: duke.usask.ca/~ss_glus

TERRITORIES

Gay and Lesbian Alliance Yukon
P.O. Box 31678, Whitehorse, YT, Y1A 6L3
Phone: 867-333-5800
Email: galayukon@canada.com
http://www.gaycanada.com/galayukon/index.html

General Trans Groups

Canada
http://groups.yahoo.com/group/TransCanada/

Vancouver
http://groups.yahoo.com/group/TransVancouver/

Transgender Mentoring
http://groups.yahoo.com/group/transgendermentoring/

Appendix 2: Introduction Letter

McGill University, Montreal

November 26, 2004

Dear Participant:

As part of my doctoral study at McGill University, I am studying Transgendered People's Life Experiences and Well-Being. This study is being done under the supervision of Prof. Peter Leonard, at the School of Social Work at McGill University.

There is very little done in this area in Canada. Variables for this research have been drawn from a previous study, existing literature in the field, and are designed to create new knowledge as well as add to the body of existing knowledge. The information will then be used to enhance our knowledge in the theoretical domain, as well as clinical practice and put forward questions for continuing research. Last but not least it is hoped to improve the quality of the education and training, that social workers, health care providers, and counselors/therapists receive regarding transgenderism.

Transgenderism includes a wide variety of gender expressions. In order to achieve the goals of this study, it is important that all of the people who fall under the transgender umbrella take part, including those who might call themselves transgendered, transsexuals, hermaphrodites or intersex or bi-genders, gender-benders, cross-dressers, and any androgynous individuals who do not conform to society's gender stereotypes.

You are asked to participate in a survey. The questionnaire you received via hardcopy or through the Net. To gain greater understanding of the data you provided, a follow-up study might be necessary. If you would agree in participating in a face-to-face interview, the time for the interview is set at approximately 45–90 minutes, please contact the researcher either via phone (toll-free) 1-866-251-5877, or email <hseidl@canada.com> to arrange your participation for a interview and to set a place and time.

Thank you in advance, for your time and effort.

Sincerely,

Helma Seidl, MSW, RSW, CCC
Doctoral Student
School of Social Work
McGill University
Email: hseidl@canada.com
Phone: (613) 749-8008
Phone: 1-866-251-5877

Prof. Peter Leonard
Assoc. Professor
School of Social Work
McGill University
Email: peter.leonard@mcgill.ca
Phone: (514) 398-7061

Appendix 3: Informed Consent for survey (paper copies)

INFORMED CONSENT FORM (SURVEY PARTICIPATION)

The purpose of the *Informed Consent Form* is to ensure that you, as the participant, understand the purpose of the research and the nature of your involvement. The *Informed Consent Form* must provide you with sufficient information on the research, in which you are about to get involved, in order to give you the opportunity to determine whether or not you want to participate.

Title: *Socially Constructed Gender Binary: Restricting a Healthy Transgender Self-Identity Development and Identity Re-Formation.*

Research Personnel: The following individuals are involved in the research project and may be contacted for further information. Helma Seidl, MSW, CCC, Principal Investigator, at (613) 749-8008, 1-866-251-5877, or <hseidl@canada.com>. Prof. Peter Leonard, Research Advisor, at (514) 398-7061, or <p+leonard@hotmail.com>. If you have any ethical concerns about this research, please contact Ms. Lynda McNeil, at (514) 398-6831. She is McGill University's Research Ethics Officer for Human Subjects.

Purpose: The purpose of this research is three-fold. The primary objective of the research is to gain a greater understanding of transgenderism and the transgender individual's experience. Secondary objective is to investigate the individual's Quality of Life and lastly, to look at the difference between the various transgender categories.

Requirements: You will be asked to fill out a survey, for which a postage-paid envelope is provided. Please place the *Informed Consent Form* in a separate postage-paid envelope, also provided for you.

Duration: The time to fill out the survey is set at approximately 60–90 minutes.

Potential Risk: There is no potential physical or psychological risk involved in this research. A list of peer support and counselling services is attached.

Anonymity/Confidentiality: The data collected in this research are strictly confidential. The data will be coded so that your name is not associated with your data. The data are made available only to the researchers associated with the project. If you wish feedback on any of the research outcomes, it will be provided. By signing this consent form, you agree that the information you provide may be used for scientific purposes as long privacy is maintained.

Right to Withdraw: You have the right to withdraw from the research at any time.

Signatures: I have read the above description on the research and understand the conditions of my participation. My signature indicates that I agree to participate in the research.

Participant

Name:_____

Signature:_____**Date:**_____

Researcher

Name: Helma Seidl, MSW; CCC; PhD Candidate

Signature:_____**Date:**_____

Appendix 4: Informed Consent for Questionnaire (send via interne)

INFORMED CONSENT

The purpose of the *Informed Consent Form* is to ensure that you, as the participant, understand the purpose of the research and the nature of your involvement. The *Informed Consent Form* must provide you with sufficient information on the research, in which you are about to get involved, in order to give you the opportunity to determine whether or not you want to participate.

Title: Survey of Transgendered People's Life Experiences and Well-Being.

Research Personnel: The following individuals are involved in the research project and may be contacted for further information. Helma Seidl, MSW, RSW, CCC, Principal Investigator, at (613) 749-8008, 1-866-251-5877, or <hseidl@canada.com>.
Prof. Peter Leonard, Research Advisor, at (514) 398-7061, or <p+leonard@hotmail.com>. If you have any ethical concerns about this research, please contact Ms. Lynda McNeil, at (514) 398-6831. She is McGill University's Research Ethics Officer for Human Subjects.

Purpose: This survey is being conducted to increase our understanding of transgenderism, the transgender individual's experience, and their well-being and quality of life. This information will then be used to inform and improve the quality of the education and training that social workers, health care providers, and counselors/therapists receive regarding transgenderism.

Requirements and Duration: You will be asked to complete a 60–90 minute survey that asks about your background, your childhood experiences, the nature of your transgenderism, your experiences of stress, and your well-being.

Potential Risk: You may find that the sensitive nature of some of the questions might contribute to feelings of distress or anxiety. In that event you have the right to refuse to answer any questions you don't want or withdraw from the research. A list of peer support and counselling services is attached.

Anonymity/Confidentiality: The data collected in this research are strictly confidential. The data will be only available to Helma Seidl, MSW, RSW, CCC, Principal Investigator and Prof. Peter Leonard, Research Advisor. I consent to the use of the written text in presentations and written products resulting from the study, provided that neither my name nor other identifying information will be associated with the transcript. If you wish feedback on any of the research outcomes, it will be provided. If you wish to participate you are provided with 2 options: via hardcopy or via internet. For the later the researcher approached a member of your community to

distribute this survey via Internet to you. You can email it directly to the researcher at <hseidl@canada.com>. To increase partaking the researcher also posted the survey to the making-a-difference.ca website, were you can fill it out and send it directly back to the researcher. At this point, the researcher will download it and code it, so that your name is not associated with your data. If you choose to take this route, please do not indicate any identifying information on the survey since it is anonymous. However, confidentiality is limited due to the nature of the Internet. In order to achieve complete anonymity you may prefer to download the survey, put it into an envelope do not write, any return address or any other identifying data on the envelope or questionnaire and mail it, **postage paid by recipient,** to:

Making a Difference Counselling and Consultation
At: Helma Seidl
200–436 MacLaren Street
Ottawa, Ontario
K2P 0M8

Right to Withdraw: You have the right to refuse to answer any question and to withdraw from the research at any time, for any reason.

Researcher

Name: Helma Seidl, MSW; RSW, CCC; Doctoral Candidate

Signature:_____ **Date:**_____

Appendix 5.0: Survey

Survey of Transgendered People's Life Experiences and Well-Being.

Instructions

This survey is divided into several sections. You are asked to respond to questions pertaining to: gender related behaviour, pattern of transgender behaviour, and childhood gender identity experiences, the later questions are tailored to male or female gender assignment at birth. Questions on perceived stress and queries on your experiences in the last 6 month are also included in this study. In addition, we are interested in your Quality of Life (QOL), as well as how do you describe yourself and your self-confidence. The demographic and background information will further help us to understand the specific needs of the transgender individual and the transgender community. At the end we added several open ended questions feel free to write as much or little you feel comfortable.

For yes /no questions, please check "yes" or "no"; for all other questions please follow the instruction provided to you at the beginning of each section or with the question. **Please note that there is no "right or wrong" answer.**

The following two section: Gender related behaviour and Pattern of Transgender Behaviour please use √ or follow the instruction.

Appendix 5.1: Gender-Related Behaviour Scale

GENDER-RELATED BEHAVIOUR

1. **How old were you when you began to question your gender?**
   Age 1–5 _____
   Age 6–10 _____
   Age 11–15 _____
   Age 16–20 _____
   Age 21–25 _____
   Age 26–35 _____
   Age 36–up _____

2. **During her pregnancy with you, what biological sex did your mother hope you would be?**

   ____ Male ____ Female ____ She had no preference ____ Don't know

3. **What, if any, name did your mother pick for you while she was pregnant?**

   ____ A male name ____A female name ____She didn't pick a name____ Don't know

The following 10 questions address your Childhood experiences (age 1-10):

1. **How carefree did you feel during your childhood (age 1-10)?**
   ____ Not at all ____ Slightly ____ Moderately ____ Very ___Extremely

5. **How strictly were traditional gender role behaviours (i.e., boys acting like boys and girls acting like girls) expected and enforced in your childhood home?**
   ____ Not at all ____ A little ____ Moderately ____ A good deal ____ A great deal

6. **How strictly were traditional gender role behaviours (i.e., boys acting like boys and girls acting like girls) expected and enforced in your childhood school?**
   ____ Not at all ____ A little ____ Moderately ____ A good deal ____ A great deal

7. **How strictly were traditional gender role behaviours (i.e., boys acting like boys and girls acting like girls) expected and enforced by your childhood friends?**
   ____ Not at all ____ A little ____ Moderately ____ A good deal ____ A great deal

8. **As a child (age 10 or less), how often did you try to conform to gender stereotypes so you could fit in?**
   ____ Never ____ Once or twice ____ Occasionally ____ Often ____ Very often

9. **During childhood were you allowed to play "dress-up" in the clothing of the opposite gender?**
____Not at all ____A little ____Sometimes ____Most of the time ____All of the time

10. **Were you allowed, at least for a time, to be a tomboy or a sissy?**
____Tomboy ____Sissy
____Not at all ____A little ____Sometimes ____Most of the time ____All of the time

11. **If you were a tomboy/sissy, did your parents ever tell you to change and behave like a girl/boy? If yes, at what age?**

☐ Yes ☐ No Age _____

12. **During childhood, what gender were your playmates?**
_____ Boys _____ Girls _____ Did not have playmates

13. **During your childhood, how often did your parents dress you in gender appropriate clothing? (According to your birth gender)**
_____ Never
_____ Rarely
_____ Sometimes
_____ About half the time
_____ Often
_____ Very often
_____ Always

The following 11 questions address your experiences during puberty (age 11-16):

14. **During puberty (age 11 - 16), how often did you try to conform to gender stereotypes so you could fit in?**
____ Never ____ Once or twice ____ Occasionally ____ Often ____ Very often

15. **How carefree did you feel during puberty?**
____ Not at all ____ Slightly ____ Moderately ____ Very ____ Extremely

16. **Did you learn your biological gender roles and expectations through social interactions with your family, peers and teachers?**

☐ Yes ☐ No

17. **Did the learned cues for gender appropriate behaviour as a boy/girl work for you or did you feel, that throughout puberty you were socially unskilled?**
____Not at all ____A little ____Sometimes ____Most of the time ____All of the time

18. During puberty did you spend time daydreaming of being the opposite gender?
__ Never ____ Once or twice ____ Occasionally ____ Often ____ Very often

19. Were you ever told that you acted like a "sissy" or a "fag" or "dyke" or anything like that?
____ Never ____ Once or twice ____ Occasionally ____ Often ____ Very often

20. Were you ever told to "act like a boy/man"?
____ Never ____ Once or twice ____ Occasionally ____ Often ____ Very often

21. Were you ever told to "act like a girl/woman"?
____ Never ____ Once or twice ____ Occasionally ____ Often ____ Very often

22. Were you pushed by family and peers to date? (If yes, please also check the enforcer)

☐ Yes
____Family ____Peers ____All of them

☐ No

23. Was your gender behaviour corrected? If yes, by whom?

☐ Yes
____Family ____Peers ____Teachers ____All of them

☐ No

24. Who taught you about masculinity/femininity?
____Family ____Peers ____Teachers ____All of them

The following 13 questions address your current experiences (age 17+):

25. Did you ever feel that as long you lived in your biological body you could never live up to the image of what you were taught a man/woman should be?
____Not at all ____A little ____Sometimes ____Most of the time ____All of the time

26. To establish "your gender identity" (i.e., gender identity opposite to your biological gender), do you use role-models?

☐ Yes ☐ No

27. Are any of these role models for you? (Please check those that apply.)

Friend(s) _____
Television character(s)_____
Co-worker(s)_____
Parent(s)_____
Other trans _____
Gender-specific fantasy image(s) _____
Gender according to gender stereotype(s) _____

Role models fitting specific masculine/feminine gender characteristic(s) or if any TV characters, whom and from what show? (Please describe)

_____
_____
_____
_____
_____

If any fantasy images, please describe.

_____
_____
_____

28. Are socially-constructed gender norms and expectations important for you?

☐ Yes ☐ No ☐ Don't know

29. Would you prefer a genderless society?

☐ Yes ☐ No ☐ Don't know

30. To what extent do you feel that a job should be gender appropriate (i.e., most people think nurses are female while firefighters are male jobs)?

____ Not at all ____ A little ____ Moderately ____ A good deal ____ A great deal

31. Please describe any gender-related characteristics that are important for you. If possible, use point form (e.g., gentle; Assertive), adding as many as you feel are needed to answer this question.)

-
-
-
-

32. Does your gender create any discomfort for you?

____Not at all ____A little ____Sometimes ____Most of the time ____All of the time

33. To what extent do you think <u>your job</u> is *gender inappropriate*, i.e., after transitioning you would like to change job; currently you feel unhappy with your job, because you think it is gender inappropriate).

____ Never ____ Once or twice ____ Occasionally ____ Often ____ Very often

34. How much did each of the following people influence your decision to work in the job you have?

Your family:

____ Not at all ____ A little ____ Moderately ____ A good deal ____ A great deal

Your friends:

____ Not at all ____ A little ____ Moderately ____ A good deal ____ A great deal

Your teachers:

____ Not at all ____ A little ____ Moderately ____ A good deal ____ A great deal

35. Do you feel guilty when you talk about transgenderism?

____Not at all ____A little ____Sometimes ____Most of the time ____All of the time

36. When, if ever, did you first start to hide your transgender feelings?

____ During childhood
____ During puberty
____ In early adulthood (19–25)
____ In adulthood (26+ years old)
____ Never

37. Do the cues for gender appropriate behaviour you learned in your childhood, currently work for you, or do you feel that they do not work and currently you experience difficulties in social interactions?

____Not at all ____A little ____Sometimes ____Most of the time ____All of the time

38. Do the cues for gender appropriate behaviour you learned in your childhood, currently work for you, or do you feel that they do not work and currently you experience difficulties in social interactions?

____Not at all ____A little ____Sometimes ____Most of the time ____All of the time

Appendix 5.2: Pattern of Transgender Behaviour Scale

PATTERN of TRANSGENDER BEHAVIOUR

1. How old were you when you first started engaging in cross-gender behaviours?
_____ years old

2. Do you experience periods (weeks/month) during which you do not cross-dress?

☐ Yes ☐ No

If you answered "YES" please answer question 3:

3. Why do you interrupted (stopped) cross-dressing for periods of time?
____ Guilt ____ Shame ____ Money ____ Time restrains ____ Other (Explain)

-
-
-

4. How often do you cross-dress?
____ 1–2 times/month ____ 1–2 times/week ____ 3–4 times/week ____ daily

5. After experiencing a dormant period during which you do not cross-dress, what initiates your cross-gender behaviour? (Select as many as you want)
____ Stress ____ Not feeling complete ____ Desire ____ Sexual Gratification

6. How stressed do you feel when you cannot engage in any cross-gender behaviours?
____ Not at all ____ A little ____ Moderately ____ A good deal ____ A great deal

7. Which of the following is the most important aspect of your cross-gender behaviour?
_____ Passing
_____ Feeling complete
_____ Feeling aroused
_____ Being able to shock people
_____ Being able to express both genders

8. How often are you aware of your body?
____ Never ____ A little ____Sometimes ____Most of the time ____All of the time

9. Did you ever get married hoping that your cross-gender behaviour would stop?

☐ Yes ☐ No

10. After you got married and your cross-gender feelings did not stop, did you come out to your partner?

☐ Yes ☐ No

11. If this was a perfect world, would you:

_____ Live full time as a woman (without hormones and without surgery)?
_____ Live full time as a woman (with hormones and without surgery)?
_____ Live full time as a woman (with hormones and with surgery)?
_____ Live full time as a man (without hormones and without surgery)?
_____ Live full time as a man (with hormones and without surgery)?
_____ Live full time as a man (with hormones and with surgery)?
_____ Live part time as a woman and part time as a man?
_____ Not change anything and live in the gender you were born?

Appendix 5.3a: Recalled Childhood Gender Identity Scale: Male version

CHILDHOOD GENDER IDENTITY

For each of the following questions, please circle the response that best describes your behaviour when you were a **child aged 12 or younger**. Please note that there are no "right or wrong' answers.

a. **If your physical/biological sex at birth was male or you were raised as a male, please answer questions 1 to 23 (i.e., do the "male version").**

b. **If your physical/biological sex at birth was female or you were raised as a female, please answer questions 24 to 46 (i.e., do the "female version").**

Male Version

1.) As a child, my favourite playmates were

a. always boys
b. usually boys
c. boys and girls equally
d. usually girls
e. always girls
f. I did not play with other children

2.) As a child, my best or closest friend was

a. always a boy
b. usually a boy
c. a boy or a girl
d. usually a girl
e. always a girl
f. I did not have a best or close friend

3.) As a child, my favourite toys and games were

a. always "masculine"
b. usually "masculine'
c. equally "masculine" and "feminine"
d. usually "feminine"
e. always "feminine"
f. neither "masculine" or "feminine"

4.) Compared to other boys, my activity level was

a. very high
b. higher than average
c. average
d. lower than average
e. very low

5.) As a child, I experimented with cosmetic (make-up) and Jewlery

a. as a favourite activity
b. frequently
c. once-in-a-while
d. very rarely
e. never

6.) As a child, the characters on TV or in the movies that I imitated or admired were

a. always girls or women
b. usually girls or women
c. girls/women and boys/men equally
d. usually boys or men
e. always boys or men
f. I did not imitate or admire characteristics on TV or in the movies

7.) As a child, I enjoyed playing sports such as baseball, hockey, basketball, and soccer

a. only with boys
b. usually with boys
c. with boys and girls equally
d. usually with girls
e. only with girls
f. I did not play these types of sports

8.) In fantasy or pretend play, I took the role

a. only of boys or men
b. usually of boys or men
c. boys/men and girls/women equally
d. usually of girls or women
e. only of girls or women
f. I did not do this types of pretend play

9.) In dress-up play I would

a. wear boys' or men's clothing all the time
b. usually wear boys' or men's clothing
c. half the time wear boys' or men's clothing and half the time wear girls' or women's clothing
d. usually wear girls' or women's clothing
e. wear girls' or women's clothing all the time
f. I did not do this type of play

10.) As a child, I felt

a. very masculine
b. somewhat masculine
c. masculine and feminine equally
d. somewhat feminine
e. very feminine
f. I did not feel masculine or feminine

11.) As a child, compared to other boys my age, I felt

a. much more masculine
b. somewhat more masculine
c. equally masculine
d. somewhat less masculine
e. much less masculine

12.) As a child, compared to my brother

a. much more masculine
b. somewhat more masculine
c. equally masculine
d. somewhat less masculine
e. much less masculine
f. I did not have a brother

[Note: If you have more than one brother, make your comparison with the brother closest in age to you.]

13.) As a child, I

a. always resented or disliked my sister
b. usually resented or disliked my sister
c. somewhat resented or disliked my sister
d. rarely resented or disliked my sister
e. never resented or disliked my sister
f. did not have a sister

[Note; If you had more than one sister, make your comparison with the sister closest in age to you.]

14.) As a child, my appearance (hair-style, clothing, etc.) was

a. very masculine
b. somewhat masculine
c. equally masculine and feminine
d. somewhat feminine
e. very feminine
f. neither masculine or feminine

15.) As a child, I

a. always enjoyed wearing dresses and other "feminine" clothes
b. usually enjoyed wearing dresses and other "feminine' clothes
c. sometimes enjoyed wearing dresses and other "feminine' clothes
d. rarely enjoyed wearing dresses and other "feminine" clothes
e. never enjoyed wearing dresses and other "feminine' clothes

16.) As a child, I was

a. emotionally closer to my mother than to my father
b. somewhat emotionally closer to my mother than to my father
c. equally close emotionally to my mother and to my father
d. somewhat emotionally closer to my father than to my mother
e. emotionally closer to my father than to my mother
f. not emotionally close to either my mother or to my father

17.) As a child, I

a. admired my mother and my father equally
b. admired my father more than my mother
c. admired my mother more than my father
d. admired neither my mother nor my father

18.) As a child, I had the reputation of a "sissy"

a. all of the time
b. most of the time
c. some of the time
d. on rare occasions
e. never

19.) As a child, I

a. always felt good about being a boy
b. usually felt good about being a boy
c. sometimes felt good about being a boy
d. rarely felt good about being a boy
e. never felt good about being a boy
f. never really thought about how I felt being a boy

20.) As a child, I had the desire to be a girl but did not tell anyone

a. almost always
b. frequently
c. sometimes
d. rarely
e. never

21.) As a child, I would tell others I wanted to be a girl

a. almost always
b. frequently
c. sometimes
d. rarely
e. never

22.) As a child, I

a. always felt that my mother cared about me
b. usually felt that my mother cared about me
c. sometimes felt that my mother cared about me
d. rarely felt that my mother cared about me
e. never felt that my mother cared about me
f. cannot answer because I did not live with my mother (or know her)

23.) As a child, I

a. always felt that my father cared about me
b. usually felt that my father cared about me
c. sometimes felt that my father cared about me
d. rarely felt that my father cared about me
e. never felt that my father cared about me
f. cannot answer because I did not live with my father (or know him)

Appendix 5.3b: Recalled Childhood Gender Identity Scale: Female version

Female Form

24.) As a child, my favourite playmate were

a. always boys
b. usually boys
c. boys and girls equally
d. usually girls
e. always girls
f. I did not play with other children

25.) As a child, my best or closest friend was

a. always a boy
b. usually a boy
c. a boy or a girl
d. usually a girl
e. always a girl
f. I did not have a best or close friend

26.) As a child, my favourite toys and games were

a. always "masculine"
b. usually "masculine"
c. equally "masculine" and "feminine"
d. usually "feminine"
e. always "feminine"
f. neither "masculine" or "feminine"

27.) Compared to other girls, my activity level was

a. very high
b. higher than average
c. average
d. lower than average
e. very low

28.) As a child, I experimented with cosmetic (make-up) and Jewelry

a. as a favourite activity
b. frequently
c. once-in-a-while
d. rarely
e. never

29.) As a child, the characters on TV or in the movies that I imitated or admired were

a. always girls or women
b. usually girls or women
c. girls/women and boys/men equally
d. usually boys or men
e. always boys or men
f. I did not imitate or admire characteristics on TV or in the movies

30.) As a child, I enjoyed playing sports such as baseball, hockey, basketball, and soccer

a. only with boys
b. usually with boys
c. with boys and girls equally
d. usually with girls
b. only with girls
c. I did not play these types of sports

31.) In fantasy or pretend play, I took the role

a. only of boys or men
b. usually of boys or men
c. boys/men and girls/women equally
d. usually of girls or women
e. only of girls or women
f. I did not do this types of pretend play

32.) In dress-up play I would

a. wear boys' or men's clothing all the time
b. usually wear boys' or men's clothing
c. half the time wear boys' or men's clothing and half the time wear girls' or
d. women's clothing
e. usually wear girls' or women's clothing
f. wear girls' or women's clothing all the time
g. I did not do this type of play

33.) As a child, I felt

a. very masculine
b. somewhat masculine
c. masculine and feminine equally
d. somewhat feminine
e. very feminine
f. I did not feel masculine or feminine

34.) As a child, compared to other girls my age, I felt

a. much more feminine
b. somewhat more feminine
c. equally feminine
d. somewhat less feminine
e. much less feminine

35.) As a child, compared to my sister (closest to you in age) I felt,

a. much more feminine
b. somewhat more feminine
c. equally feminine
d. somewhat less feminine
e. much less feminine
f. I did not have a sister

[Note: If you have more than one sister, make your comparison with the sister closest in age to you.]

36.) As a child, I

a. always resented or disliked my brother
b. usually resented or disliked my brother
c. sometimes resented or disliked my brother
d. rarely resented or disliked my brother
e. never resented or disliked my brother
f. I did not have a brother

[Note; If you had more than one brother, make your comparison with the brother closest in age to you.]

37.) As a child, my appearance (hair-style, clothing, etc.) was

a. very feminine
b. somewhat feminine
c. equally masculine and feminine
d. somewhat masculine
e. very masculine
f. neither masculine or feminine

38.) As a child, I

a. always enjoyed wearing dresses and other "feminine" clothes
b. usually enjoyed wearing dresses and other "feminine' clothes
c. Sometimes enjoyed wearing dresses and other "feminine' clothes
d. Rarely enjoyed wearing dresses and other "feminine" clothes
e. Never enjoyed wearing dresses and other "feminine' clothes

39.) As a child, I was

a. emotionally closer to my mother than to my father
b. somewhat emotionally closer to my mother than to my father
c. equally close emotionally to my mother and to my father
d. somewhat emotionally closer to my father than to my mother
e. emotionally closer to my father than to my mother
f. not emotionally closer to either my mother or to my father

40.) As a child, I

a. admired my mother and my father equally
b. admired my father more than my mother
c. admired my mother more than my father
d. admired neither my mother nor my father

41.) As a child, I had the reputation of a "tomboy"

a. all of the time
b. most of the time
c. some of the time
d. on rare occasions
e. never

42.) As a child, I

a. always felt good about being a girl
b. usually felt good about being a girl
c. sometimes felt good about being a girl
d. rarely felt good about being a girl
e. never felt good about being a girl
f. never really thought about how I felt being a girl

43.) As a child, I had the desire to be a boy but did not tell anyone

a. almost always
b. frequently
c. sometimes
d. rarely
e. never

44.) As a child, I would tell others I wanted to be a boy

a. almost always
b. frequently
c. sometimes
d. rarely
e. never

45.) As a child, I

a. always felt that my mother cared about me
b. usually felt that my mother cared about me
c. sometimes felt that my mother cared about me
d. rarely felt that my mother cared about me
e. never felt that my mother cared about me
f. cannot answer because I did not live with my mother (or know her)

46.) As a child, I

a. always felt that my father cared about me
b. usually felt that my father cared about me
c. sometimes felt that my father cared about me
d. rarely felt that my father cared about me
e. never felt that my father cared about me
f. cannot answer because I did not live with my father (or know him)

Appendix 5.4: Trauma Symptom Checklist

Experiences in the Last 6 Months

These questions ask about various experiences that you may or may not have had. Please circle the one answer that best describes **how often you have had each experience in the last 6 months**, using the following scale:

0	1	2	3
Never	A few times	Fairly often	Many times

Experience	Answer (circle)
1. Nightmares or bad dreams	0 1 2 3
2. Trying to forget about a bad time in your life	0 1 2 3
3. Irritability or moodiness	0 1 2 3
4. Stopping yourself from thinking about the past	0 1 2 3
5. Getting angry about something that wasn't very important	0 1 2 3
6. Feeling empty inside	0 1 2 3
7. Sadness	0 1 2 3
8. Flashbacks (sudden memories of upsetting things)	0 1 2 3
9. Not being satisfied with your sex life	0 1 2 3
10. Feeling like you were outside your body	0 1 2 3
11. Lower back pain	0 1 2 3
12. Sudden disturbing memories when you were not	0 1 2 3
expecting them	0 1 2 3
13. Wanting to cry	0 1 2 3
14. Not feeling happy	0 1 2 3
15. Becoming angry for little or no reason	0 1 2 3
16. Feeling like you don't know who you really are	0 1 2 3
17. Feeling depressed	0 1 2 3
18. Having sex with someone you hardly knew	0 1 2 3
19. Thoughts or fantasies about hurting someone	0 1 2 3
20. Your mind going blank	0 1 2 3

0	1	2	3
Never	A few times	Fairly often	Many times

	Experience	**Answer (circle)**
21.	Fainting	0 1 2 3
22.	Periods of trembling or shaking	0 1 2 3
23.	Pushing painful memories out of your mind	0 1 2 3
24.	Not understanding why you did something	0 1 2 3
25.	Threatening or attempting suicide	0 1 2 3
26.	Feeling like you were watching yourself from far away	0 1 2 3
27.	Feeling tense or "on edge"	0 1 2 3
28.	Getting into trouble because of sex	0 1 2 3
29.	Not feeling like your real self	0 1 2 3
30.	Wishing you were dead	0 1 2 3
31.	Worrying about things	0 1 2 3
32.	Not being sure of what you want in life	0 1 2 3
33.	Bad thoughts or feelings during sex	0 1 2 3
34.	Being easily annoyed by other people	0 1 2 3
35.	Starting arguments or picking fights to get your anger out	0 1 2 3
36.	Having sex or being sexual to keep from feeling lonely or sad	0 1 2 3
37.	Getting angry when you didn't want to	0 1 2 3
38.	Not being able to feel your emotions	0 1 2 3
39.	Confusion about your sexual feelings	0 1 2 3
40.	Using non-prescribed drugs other than marijuana	0 1 2 3
41.	Feeling jumpy	0 1 2 3
42.	Absent-mindedness	0 1 2 3
43.	Feeling paralyzed for minutes at a time	0 1 2 3
44.	Needing other people to tell you what to do	0 1 2 3
45.	Yelling or telling people off when you shouldn't have	0 1 2 3
46.	Flirting or "coming on" to someone to get attention	0 1 2 3

0	1	2	3
Never	A few times	Fairly often	Many times

	Experience	**Answer (circle)**
47.	Sexual thoughts or feelings when you thought you shouldn't have them	0 1 2 3
48.	Intentionally hurting yourself (e.g., scratching, cutting or burning) even though you weren't trying to commit suicide	0 1 2 3
49.	Aches and pains	0 1 2 3
50.	Sexual fantasies about being dominated or overpowered	0 1 2 3
51.	High anxiety	0 1 2 3
52.	Problems in your sexual relations with another person	0 1 2 3
53.	Wishing you had more money	0 1 2 3
54.	Nervousness	0 1 2 3
55.	Getting confused about what you thought or believed	0 1 2 3
56.	Feeling tired	0 1 2 3
57.	Feeling mad or angry inside	0 1 2 3
58.	Getting into trouble because of your drinking	0 1 2 3
59.	Staying away from certain people or places because they reminded you of something	0 1 2 3
60.	One side of your body going numb	0 1 2 3
61.	Wishing you could stop thinking about sex	0 1 2 3
62.	Suddenly remembering something upsetting from the past	0 1 2 3
63.	Wanting to hit someone or something	0 1 2 3
64.	Feeling hopeless	0 1 2 3
65.	Hearing someone talk to you who wasn't really there	0 1 2 3
66.	Suddenly being reminded of something bad	0 1 2 3
67.	Trying to block out certain memories	0 1 2 3
68.	Sexual problems	0 1 2 3
69.	Using sex to feel powerful or important	0 1 2 3
70.	Violent dreams	0 1 2 3
71.	Acting "sexy" even though you really didn't want sex	0 1 2 3

0	1	2	3
Never	A few times	Fairly often	Many times

	Experience	Answer (circle)
72.	Just for a moment, hearing or seeing something upsetting that happened earlier in your life	0 1 2 3
73.	Using sex to get love or attention	0 1 2 3
74.	Frightening or upsetting thoughts popping into your mind	0 1 2 3
75.	Getting your own feelings mixed up with someone else's	0 1 2 3
76.	Wanting to have sex with someone who you knew was bad for you	0 1 2 3
77.	Feeling ashamed about your sexual feelings or behaviour	0 1 2 3
78.	Trying to keep from being alone	0 1 2 3
79.	Losing your sense of taste	0 1 2 3
80.	Feeling worthless	0 1 2 3
81.	Your feelings or thoughts changing when you were with other people	0 1 2 3
82.	Having sex that had to be kept a secret from other people	0 1 2 3
83.	Worrying that someone is trying to steal your ideas	0 1 2 3
84.	Not letting yourself feel bad about the past	0 1 2 3
85.	Feeling like things weren't real	0 1 2 3
86.	Feeling like you were in a dream	0 1 2 3
87.	Not eating or sleeping for 2 or more days	0 1 2 3
88.	Trying not to have any feelings about something that once hurt you	0 1 2 3
89.	Daydreaming	0 1 2 3
90.	Trying not to think or talk about things in your life that were painful	0 1 2 3
91.	Feeling like life wasn't worth living	0 1 2 3
92.	Being startled or frightened by sudden noises	0 1 2 3
93.	Seeing people from the spirit world	0 1 2 3

0	1	2	3
Never	A few times	Fairly often	Many times

Experience	Answer (circle)
94. Trouble controlling your temper	0 1 2 3
95. Being easily influenced by others	0 1 2 3
96. Wishing you didn't have any sexual feelings	0 1 2 3
97. Wanting to set fire to a public building	0 1 2 3
98. Feeling afraid you might die or be injured	0 1 2 3
99. Feeling so depressed that you avoided people	0 1 2 3
100. Thinking that someone was reading your mind	0 1 2 3

Appendix 5.5: Bem-Sex Role Inventory (BSRI)

Self-Description Questionnaire

For each of the following 60 characteristics, please rate the extent to which it describes you by putting the most appropriate number, beside the characteristic: Please do not leave any characteristics unmarked, if possible.

1 = Never or almost never true
2 = Usually not true
3 = Sometimes but infrequently true
4 = Occasionally true
5 = Often true
6 = Usually true
7 = Almost or almost always true

Answer	Characteristic	Answer	Characteristic	Answer	Characteristic
____	Defend my own beliefs	____	Affectionate	____	Conscientious
____	Independent	____	Sympathetic	____	Moody
____	Assertive	____	Sensitive to the needs of others	____	Reliable
____	Strong personality	____	Understanding	____	Jealous
____	Forceful	____	Compassionate	____	Truthful
____	Have leadership abilities	____	Eager to soothe hurt feelings	____	Secretive
____	Willing to take risks	____	Warm	____	Adaptable
____	Dominant	____	Tender	____	Conceited
____	Willing to take a stand	____	Love children	____	Tactful
____	Aggressive	____	Gentle	____	Conventional
____	Self-reliant	____	Yielding	____	Helpful
____	Athletic	____	Cheerful	____	Unsystematic
____	Analytical	____	Shy	____	Inefficient

____Make decisions easily	____Flatterable	____Theatrical
____Self-sufficient	____Loyal	____Happy
____Individualistic	____Soft-spoken	____Unpredictable
____Masculine	____Gullible	____Solemn
____Competitive	____Childlike	____Likeable
____Ambitious	____Do not use harsh language	____Sincere
____Act as a leader	____Feminine	____Friendly

Appendix 5.6: The Memorial University Scale of Happiness (MUNSH)

Quality of Life Questions (1)

In the past month**, have you ever felt** (please circle):

1. On top of the world	Yes	No	Don't know
2. In high spirits	Y	N	DK
3. Particularly content with your life	Y	N	DK
4. Lucky	Y	N	DK
5. Very lonely or remote from people	Y	N	DK
6. Bored	Y	N	DK
7. Depressed or very unhappy	Y	N	DK
8. Flustered because you didn't know what to do	Y	N	DK
9. Bitter about the way your life has turned out	Y	N	DK
10. Generally satisfied with the way your life has turned out	Y	N	DK

The next 14 questions have to do with more general life experiences.
Please indicate whether or not these statements are true for you.

11. This is the dreariest time of my life	Yes	No	Don't know
12. I am just as happy as when I was younger	Y	N	DK
13. Most of the things I do are boring or monotonous	Y	N	DK
14. The things I do are as interesting to me as they ever were	Y	N	DK
15. As I look back on my life, I am fairly well satisfied	Y	N	DK
16. Things keep getting worse as I get older	Y	N	DK
17. I often feel lonely	Y	N	DK
18. Little things bother me more this year	Y	N	DK
19. I like living in this city (town, etc.)	Y	N	DK
20. I sometimes feel that life isn't worth living	Y	N	DK

21.	I am as happy now as I was when I was younger	Y	N	DK
22.	Life is hard for me most of the time	Y	N	DK
23.	I am satisfied with my life today	Y	N	DK
24.	My health is as good as, or better than, most people my age	Y	N	DK

Appendix 5.7: Bradley Well-Being Scale (BWB)

Quality of Life (2)

Please indicate how often have you have had each experience in **the past few weeks**, using the following scale:

0	1	2	3
Never	**Almost never**	**Some times**	**All the time**

1. I feel that I am useful and needed	3	2	1	0
2. I have crying spells or feel like it	3	2	1	0
3. I find I can think quite clearly	3	2	1	0
4. My life is pretty full	3	2	1	0
5. I feel downhearted and blue	3	2	1	0
6. I enjoy the things I do	3	2	1	0
7. I feel nervous and anxious	3	2	1	0
8. I feel afraid for no reason at all	3	2	1	0
9. I get upset easily or feel panicky	3	2	1	0
10. I feel like I'm falling apart and going to pieces	3	2	1	0
11. I feel calm and can sit still easily	3	2	1	0
12. I fall asleep easily and get a good night's rest	3	2	1	0
13. I feel energetic, active or vigorous	3	2	1	0
14. I feel dull or sluggish	3	2	1	0
15. I feel tired, worn out, used up, or exhausted	3	2	1	0
16. I have been waking up feeling fresh and rested	3	2	1	0
17. I have been happy, satisfied, or pleased with my personal life	3	2	1	0
18. I have felt well adjusted to my life situation	3	2	1	0
19. I have lived the kind of life I wanted to	3	2	1	0
20. I have felt eager to tackle my daily tasks or make new decisions	3	2	1	0

21. I have felt I could easily handle or cope with any serious problem or major change in my life	3	2	1	0
22. My daily life has been full of things that were interesting to me	3	2	1	0

Appendix 5.8: Self-Confidence Scale (Oakley)

SELF CONFIDENCE SCALE

The next questions ask about your overall level of confidence. Please indicate how you feel about each of the following statements by **circling the number** which best indicates how much you agree or disagree, using the following scale.

+2 Strongly Agree	+1 Slightly Agree	0 Neither Agree/ nor Disagree	-1 Slightly Disagree	-2 Strongly Disagree

1.	I would describe myself as self-confident	+2	+1	0	-1	-2
2.	I feel confident about my appearance	+2	+1	0	-1	-2
3.	When in a group of people, I have trouble thinking of what to say	+2	+1	0	-1	-2
4.	I feel uncomfortable in large groups	+2	+1	0	-1	-2
5.	I would describe myself as self-critical	+2	+1	0	-1	-2
6.	I feel confident meeting new people	+2	+1	0	-1	-2
7.	It is hard for me to start a conversation with strangers	+2	+1	0	-1	-2
8.	I frequently find it difficult to defend my point of view when confronted with the opinions of others	+2	+1	0	-1	-2
9.	I feel comfortable in most social situations	+2	+1	0	-1	-2
10.	I am often harder on myself than on others	+2	+1	0	-1	-2
11.	I feel I can confidently approach and deal with most people	+2	+1	0	-1	-2
12.	I feel less confident now than when I was younger	+2	+1	0	-1	-2

Appendix 5.9: Perceived Stress Scale (PSS)

PERCEIVED STRESS

The questions in this section ask you about feelings and thoughts **during the last month.** Each question asks you how often you felt or thought a certain way. Please circle the number.

0	1	2	3	4
Never	Almost never	Sometimes	Fairly often	Very often

1. In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2. In the last month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
3. In the last month, how often have you felt nervous and "stressed"?	0	1	2	3	4
4. In the last month, how often have you felt that things were going your way?	0	1	2	3	4
5. In the last month, how often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
6. In the last month, how often have you been able to control irritations in your life?	0	1	2	3	4
7. In the last month, how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
8. In the last month, how often have you felt that you were on top of things?	0	1	2	3	4
9. In the last month, how often have you been angered because of things that were outside of your control?	0	1	2	3	4
10. In the last month, how often have you felt difficulties were pilling up so high that you could not overcome them?	0	1	2	3	4

Appendix 5.10: Personal Demographics

Background Information

For each of the following questions, please pick one which describes you by putting a check (√ or **X**): Please do not leave any answers unmarked, if possible.

1. Your age: _____ years old.

Your chromosomal sex (√ one):
_____ XX (female)
_____ XY (male)
____ Other - please specify: _____

3. Anatomical Sex/ Genitalia
_____Female
_____Male
_____Other (Please specify) _____

4. Preferred Gender Expression:
_____Woman

_____Man

_____Other (Please specify) _____

5. Which of the following expressions best reflects your identity? (Tick one)
_____Transgendered (24/7 [full-time] without hormone therapy)
_____Transgendered (24/7 [full-time] with hormone therapy)
_____Cross-dresser
_____Transsexuals (Pre-OP)
_____Transsexual (Post-OP)
_____Hermaphrodite / intersex
_____Bi-gender
_____Gender-bender
_____Androgynous
_____Gender questioning
_____Transvestite (use clothing of opposite sex for pleasure only)
_____Drag-Queen, (Gender Questioning)
_____Drag-King (Gender Questioning)
_____Drag-Queen, (with no questions about your gender identity)
_____Drag-King, (with no questions about your gender identity)

6. Ethnic background:

_____English
_____French
_____Other - please specify: _____

7. Racial background:

_____Caucasian (White)
_____African American
_____Asian
_____Hispanic
_____Aboriginal
_____Other - please specify: _____

8. Religion:

_____Anglican
_____Buddhism
_____Catholic
_____Muslim
_____Protestant
_____Wiccan
_____Agnostic
_____Atheist
_____Other (Please specify) _____
_____None

9. Marital status:

_____Single
_____Married
_____Common Law
_____Divorced
_____Separated
_____Widowed
_____Other - please specify: _____

10. Income:

_____$5000 - $14,999
_____$15,000 - $24,999
_____$25,000 - $34,999
_____$35,000-$44,999
_____$45,000-$54,999
_____$55,000-$74,999
_____$75,000-$99,999
_____Over $100,000

11. Educational background: (Please check [√] off or circle your answer)

_____Elementary School
_____High School
_____Some College Education Years 1 2 3 4
_____University-Undergraduate Years 1 2 3 4
_____Masters
_____PhD
_____Post-Doctoral Education

12. Employment:

_____Working/Employed
_____Working/Self-Employed
_____Unemployed but Volunteering
_____Unemployed
_____Disability
_____Between Jobs/In Transition
_____Retired
_____Student

13. Occupation:

_____High Tech
_____Government
_____Military
_____Ex-Military
_____Police/RCMP
_____Professional
_____Blue Collar

Please describe your occupation in words:

_____
_____
_____

14. Sexual Orientation (In your self-identified gender)

_____Gay
_____Bisexual
_____Heterosexual
_____Asexual
_____Questioning

15. Location of Residence:

___ Province or Territory:
___ Alberta
___ British Columbia
___ Manitoba
___ New Brunswick
___ Newfoundland/ Labrador
___ North West Territories
___ Nova Scotia
___ Nunavut
___ Ontario
___ Prince Edward Island
___ Quebec
___ Saskatchewan
___ Other - Please specify _____

City or Town _____

16. Type of Residential Area:

_____Urban
_____Rural
_____Suburban

17. Citizenship:

_____Canadian (born in Canada)
_____Canadian Citizen (by naturalization)
_____Landed immigrant
_____Refugee
_____Permanent residence in Canada
_____Canadian residing outside Canada
_____Student or work visa
_____Other – Please indicate country _____

18. Have you ever received counselling?

☐ Yes ☐ No

If yes:

Are your currently in counselling? ☐ *Yes* ☐ *No*

How satisfied are/were you with your counselling experience?

-3	-2	-1	0	+1	+2	+3
Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Neutral	Slightly Satisfied	Moderately Satisfied	Very Satisfied

Open –Ended Questions

Listed below are several questions that we would like you to answer. Please feel free to write as much or as little as you like. If you need more space, please use the back of the page or add more pages if necessary.

1.) In your opinion how much did family and/or peer pressure cause you to repress your transgenderism? Can you describe some of the pressure tactics that your family and/or peers used?

2.) In the past, was there any shame or guilt associated with your transgenderism, and if so, how did you deal with these feelings of guilt and shame?

2.a) At the current time are there any feelings of guilt or shame associated with your transgenderism, and if so, how do you deal now with these feelings of guilt and shame?

2. b) During your upbringing (i.e., childhood or puberty), what years were the most difficult for you and why?

3.) Do you think that you experienced a socially accepted, gender specific upbringing, and if so, was gender appropriate behaviour, reinforced by your family, peers, and the school environment? Can you give some examples?

4.) Does your body give you any discomfort and, if so, how and/or why?

5.) Can you accept and live comfortably with both your male and female personae?

6.) Do you know other transgender people and if so what was your first reaction to meeting them?

6a.) You've just come away from meeting some new people for the first time. Do you worry about what they thought of you and your gender?

Continuing question 6.a) Can you describe your feelings and thoughts you had afterwards?

6.b) When you get up in the morning and look at yourself in the mirror, how to you behave toward yourself?

7.) What part(s) of your body do you acknowledge and what part(s) do you avoid, when you look at yourself in the mirror?

7.a) Who taught you to view yourself in this way?

Is there anything else that you think we should know in order to more fully understand transgenderism?

Your participation was greatly appreciated, thank you.

Appendix 6: User IDs

Dumbell
727605
Reece
Kenda L
Anna Maria
Paul_will
Rootbear
Karentv
Can743v
Kitten
Corvus
Georgie
cpi23
2515151
tt_mcginn
saramara
StephanyTS
Caitlin
Margaliz
MLM
Julia
Alxpar
Vauuav
Nevets
Rwash
Bobbi Sue
Deniseann
Rivers
Karenc
Mellian
Alex
cathy_1949
Karenz
advent6
mitchmd
desseb
aki kaze
darla
pink lady

Titus7811
Robin Sout
trannybear
Bunny L
BCTall
88975
chrisl
mkcjzb
SamanthaP
Elizabeth
666666
Jkblack
cindy
mirella214
devonmac
ambersmith
alaina
mattyboy
lauraellyn
CosmicTami
Willow
Merlin
Henrietta
frostfire
nz
Andromeda
Menace(d)
Cdpaula
LinK
Jonah
briannaRI
suzie_cd
Prettyone
charity2b
sarahcg
Virginia
char
bob
19

ab625
Lady Fair (h4)
darlie
cjfvic
Girl
Mandyniki
Cheryl
KimMills
rcand1995
Kyrie
Michelle_s
lynnspa
petra
Stepanie
alyssao71
mla9rlx7
wine
C_saoirse
ecurb
Confused
Crystal
oted158
Leslea
Journey1
taylor k
Anngarvald
Nikkii248
asdfghjklo
Tyresias
chloecd200
Quetzal
84
cassy_au
sussy01
annie
lindap
here I am
joie

1979SS
blank
sacchi
151154
LT Sal
iceman
liffe
OttFunkyTS
kailynbarr
Marissa
Sabrina
anneg
guy_a
carol
JADriver
nancya
Samantha
Valerie
comoxbcrs
siam
RandiP
bobcat
katiets
circuitgirl
MelindaPA
1903
transstate
darkesta
DJ_Izumi
ellenora
carpete
Maria
mimivogue
gherg
tad
marcus
belinda
asasas

Signature: I have read the above description of the study and understand the conditions of my participation. My signature indicates that I agree to participate in the study.

Please check one of each pair of options.

☐ Yes I consent to have my interview taped.

☐ No I do **not** consent to have my interview taped.

☐ Yes I consent to the use of direct quotes in presentations and written products resulting from the study, provided that neither my name nor other identifying information will be associated with the transcript.

☐ No I do **not** consent to the use of direct quotes in presentations or written products resulting from the study.

Participant

Signature:_____Date:_____

Researcher

Name: Helma Seidl, MSW; RSW, CCC; Doctoral Candidate

Signature:_____Date:_____

Appendix: 8 Face-to-Face Interview Questions

FACE-TO-FACE INTERVIEW QUESTIONS

1.) What would be the label that you would give to yourself: TG 24/7 without HRT, TG 24/7 with HRT, CD, TS pre-op, TS post-op, Hermaphrodite or Intersex, Bi-gender, Gender-bender, Androgynous, Gender questioning, Female, Male, TG-Women, TG-Man?

2.) Can you describe in your own words if your biological gender upbringing during childhood, adolescence and early to mid adulthood was influenced by society (family, peers, teachers, others)?

3.) If so, in your opinion how did this affect your QOL during the different developmental timelines (childhood, adolescence and early to mid adulthood)?

4.) What influence does society (again: family, peers, teachers, others) on your gender-identity now?

5.) What influence does society (again: family, peers, teachers, others) have on the QOL you experience now?

6.) During your upbringing and now, can you relate to issues such as: shame, guilt, loss, and trauma? Can you talk about your own experience?

7.) Do you think that health (Doctors), mental health (psychiatrists, psychologists, and social worker) understands transgenderism and the issues affecting TG people?

8.) What would you change in the education of health professionals and counselors/therapists?

9.) What you think are the differences between TG 24/7 without HRT, TG 24/7 with HRT, CD, TS pre-op, TS post-op, Hermaphrodite or Intersex, Bi-gender, Gender-bender, Androgynous, Gender questioning, Female, Male, TG-Women, TG-Man and are the groups differently affected by social gender norms and expectations?

10.) How important is it for you to find a biological reason for transgenderism?

11.) Do you prefer a gender-binary or would you prefer gender-fluidity?

12.) In your opinion what to we need to change to achieve gender openness and acceptance of TG people in the current social structure?

13.) Free flowing talk about their experience of the influence of gender-norms and expectations on their QOL and especially their own gender identity development.

Appendix: 11 Amendment

1.) The purposes of this thesis were multiple. Since the current terminology is often confusing to clinicians as well as to transgender people, a new terminology was created. This was achieved by clustering the spectrum of transgender identities into two groups – fixed or fluid.

Subsequently transgender people's QOL was investigated. Given that these terminologies were never used before, two different QOL tools were tested for their reliability using these particular terminologies for this population.

The final part of the research was to offer participants an opportunity to talk in length about their life experience, gender pressures and traumatic events that they experienced in childhood, adolescence or even as adults because these all influence their QOL.

Because there is not enough understanding of transgenderism it was important to include a detailed section on history in this thesis. Transgenderism was viewed for many years as an illness. Understanding transgenderism through the historical context will help to deconstruct the belief that transgenderism is an illness. The deconstruction of this assumption was furthermore achieved by testing a specific QOL tool, the BWB scale. A scale that is reliable in testing the QOL for people with illnesses. It was established before hand that the BWB scale would not be useful for the transgender population since transgenderism is not an illness. The test results demonstrated that the BWB scale was unacceptably low which lead to the exclusion of this particular scale.

I chose to employ a mixed method of quantitative and qualitative approaches. Barbour (1998) suggested that using a multimethod study is often a pragmatic one in that it recognizes the incomplete view of using only one method over the other which is especially important when studying a under researched or new subject matter.

2.) First the internal consistency reliability was tested to assess the homogeneity of the instruments. This is according to Rubin and Babbie (1989) a practical and common way to test reliability of written instruments. The best method of assessment is to use coefficient alpha because it equals the average of all correlations, this was done with SPSS computer software for data analysis.

The fixed and the fluid groups were used as the independent variable in the quantitative analysis. However, Rubin and Babbie (1989) identified "that any given variable might be treated as *independent* in one part of an analysis and dependent in another part of the analysis" (G-4 Glossery).

3.) The research method used to analyze the qualitative data was grounded theory (Glaser and Strauss, 1967). Since qualitative data is usually large, messy and discursive, the data had to be reduced. The reduction was done through cross-sectional coding and retrieving method. This method is felt to offer a systematic overview and aid in finding themes, concepts and categories.

4.) Understanding of the difference between the fixed and fluid transgender population will not only influence the selection of treatment modality it also will determine the failure or the success of treatment outcome. Transitioning a fluid transgender individual would be detrimental to the individuals QOL. Therefore it is important to know and acknowledge the difference of a fixed or fluid gender identity.