



ranZnation

A report on the health and wellbeing
of transgendered people in Australia
and New Zealand

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Executive Summary

Background

This research has its beginnings in an act of transgender activism, arising as it did out of dissatisfaction with the capacity of the 2005 Private Lives project (Pitts, Smith, Mitchell, & Patel, 2006, p. 65) to capture the complexity of transgender lives. A central pivot in the concerns of the transgender communities about health services is that of **recognition**. Practices of medicine are implicated in many of the attempts by transgender people to achieve positive health and self- and social-recognition for their preferred gender. Additionally, recognition on formal documentary records is, in many cases, dependent upon certified medical intervention.

Methodology and Recruitment

Studies investigating health and wellbeing of transgender people have typically been conducted in medical environments such as gender clinics and through sexual health centres. This study set out to recruit the broadest possible community sample by using a range of recruitment techniques and an online survey. This methodology provides an opportunity for participants to protect their identity, and reduces fear of discovery or being 'outed' in terms of their non-conforming gender identity or feelings. To capture the variation of identity and experience present in this population, a combination of quantitative and qualitative questions was used in the survey. Participants were given opportunity, throughout the survey, to give an account of their lives and experiences with health services, in their own way and in their own words and expression.

About the respondents

In total, 253 respondents completed the survey. Of these 229 were from Australia (90.5%) and 24 (9.5%) were from New Zealand. They included people from all states and territories in Australia and from both islands of New Zealand, mostly from the North Island. The majority of respondents had been born in the country in which they currently lived and 1.6% were of Aboriginal or Torres Strait Islander background and 1.6% were of Maori background. Mean age of the total sample was 41.1 years, and age ranged between 18 and 73 years.

Sex, gender and identity

Some of the most complex and contested issues in any study of transgender people come from the diverse history and range of transgender and transsexual theories, and the consequent sex, gender and identity categories that are used in medical, other professional and everyday discourses. On their original birth certificate 75.5% reported male and 24.5% female. Participants whose sex was assigned male at birth were on average older than those who were assigned female. In relation to gender identity, it is common for transgender people to resist attempts to classify their lived experience through the use of simple categories. Of the participants, 79.0% used a single term to describe their current gender identity, 16.3% two terms, and 4.8% used three terms. There were two dominant patterns of response. The first was to choose words indicating either 'male' or 'female'. The second was to choose words which conveyed the sense of some element of transition, for example "transman". Of the preferred gender identity terms, slightly more than half (127) were the words 'male' or 'female' or similar. One hundred and thirteen (44.8%) of the preferred words related to transition and another commonly used reference point was to use the term "queer" as part of an identity term.

In this study the majority of participants identified with one of the four standard categories of sexual identity, namely heterosexual, bisexual, homosexual, and asexual. Others used single words such as "Non-specific" (TN129) and "Variable (not bisexual)" (TN27) to indicate that they did not fit the usual labels of sexual identity.

Health and wellbeing

Respondents rated their health on a five point scale from 'poor' to 'excellent'. The majority of the sample rated their health as 'good' or 'very good' (35.2% and 28.9% respectively). These ratings of general health were nevertheless comparably lower than those reported in the Australian National Health Survey (ABS, 2006b). On the SF36 scale, which is a standard measure of health, participants had poorer health ratings than the general population in Australia and New Zealand. However a majority of participants reported that they were happy about their life, with almost two thirds reporting that they felt mostly or extremely happy.

There are many reasons why a transgender person may experience depression which may be related or unrelated to gender identity. Participants in this survey showed a rate of depression much higher than the level of depression found in the general Australian population with assigned males being twice as likely to experience depression than assigned females. It was of considerable concern that one in four respondents reported suicidal thoughts in the two weeks before they completed the survey.

Most participants took active measures to sustain their health and wellbeing, particularly by eating well and exercising regularly. Social contact was reported as another important aspect of health and well-being, spending time with family, friends, and partners. Having meaningful work was significant for participants, whether this was paid employment, volunteer work, or housework and gardening. Focussing on personal development, having goals to achieve, and doing things for self-motivation were also part of participants' health and well-being.

Health service use and experiences

For transgender people, health issues associated with gender and transitioning are multi-faceted and may be difficult. However positive interaction with the medical community could be a profoundly legitimating experience. Four out of every five participants reported that they had a regular doctor (82.1%) and also used a wide range of other health services. The most commonly accessed health service was a mental health professional, used by almost half the sample. Half (50.7%) of the Australian respondents had private health insurance and just over half of those (51.3%) said that they had used private health insurance for a gender-related matter. One third of participants who did not have private health insurance cited a reason other than cost for their decision.

Participants described their best and worst experiences with a health practitioner or health service in relation to being transgender. For many respondents, the best experiences in the health system involved encounters where they felt accepted and supported by their practitioners. Respondents' worst experiences with health services usually involved encounters where they were met with hostility and not treated respectfully.

A number of participants said that they had never spoken to health professionals about transgender health issues and others said that they were often reluctant to disclose their transgender status with practitioners when being treated for health problems. Practitioners were greatly appreciated if they were knowledgeable and experienced in transgender issues, and if they were sensitive to gender diversity and to the difficulties that transgender people face in health care settings.

Participants were also acutely aware of needing to meet certain criteria in order to qualify for hormone treatment and surgery and reported a diversity of experiences of this process. The scarcity of health services for transgender people in the public system and long waiting periods for accessing services were also problems. Nevertheless, two thirds (66.7%) of participants reported that they had received enough satisfactory information about their gender issues from health practitioners/services with many also relying on the internet for information about health matters.

Use of hormone treatments

Almost three quarters (73.1%) of the sample had used hormone treatments. Of the 26.9% who had not, almost half (45.5%) did not intend to do so in the future, around a third (36.4%) said that they would in the future, and the remainder (18.2%) were not sure. In addition, 13.1% participants had used non-medically prescribed hormones or supplements for gender-related reasons. Most participants who had used hormones reported both positive and negative aspects of the therapy. The positive aspects that participants reported were mainly concerned with bodily changes, and the feeling of well-being that followed these changes. The negative aspects of hormone therapy reported included side-effects of treatment such as headaches, migraines, nausea, allergic reactions, and digestive problems, as well as longer term effects on their health such as liver disease, high cholesterol, and cardiac problems. Many participants who had had hormone therapy felt that it was a necessary part of their lives. A small number, who had decided not to go on hormone therapy, did so because they did not feel that it was necessary for their well being. Health and financial concerns were also reasons for opting not to go on hormone therapy.

Surgery

The majority of respondents had not had any form of surgery, while 39.1% respondents reported having had some form of surgery. A similar proportion of assigned males had had surgery as assigned females (39.3% and 38.7% respectively). Participants reported on 15 different surgical procedures which were carried out in both the public and private system. Seventeen participants indicated that they had undergone surgery overseas. Participants who had had surgery were older than those who had not had surgery. Most of those who had undergone surgery described a deep sense of satisfaction, relief and completeness with having a body that they have felt to be right for them, despite the pain and sometimes complications of surgery. Participants named a variety of barriers to obtaining surgery including work, family, legal issues, access to specialists, although cost was by far the most significant barrier.

Changing documentation

Half of respondents (50.6%) reported that they had tried to amend public documentation to reflect their current gender identity and this was crucial to a sense of personal and identity recognition. Experiences and outcomes varied, and even within the same organization there appeared to be different practices, leading to different experiences and degrees of difficulty and frustration. For gender or sex to be changed on documentation, often the individual is required to show evidence of having had a related surgical procedure and no change can be made until surgery has been performed. Almost 90% of participants who had undergone surgery had also made attempts to change documentation. A quarter of participants who had not undergone any surgical procedures had also made attempts to change documentation, indicating that the desire to have a current gender identity reflected on documentation is not dependent on whether someone has had gender related surgery. Participants who had been able to successfully change their documentation experienced this as affirming of their gender. The inability to change their documents naturally had consequences in participants' lives. Participants noted that the mismatch between their documents and their gender presentation could expose them to discrimination and danger, especially in airports.

Stigma and discrimination

Most participants, (87.4%) had experienced at least one form of stigma or discrimination on the basis of gender. Social forms of stigma such as verbal abuse, social exclusion and having rumours spread about them were reported by half the participants. A third had been threatened with violence. A similar number had received lesser treatment due to their name or sex on documents, as well as been refused employment or promotion. Almost a quarter had been refused services and 19% physically attacked. Many participants generally kept their gender identity to themselves, or to only express it in private, and in safe spaces. Discrimination from family members (who could also be victims of discrimination themselves) and in the workplace were commonly discussed. Participants expressed strong fears for their safety based on their experiences of discrimination.

Respondents who had experienced a greater number of different types of discrimination were more likely to report being currently depressed and almost two-thirds (64.4%) of participants reported modifying their activities due to fear of stigma or discrimination. Partner violence was reported by 16.1% of participants. Only 18.2% of these had reported it to police and of those that did report less than half (34.8%) were treated with courtesy and dignity.

The Lived Experience: Recognition and negotiation

At the end of the survey, participants were given an opportunity to comment generally on their gender identity and gender presentation. The responses came in a variety of ways, discussing experiences of the health system, formal processes, and stigma and discrimination within the context of their overall lives and these comments reflect the diversity of ways in which people live transgender lives. They concerned negotiating public and private selves as well as negotiating transition. Seeking recognition in the health system and finding ways to counterbalance the medicalisation of their lives were also key themes.

Last words

The survey concluded with some commentary on the survey from the participants. One identified three social and political domains where the survey results could have impact and where the voices and positions of transgender people need to be heard. These were the lawmakers, the medical world and the general population. Others expressed dissatisfaction with aspects of the survey, but on the whole responses to completing it were positive.

Section 1

Introduction and background to the study

This research report has its beginnings in an act of transgender activism.

In 2005, the Australian Research Centre in Sex, Health and Society (ARCSHS) was collecting data, online, from the gay, lesbian, bisexual, transgender and intersex (GLBTI) communities for the Private Lives project (Pitts, Smith, Mitchell, & Patel, 2006, p. 65). Members from various transgender communities in Australia, in an organised campaign, contacted ARCSHS. A conversation began about the need for an additional survey to address the particular shape of transgender lives, and some of the specific shared issues, including access to, and the quality of, health services. Out of these conversational beginnings, the TranZnation Survey was developed and implemented.

A central pivot in the concerns of the transgender communities about health services is that of **recognition**. As shall be seen in this report, practices of medicine are implicated in many of the attempts by transgender people to achieve positive health and self- and social-recognition for their preferred gender. Additionally, recognition on formal documentary records is, in many cases, dependent upon certified medical intervention. One of many examples is achieving recognition of preferred sex on Australian passports. The regulations of the Department of Foreign Affairs and Trade covering change of sex on passports¹, require certification of 'gender reassignment'.

Since 2000, discussion about transgender people in the Australian published literature has included a number of threads: high profile national legal cases; discussion occasioned by debates on law reform; and access and quality of health services. Woven through each of these are matters of recognition and the practice of medicine.

Legal Cases

The first of the high profile cases was *Re Kevin and Jennifer v Attorney-General for the Commonwealth* [2001] FamCA 1074, the determination of which was later affirmed by the Full Court of the Family Court of Australia, following an appeal by the Attorney-General for the Commonwealth (Sharpe, 2002; Wallbank, 2004). The outcome of these cases saw the recognition by the Court of the sex claims of a transsexual man for the purposes of marriage.

The second case was *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* [2004] FamCA 297 (Edgar, 2005; Mills, 2004). Alex presented as a female infant: at age 13, he expressed to the NSW Family Court a deep conviction of himself as a male. His Honour, Nicholson CJ, agreed to the first step proposed in a staged process: "the administration of a form of contraceptive pill containing oestrogen and progesterone to suppress Alex's menses" (Mills, 2004), in effect permitting "a sex transition from a girl to a boy" (Edgar, 2005).

1 *Change of sex*

A valid passport in the new gender may be issued to a transgender person subject to the applicant meeting all relevant passport application requirements including:
For applicants born in Australia – a birth certificate from their state/territory RBDM [Registry of Births, Deaths & Marriages] showing the gender of reassignment;
For applicants born overseas – a revised citizenship certificate to reflect their new identity, or given current citizenship certificates no longer record a person's gender, formal evidence from DIAC it has accepted the reassigned gender and amended its citizenship records to reflect the new gender. Clients should be referred to DIAC for advice on how to obtain a revised certificate/documentary evidence. Passport offices have no authority to vary this policy.

(Department of Foreign Affairs and Trade, 2007)

Law reform

There is a consistent flow of debate and discussion in Australia of proposed changes in human rights and anti-discrimination legislation (Bird, 2001; Gurney, 2004, 2006), much of it centring on recognition and affirmation of gender identities, and including matters such as privacy and marriage (David & Blight, 2004), imprisonment (Edney, 2004), legal documentation (Gurney, 2005), consent to treatment for children (Parlett & Weston-Scheuber, 2004), and in relation to specific jurisdictions, e.g. Western Australia and New Zealand (Sharpe, 2001a, 2001b).

Health Services

There is less recent Australian evidence on the provision of health services to transgender people than there is on legal determinations and law reform debates. Two notable exceptions, to which further reference will be made in this report, are an assessment of satisfaction with sex re-assignment surgery in New South Wales (Collyer & Heal, 2002), and a discussion paper, commissioned by the Victorian government, on best practice models for the assessment, treatment and care of transgender people and people with transsexualism (Sinnott, 2005).

Structure of the Report

Sections 2-4 introduce the study, outline the methodology, and describe the participants, including self- descriptions of identity, including gender and sexuality.

In Section 5, there is an account of the self-reported health of the sample, and Section 6 deals with participants' reports of their general experience in using health services. In the following sections (7 and 8), specific interventions seen by some as central to the transgender experience - hormone treatment and surgery - become the focus.

In Section 9, the ethics of recognition and the legitimising role of medicine come together in participants' accounts of experiences in the changing of documentation. Section 10 includes participants' reports of stigma and discrimination.

In the final data section (11), some general comments made by participants, giving substance to their 'lived experience', are brought together.

Section 12 offers some last words from participants.

Section 2

Methodology

Studies investigating health and wellbeing of transgender people have typically been conducted in medical environments such as gender clinics and through sexual health centres. The number of studies that have used community samples of transgender people is relatively small. In part, this may be due to the difficulties associated with recruiting from a small, highly dispersed and somewhat marginalized population. Regardless of setting, studies that have been conducted with transgender people have often suffered from small sample sizes and existing research has focused on a small number of topics, including outcomes of sex reassignment surgery (SRS) (Barrett, 1998; De Cuypere et al., 2005; Lawrence, 2005; Rehman, Lazer, Benet, Schaefer, & Melman, 1999; Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005) estimates of mental illness (Haraldsen & Dahl, 2000; Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2005), and HIV prevalence and risk behaviours (Clements-Nolle, Marx, Guzman, & Katz, 2001; Edwards, Fisher, & Reynolds, 2007). In sum, many aspects of the transgender experience have not been adequately described and the current body of research under-represents transgender people who do not wish to transition (or those who can not), those who are not mentally ill and those who are HIV negative or not at risk of contracting HIV. Further, there is only a limited amount of research conducted with Australian and New Zealand transgender people.

Survey design

The decision was taken to conduct an online survey. Recently, a number of studies have successfully used the internet and online surveys to recruit non-medical samples of transgender individuals (eg. Lombardi, Wilchins, Priesing, & Malouf, 2001; Mathy, 2001; Newfield, Hart, Dibble, & Kohler, 2006). Online surveys have also been proven to be effective in recruiting other marginalized populations such as gays, lesbians and bisexuals in Australia, New Zealand and overseas (Henrickson, Neville, Jordan, & Donaghey, in press; Hillier, Turner, & Mitchell, 2005; Pitts et al., 2006; Riggle, Rostosky, & Reedy, 2005). The internet provides safe spaces for non-heterosexual individuals and communities, and so can be used to reach fragmented populations spread across large distances. The anonymity of an online survey provides an opportunity for participants to protect their identity, and reduces fear of discovery or being 'outed' in terms of their non-conforming gender identity or feelings.

The survey was designed by a team of researchers at La Trobe University's Australian Research Centre in Sex, Health and Society (ARCSHS), in consultation with members of a number of transgender communities. Submissions offered by transgender men and women on their experience with the Private Lives survey (Pitts et al., 2006) were used to begin the development of the survey. Through consultation it became clear that questions of access to health services were considered important to the transgender population. Consultation also contributed to the development of questions, and their appropriate wording. A number of transgender people from around Australia also provided useful questions and suggestions via email. Once the survey was online, the transgender communities and individuals who had participated in the initial consultations became instrumental in encouraging others to participate.

To capture the variation of identity and experience present in this population, a combination of quantitative and qualitative questions was used in the survey. Participants were given opportunity, throughout the survey, to give an account of their lives and experiences with health services, in their own way and in their own words and expression.

The survey was hosted by www.demographix.co.uk. Participants aged over 18 were invited to take part and those under that age were discouraged from responding. The survey was only made available in English. Each participant was required to indicate their country of residence; those who were not living in Australia or New Zealand were directed to a web page that informed them that they were not able to complete the survey.

Ethics

Ethics approval for the survey was granted by the La Trobe University Human Research Ethics Committee (Reference No. 06-90).

Advertising and recruitment strategies

Emails publicising the survey were sent out to transgender support organisations in Australia and New Zealand. AIDS councils, which have regular contact with the transgender communities in both countries, were also contacted. Email invitations were also sent out to key community members who have close contact with, or are a part of, the transgender communities. The launching of the survey was reported in the Australian queer press and on Joy FM radio in Melbourne. Efforts were also made to recruit transgender people from indigenous communities through respective AIDS councils and the Outblack organisation. The invitations asked people who identified as transgender to 'be part of Australia's largest online survey of the health and well-being of transgender people'.

Business cards were designed which had a brief description of the survey and the URL (Figure 1). These cards were distributed to various locations across Australia, in particular, AIDS councils, at the 2007 conference of the Australasian Society for HIV Medicine, and at GP clinics with high case loads of transgender patients.



Figure 1. Business Card Advertising the Tranznation Survey

Data analysis

Quantitative data were analysed using SPSS Version 14, descriptive statistics were computed and comparative statistical analyses such as chi-square analyses and t-tests were performed to detect differences between different groups of participants. All statistical differences are reported at $p < .05$.

The analysis of the qualitative data was managed using the software package NVivo, version 7. Open and axial coding was used to identify themes and their interconnection.

To aid in the interpretation of the results, the two data types (quantitative and qualitative) were considered in interaction.

Section 3

About the respondents

In total, 287 people responded to the survey. Of these, 27 resided in a country other than Australia or New Zealand and 7 had substantial missing data. In total, 253 respondents completed the survey.

Patterns of participants

The survey was launched on Monday 2nd October 2006. Ninety one responses to the survey were received in the first week, and just over fifty percent of total responses were received in the first four weeks of the survey being published online. After this time responses tapered off; the survey was closed on the 1st February 2007.

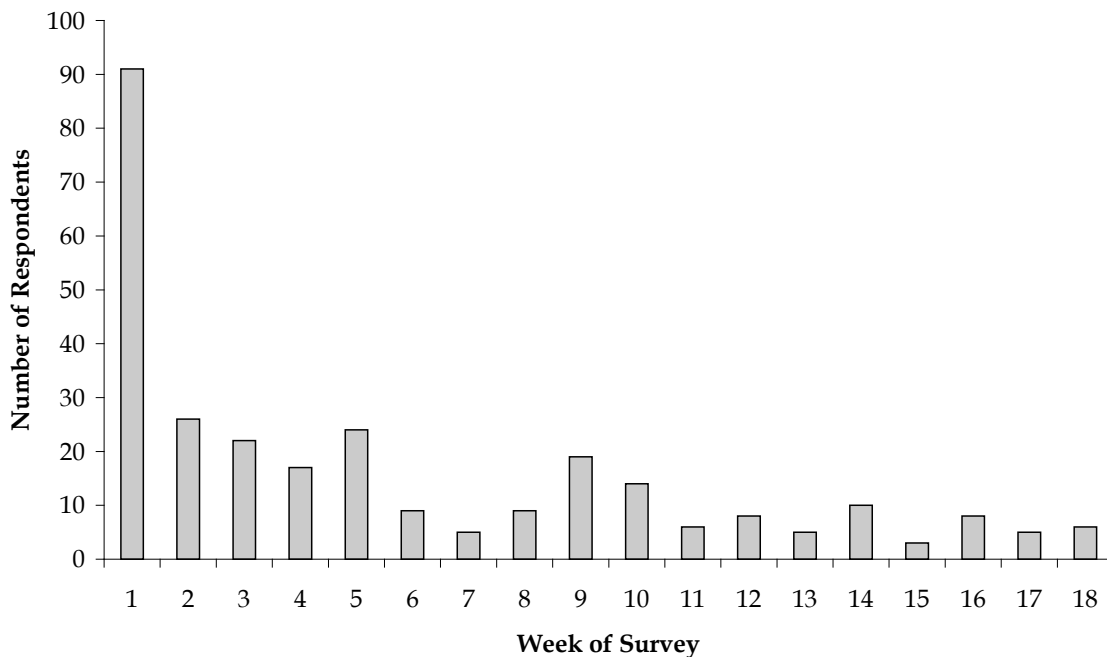


Figure 2. Pattern of Responses

Country of residence

Of the 253 participants, 229 were from Australia (90.5%) and 24 (9.5%) were from New Zealand. They included people from all states and territories in Australia and from both islands of New Zealand (Figure 2).



Figure 3. Percentages of Respondents by State/Territory/Island

Australian participants

The majority of Australian respondents were living in the eastern states and the sample had a similar distribution to Australian census data (ABS, 2006a), except that there was an over representation of respondents from Victoria (Table 1). The overall distribution of Australian participants from different states was similar to the Private Lives (Pitts et al., 2006), an online survey which investigated the health and well-being of GLBTI Australians.

Table 1
Distribution of Australian Participants by State, Comparison with Census Data

	Tranznation %	ABS (2006) %
Australian Capital Territory	2.2	1.6
New South Wales	28.4	33.1
Northern Territory	1.7	1.0
Queensland	14.4	19.7
South Australia	6.6	7.5
Tasmania	3.9	2.4
Victoria	33.2	24.7
Western Australian	9.6	10.0
Total	100.0	100.0

Of the 60.4% of Australian participants who provided post-codes, 67.3% were living in a major city, 20.1% in an inner regional area, 8.6% from an outer regional area and 3.6% in remote areas. This is very similar to 2001 census data, where 66% of the Australian population was living in major cities, 21% in inner regional areas, 11% in outer regional and 3% in remote areas.

New Zealand participants

In line with New Zealand census data (SNZ, 2006), the majority (58.8%) of New Zealand respondents were living in the North Island and Auckland (33.3%) was the city most commonly listed as site of residence.

Country of birth

The majority of respondents had been born in the country in which they currently lived. Of Australian participants, 75.0% had been born in Australia, a similar figure to Private Lives (80.7%). Of New Zealand participants, 70.8% had been born in New Zealand a level roughly equivalent to that found in Lavender Islands (78.8%) a New Zealand online survey of the health and well-being of people who are GLBT (Henrickson et al., in press). For respondents born overseas, England was the most common country of birth, followed by either New Zealand (for Australian participants) or Australia (for New Zealand participants). The breakdown of participant's country of birth according to their country of residence is presented in Table 2.

Table 2
Country of Birth and Country of Residence

Country of Birth	Country of Residence				Total	
	Australia		New Zealand		N	% ^(a)
	N	% ^(a)	N	% ^(a)		
Australia	168	75.0	1		169	68.1
New Zealand	11	4.9	17	70.8	28	11.3
England	27	12.1	4	16.7	31	12.5
Scotland	2	0.9			2	0.8
Germany	2	0.9			2	0.8
South Africa	2	0.9			2	0.8
Thailand	1		1		2	0.8
Ireland	1				1	
Netherlands	1				1	
Norway	1				1	
Italy	1				1	
Viet Nam	1				1	
Indonesia	1				1	
Malaysia	1				1	
Philippines			1		1	
Singapore	1				1	
Japan	1				1	
India	1				1	
Canada	1				1	
Total	224	100.0	24	100.0	248	100.0

(a) Percentages for counties with values of 1 are not displayed

Aboriginal, Torres Strait Islander or Maori descent

Of the total sample, 1.6% were of Aboriginal or Torres Strait Islander background (4 respondents), and 1.6% were of Maori background (4 respondents). This small number of indigenous respondents is roughly equivalent to 2001 Australian census data but substantially lower than found in 2006 New Zealand census data (14.6%).

Age of participants

Age in years was reported by 94.9% of participants (240). Mean age of the total sample was 41.1 years (SD 13.7), median age was 41.5 years, and age ranged between 18 and 73 years. This is older than the mean age of participants in Private Lives (34 years), and older than in Lavender Islands (38.5 years).

Education

Just over one third (35.1%) of the sample had a university degree and similar proportions had a secondary school education or a tertiary trade/diploma certificate (Table 3). The proportion of those with a university education is higher than reported in Australian census data (18%) (ABS, 2005) and New Zealand census data (11%) (SNZ, 2006), indicating the sample is relatively well educated. Interestingly, however, the level of university education in the sample was lower than found in Private Lives (50.7%) (Pitts et al., 2006) and in Lavender Islands (51.1%) (Henrickson et al., in press).

Table 3
Highest Level of Education Attained

Education	N	%
Primary School	2	0.8
Secondary School	82	32.4
Tertiary diploma/trade certificate	80	31.6
University or Polytechnic Degree	54	21.3
Postgraduate Degree	35	13.8
Total	253	100.0

Employment

In terms of employment, 41.1% were in full time employment, 17.8% were students, 16.2% were on benefits and 6.7% were retired. Unemployment was at 9.1%, a level similar to the transgender respondents in Private Lives (Transgender Men 8.8%, Transgender women 12.3%) but higher than found for the total Private Lives sample (3.4%) (Pitts et al., 2006).

Income

Annual income of participants is shown in Table 4. The figures are in the currency of the respective country. The largest proportion of participants in both countries was in the “less than \$20,000” category. When comparing Australian respondents with the Private Lives sample, TransZnation respondents were more likely to earn less than \$20,000 (35.4% and 21.7% respectively) and proportionally fewer earning more \$60,000 (15.7% and 25.7%). Similar results were found when comparing New Zealand participants with Lavender Islands. That is, this transgender sample was more likely to report a lower annual income than comparable GLBTI samples.

Table 4
Annual Income by Country of Residence

Income	Country of Residence			
	Australia		New Zealand	
	N	%	N	%
Less than \$20,000	81	35.4	10	41.7
\$20,001-\$40,000	54	23.6	7	29.2
\$40,001-\$60,000	58	25.3	3	12.5
\$60,001+	36	15.7	7	16.7
Total	229	100.0	24	100.0

Section 4

Sex, gender and identity

Some of the most complex and contested issues in any study of transgender people come from the diverse history and range of transgender and transsexual theories, and the consequent sex, gender and identity categories that are used in medical, other professional and everyday discourses. By way of example, UK transgender activist and academic, Stephen Whittle offers the following definition of 'transgender,' capturing something of this diversity of useage.

Transgender is an umbrella term used to define a political and social community which is inclusive of transsexual people, transgender people, cross-dressers (transvestites), and other groups of "gender variant" people such as drag queens and kings, butch lesbians, and "mannish" or "passing" women. "Transgender" has also been used to refer to all persons who express gender in ways not traditionally associated with their sex. Similarly, it has also been used to refer to people who express gender in non-traditional ways, but continue to identify as the sex of their birth' (Whittle, 2000, p. 65).

Finding a single term which captures this complexity has been negotiated in other ways. For example, Sinnot (2005, p. 6) uses the phrase 'transgender people and people with transsexualism' to be inclusive of this diversity. In this report for the purpose of readability, we have used 'transgender people' to refer to the participants. In the survey itself participants were asked to indicate the sex on their original birth certificate, and given open fields to report their preferred words for gender identity and sexuality. The wide variety of responses to these questions is discussed below.

Sex on original birth certificate

Respondents reported the sex recorded on their original birth certificate. Of the sample, 75.5% (191) reported male and 24.5% (62) female. This ratio of 3:1 assigned males to assigned females is roughly equivalent to the sex ratios reported in prevalence studies of Gender Identity Disorder (GID) and transsexualism that have been conducted in European countries (De Cuypere et al., 2007; Garrels et al., 2000; van Kesteren, Gooren, & Megens, 1996; Weitze & Osburg, 1996; Wilson, Sharp, & Carr, 1999)

Participants whose sex was assigned male at birth were on average older than those who were assigned female (44.6 years and 30.6 years respectively; $t(125.2) = 8.55, p < .0005$). Table 5 presents the distribution of participants across age groups; proportionally more assigned females were aged less than <30 age, fewer were aged between 30-59 years and none were aged over 60 years ($\chi^2(2) = 46.02, p < .0005$). It is unclear as to why there is an age difference between these two groups. One possible explanation is that age difference reflects that female to male transsexuals typically present for treatment of gender dysphoria or transgender feelings at a younger age than male to female transsexuals (Garrels et al., 2000; Olsson & Moller, 2003). It is rare for female to male transsexuals to seek treatment for the first time during middle age, but not uncommon for male to female transsexuals (van Kesteren et al., 1996).

Additional analyses revealed no differences in education, income, location of residence (metropolitan or rural) or country of residence between those assigned male at birth and those assigned female².

2

In general, very few differences were found between those assigned male and those assigned female at birth, and unless noted directly, the reader should assume there were no differences between these two groups.

Table 5
Age Groups by Assigned Sex

Age Group	Sex on original birth certificate				Total	
	Male		Female			
	N	%	N	%	N	%
<30 years	27	14.9	34	57.6	61	25.4
30-59 years	128	70.7	25	42.4	153	63.8
60+ years	26	14.4	-	-	26	10.8
Total	181	100.0	59	100.0	240	100.0

Gender identity

It is common for transgender people to resist attempts to classify their lived experience through the use of simple categories. Taking this into account, participants were asked what word (or words) they preferred to be used to describe their current gender identity. All of the responses were examined, and patterns of preference identified. Of the participants, 79.0% (199) used a single term to describe their current gender identity, 16.3% (41) two terms, and 4.8% (12) used three terms. Each term used was coded, allowing for the coding of multiple terms for gender identity for a single participant.

There were two dominant patterns of response. The first was to choose words indicating either 'male' or 'female'. The second was to choose words which conveyed the sense of some element of transition.

Of the preferred gender identity terms, slightly more than half (127) were the words 'male' or 'female' or similar. Of these, 17 were used with an accompanying transition term e.g. "Currently female (haven't transitioned)" (TN192)3, "Female, trapped in a male's body, that is becoming more female every day" (TN283). Of those using a male/female term, only in four cases was the preferred term the same as that of the sex assigned on the birth certificate.

One hundred and thirteen (44.8%) of the preferred words related to transition, e.g. "post-op transsexual" (TN23), "transman, transsexed FTM" (TN67), "Transgender" (TN244), "Granny tranny" (TN222).

Fifty (19.8%) of the preferred terms had reference points other than male/female or transition, with 31 (12.3%) not overlapping in use with either of the dominant patterns. A common point of reference was 'queer' or cultural references associated with it e.g. "genderqueer transboi" (TN21), "boi, femmey-boi, faggot-boi" (TN84). Another reference was to crossdressing e.g. "male cross dresser or transvestite" (TN220), "Crossdresser and Tranny"(TN231). Apart from those referenced to queer or crossdressing, terms related to presentation style e.g. "Butch" (TN132), and qualifications of gender and sexuality e.g. "Bi gendered" (TN117), "agendered" (TN26), and, in several cases "androgynous" (TN48, 211).

Some participants who listed more than one label for their gender identity, noted that, for them, gender identity was variable and dependent upon context, e.g. "depends on context: but mostly woman" (TN129), "Generally man, male, etc but in the queer community I sometimes use transman, transguy" (TN04), "It depends upon safety. If I feel safe I use transgender, if I feel unsafe I do not disclose" (TN105), "Female. Transgender only when relevant" (TN289).

Some respondents gave indications that their gender identity would be different if circumstances changed.

I am a Crossdresser who wishes to live fulltime as a Female. Have genuine Transgender feelings and issues. I am only restricted by current employment and financial positions in going full time. (TN131)

In some cases, there were responses indicating some confusion, e.g. "I don't know, male lol" (TN260), "A confused female" (TN269).

3 All participants were assigned a participant number with the prefix of TN

In general terms, these findings concur with Sally Hines' findings that transgender people "articulate gender identities that fall beyond a traditional binary framework" (Hines, 2006, p. 63). According to Hines, such identities are contingently situated, constructed in relation to temporal factors of generation and transition, through and in opposition to medical discourse, and "are negotiated within affective relations and intimate networks" (p.64).

Sexual identity

Generally research with transgender or transsexual populations has grouped participants into four categories of sexual orientation, namely heterosexual, bisexual, homosexual, and asexual (Lawrence, 2005). Reductionist categories such as these may not capture the full variety in sexual orientation and identity that is present in the transgender population. In this study, participants were asked the word (or words) they preferred to be used to describe their sexuality or sexual identity. Similar to gender identity, participant's responses were coded thematically. If there was more than one term for sexual identity provided, all terms were coded. In comparison to gender identity, few people used multiple terms to describe their sexual identity, 90.9% used one term, 6.8% used two terms (e.g. "gay and/or bisexual" (TN80), "straight bisexual" (TN110)) and only two participants (0.8%) used three terms.

The majority of participants identified with one of four sexual identities - Heterosexual, Gay, Lesbian, or Bisexual - in line with established cultural norms. Many of these participants gave additional comments which indicated that they were aware that how they defined their sexual identity maybe different to how others might see them, or that they were flexible in how they were seen by others.

I am bisexual, but I don't have an issue with being called a straight or gay man either. (TN142)

In the eyes of society gay, but technically straight. (TN269)

A small number indicated they were unsure about their sexual identity, for example "um confused" (TN25) "Still not sure" (TN161), "No fuckin clue" (TN200). Some indicated they try not to define their sexual identity: "I've never told anyone, I always avoid it and don't like anyone to call me anything" (TN192). Others used single words such as "Non-specific" (TN129) and "Variable (not bisexual)" (TN27) to indicate that they did not fit the usual labels of sexual identity.

Almost 20% of the sample responded to the question of sexual identity with a word for gender or sex (e.g. male, female, transgender) rather than a word for sexual identity or orientation.

Section 5

Health and wellbeing

The general health and well-being of transgender people are often overlooked in the research literature, with the attention dominated by specific transgender-related topics, such as hormone and surgical treatments, transmission of HIV and prevalence of psychopathology. Such a focus can provide a narrow and skewed impression of the population. The TranZnation survey, however, included several widely used measures of general health, well-being, and depression.

General health

Respondents rated their health on a five point scale from 'poor' to 'excellent' (Figure 4). The majority of the sample rated their health as 'good' or 'very good' (35.2% and 28.9% respectively). These ratings of general health were comparably lower than those reported in the Australian National Health Survey (ABS, 2006b).

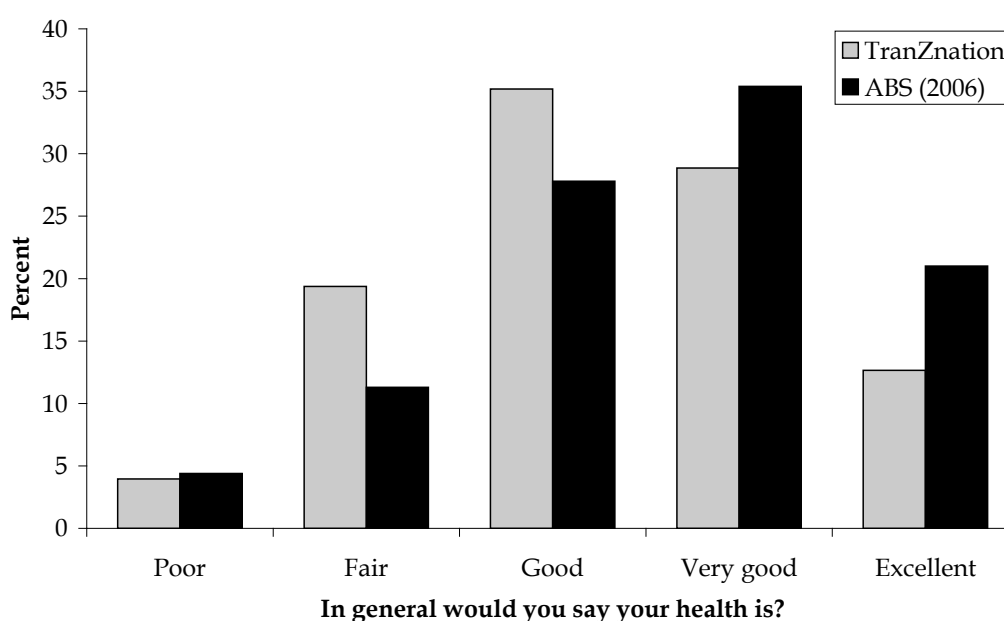


Figure 4. Self-Rated Health

Health in the past year

Respondents rated their current health compared with their health one year ago on a five point scale (Figure 5). The majority of the sample rated their health as 'about the same', just over a third rated it as 'somewhat' or 'much better', while a minority rated it as 'somewhat' or 'much worse'. More New Zealand participants rated their health as 'much better' than one year ago, while more Australia participants rated themselves as 'somewhat better' ($\chi^2(4) = 9.89, p = .042$).

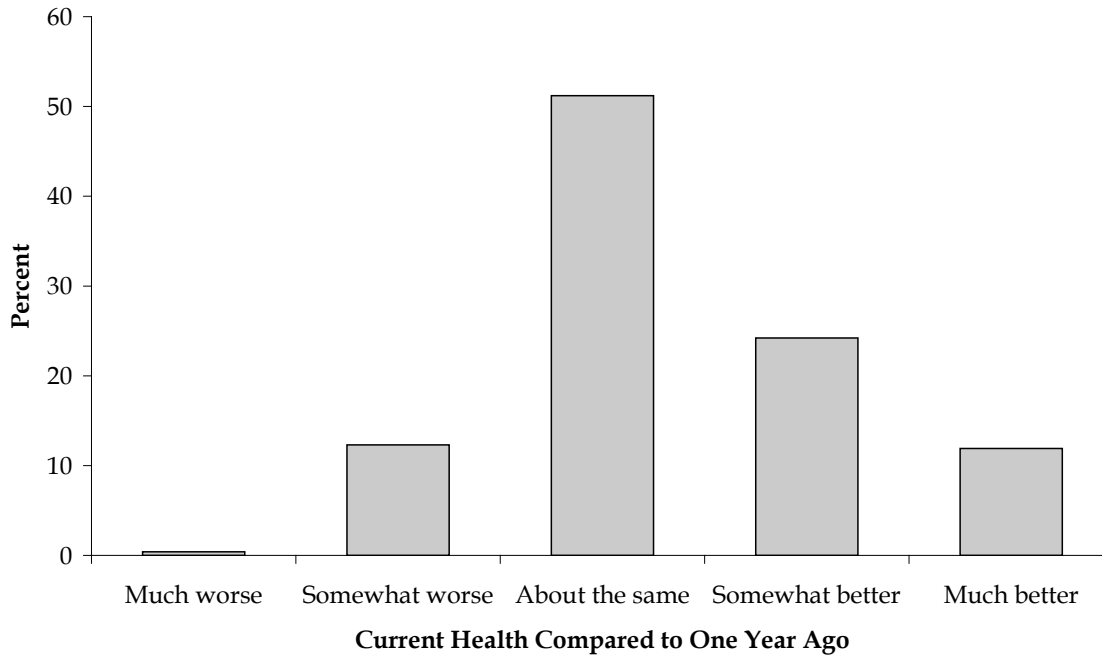


Figure 5. Ratings of Health Over the Past Year

SF-36 – General health

The general health subscale of the SF-36 is a five item scale that assesses perception of general health function (Ware & Gandek, 1998). The SF-36 has been used as a measure of health in a large number of studies worldwide (Hemmingway, Stafford, Stansfeld, Shipley, & Marmot, 1997; Ware et al., 1998) and has been demonstrated to have good reliability and validity in Australian (Butterworth & Crosier, 2004; Sanson-Fisher & Perkins, 1998) and New Zealand (SNZ, 1999) populations. Each item is rated on 1-5 scale, with the items weighted and summed so that measure has a range of 0-100. A greater score indicates better health. The Cronbach alpha for the scale was 0.83, which indicated good reliability for the measure. The average score was 65.06 (SD 20.82) (Median 67.00, Mode 72.00), which is lower than the average reported in population norms for Australia (71.6, ABS, 1995) and New Zealand (73.8; SNZ, 1999) population norms. A difference of five points is suggested to be of clinical or social significance (Ware, Kosinski, & Keller, 1994).

The results indicate that the health of transgender people is poorer than the general population in Australia and New Zealand. It is also slightly lower than the average score of 68.6 obtained for all Private Lives participants (Pitts et al., 2006).

Well-Being

Early studies typically viewed transsexuals as suffering from serious mental health problems and gender dysphoria was taken as an indication of severe underlying psychopathology (Haraldsen & Dahl, 2000). Many of these studies, however, were flawed methodologically, with a lack of consistent measurement, poor sampling and limited use of control or comparison groups (Midence & Hargreaves, 1997). More recently, an increasing number of studies have not supported the claim that transsexualism is associated with psychopathology. Rather it has been found that transsexuals or people diagnosed with Gender Identity Disorder experience low levels of psychopathology (e.g. depression, anxiety, personality disorders), with rates that are similar or slightly higher than found in the general population (Cole, O'Boyle, Emory, & Meyer, 1997; Haraldsen & Dahl, 2000; Hepp et al., 2005). Furthermore, transsexuals report improved mood and general functioning once gender dysphoria is acknowledged and a process of treatment (e.g. therapy, hormones or surgery) initiated (Cole et al., 1997).

A majority of participants reported that they were happy about their life, with almost two thirds reporting that they felt mostly or extremely happy (Figure 6).

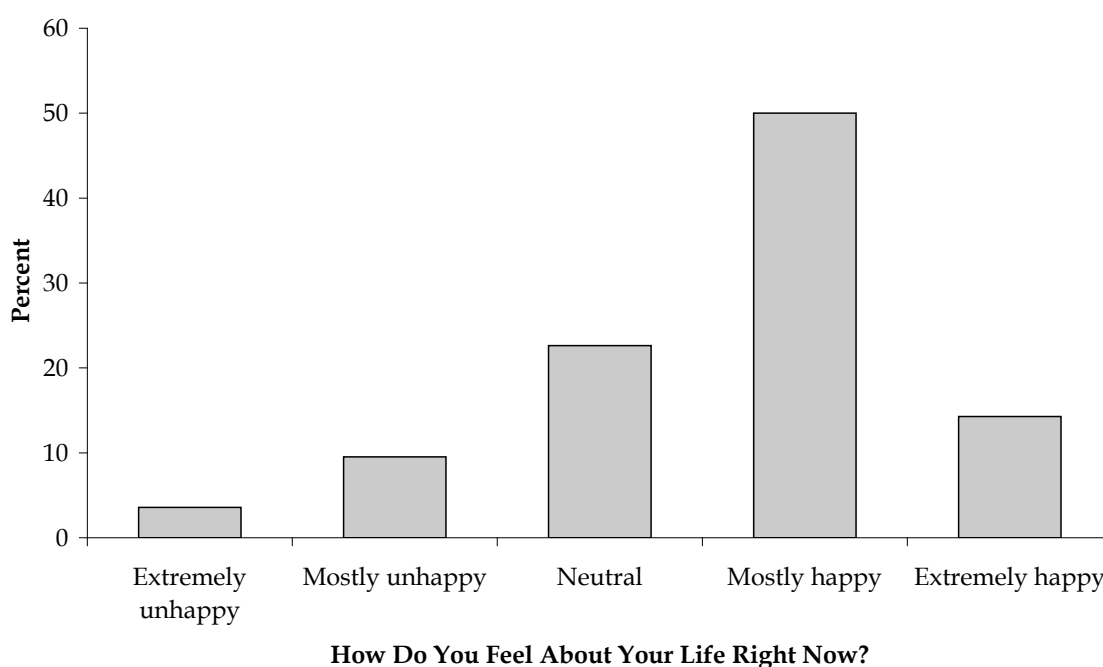


Figure 6. Well-Being

Depression

Of the few studies that have examined the prevalence of depression in transgender or transsexual populations most have found a slightly higher rate of depression than in the general population. Hepp (2005) reported that 13% of 31 participants diagnosed with Gender Identity Disorder who were receiving treatment for sex reassignment were currently depressed, while Haraldsen and Dahl (2000) reported 17% of 86 transsexuals who had applied for or received SRS (sex reassignment surgery) were currently depressed.

There are many reasons why a transgender person may experience depression or depressive symptoms. Depression and distress may arise as a result of experiencing gender dysphoria; it can be associated with the process of sex reassignment (including attempts to gain access to such treatments), it may develop in response to gender related treatments (e.g. adverse reactions to hormones or through unsatisfactory outcomes), or because of discrimination and abuse relating to their gender identity (Clements-Nolle, Marx, & Katz, 2006). Alternatively, depression may be unrelated to an individual's gender identity.

Depression was assessed in TranZnation by the Prime MD, a short 9 item scale that has been used to measure depression in the Australian general population (Goldney, Fisher, Wilson, & Cheok, 2000) and in Australian GLBTI samples (Pitts et al., 2006; Rogers et al., 2003). Participants indicated whether they had experienced symptoms of depression in the past two weeks (Table 6). Two items are screening question: one asks about feeling down, depressed or hopeless and the other asks about anhedonia (little interest or pleasure in doing things).

Table 6

Depression: In the past two weeks have you experienced any of the following?

	Total Sample	
	N	%
Feeling down, depressed or hopeless	123	49.0
Little interest or pleasure in doing things	88	35.3
Trouble falling asleep or sleeping too much	132	52.6
Feeling tired or having little energy	168	66.9
Poor appetite or over eating	104	41.6
Feeling bad about yourself	114	45.6
Trouble concentrating	76	30.2
Change in activity levels	59	23.7
Better off dead or thought of hurting yourself	63	25.0

Overall, 53.4% of respondents answered affirmative to at least one of the two screening questions and just over one third (36.2%) met the criteria for a current major depressive episode. This rate of depression is higher than that found in Private Lives (which used the same measure of depression) where a quarter (24.4%) of the sample was currently depressed. Furthermore, it is much higher than the level of depression found in the general Australian population. For example, Goldney, Fisher, Wilson and Cheok (2000), using the Prime MD, reported 6.8% of participants in a large representative community sample were clinically depressed.

Of some concern, one in four respondents reported suicidal thoughts in the two weeks before they completed the survey. This level of suicidal ideation was also higher than what was found in Private Lives (15.7%). Other studies of transgender populations have also reported high rates of suicidality. Mathy (2002) found in a community sample of 73 transgender participants found that 37.0% reported having had suicidal ideation at some point in their lives. Similarly, Clements-Nolle, Marx, & Katz (2006) reported that 32% of 515 transgender respondents had attempted suicide.

When analyses were conducted that grouped participants according to their sex at birth, it was found that almost twice as many assigned males were suffering from a depressive episode at the time of the survey than assigned females (40.9% and 21.3% respectively) ($\chi^2(1) = 7.24, p = .007$) (Table 7). Furthermore, roughly double the proportion of those assigned male at birth reported suicidal ideation in the past two weeks than those assigned female (28.3% and 14.8%, $\chi^2(1) = 4.51, p = .034$). It is unclear why there is a higher rate of depression amongst assigned males in the sample. Additional analyses (not shown here) indicated that the difference was not due to the difference in ages between the two groups of participants.

There was a clear relationship between increasing age and lower rates of depression in those assigned male at birth (Table 7, $\chi^2(2) = 9.65, p = .008$). No relationship between age and depression was found for participants with female on their original birth certificate.

Table 7
Depression and Age in Assigned Males

	<30 years		30-59 years		60+ years	
	N	%	N	%	N	%
Experiencing depression	16	59.3	53	42.4	4	16.7
Not Depressed	11	40.7	72	57.6	20	83.3
Total	27	100.0	125	100.0	24	100.0

Note. The relationship between age and depression was only present for assigned males, the same relationship was not observed in assigned females.

Past history of depression

Experience of depression in the past was assessed two ways. First, participants were asked if they had experienced a time when they were more depressed or down or had less interest in things. Second, participants reported whether they had been diagnosed with depression in the past. These results are presented sequentially.

Of the respondents, 82.1% said that they had had a time when they were more depressed/down, or had less interest in things. There were significantly more participants from Australia reporting a period when they had been depressed than New Zealanders (84.2% and 65.2% respectively) ($\chi^2(1) = 5.21, p = .022$). For participants who indicated that they had had a time when they were more depressed, they were also asked whether they experienced any of the symptoms of depression mentioned above (in Table 6) like trouble sleeping, concentrating, feeling tired, poor appetite, little interest in doing things. Of the participants who had indicated that they had had a time when they were more depressed, 96.6% indicated that they had suffered one or more of the symptoms of depression measured by the Prime-MD.

Almost half of all participants (49.4%) reported that they had been diagnosed with depression in the past. Of those that had, the mean age of the when first diagnosed was 32.0 years and the mean number of years between being first diagnosed with depression and the time of survey was 10.6 years.

Dysthymia

Dysthymic disorder is a less intense condition of depressed mood which impacts significantly on a person’s functioning on the majority of days for a minimum of two years (APA, 2000). Participants were asked whether they had felt down or depressed or had little interest or pleasure in doing things, on more than half the days over the past two years. Forty percent reported that they had felt down or depressed or had little pleasure in doing things on more than half of days in the past two years. The majority of these participants also indicated that it had made it hard for them as a result. Of all respondents, almost a third met the criteria for Dysthymic disorder (ie. answered yes to both questions). A summary of these results is presented in Table 8.

Table 8
Dysthymic Disorder

	Yes		No	
	N	%	N	%
Over the past two years have you felt depressed on more than half the days?	102	40.5	150	59.5
If yes, was it hard to do your work etc?	79	79.0	21	21.0
Meets criteria for Dysthymic Disorder	79	31.6	171	68.4

Sustaining health and well-being

Participants reported what they did to sustain their health and wellbeing. The main things that most participants mentioned as ways in which they took care of themselves were eating well and exercising regularly.

Some of the ways in which participants tried to maintain a good diet included eating “lots of fruit and vegetables”, “drinking lots of water”, avoiding take-away food, limiting consumption of meat or keeping to a vegetarian or vegan diet, as well as growing their own organic vegetables. Participants also listed avoiding smoking, excessive alcohol consumption, drug use, and the consumption of sugary foods as important health practices. For others, a regular moderate intake of alcohol, chocolate, and other foods that they enjoyed were also important for their well-being. These responses do not appear to be different to what might be expected from a general population.

The most commonly cited way in which participants kept active was by walking; other activities included cycling, running, swimming, yoga, Pilates, tai chi, kung fu, belly dancing, salsa, rock climbing, golf, going to the gym, and playing team sports such as basketball.

Social contact was another aspect of participants’ health and well-being. Participants made it a point to spend time with family, friends, and partners, to have meaningful conversations with close friends, or to just “hang out”. “Getting out of the house” and socialising was important, even if just having a chat with neighbours.

Having meaningful work was significant for participants, whether this was paid employment, volunteer work, or housework and gardening. Participants said that keeping busy, and “working long and fulfilling hours” (TN62), as well as doing some “physical work” (TN292) were important for their well-being. Focussing on personal development, having goals to achieve, and doing things for self-motivation were also part of participants’ health and well-being. And, some reported, it helped to “focus on what (was) working” and to “celebrate...successes” (TN93).

Participants reported that they also get involved in community organizations, including transgender groups, GLBTI groups, as well as religious organisations, participating in activities such as lobbying for gender rights, or volunteering in aged care. This helped participants experience a “sense of community” (TN214). One participant said that caring for others contributed to her well-being because it prevented her from being “totally self absorbed” (TN67). Participants also found caring for their pets to be beneficial, and they also enjoyed their walks with their dogs, as well as the company of their birds and geese.

Having hobbies and taking time to do “fun things” (TN112) was also part of participants’ self-care. The activities that they listed included visiting art galleries, reading, dancing, doing crosswords, “watch(ing) movies to escape” (TN170), shopping, eating out, “Get(ing) dressed in girl mode and go out clubbing as often as (they) can” (TN36), woodwork, having lots of sex, playing computer games, spending time outdoors and being close to nature, as well as writing and making films, music, and art.

Respondents also frequently talked about ways in which they took care of their mental health. Common practices included meditation, making sure that they got enough rest and sleep, spending time alone, “being a spiritual person” (TN275), as well as nurturing and maintaining a positive mental attitude. Some participants made it a point to “surround (themselves) with happy positive people and avoid those in a “down mood” (TN178), purposefully seeking friends who “were more positive about life” (TN191). Participants also wrote about the importance of learning how to cope with depression and anxiety, how to be aware of and not brush aside their feelings, how to focus on the present, how to let things go, and how to “respond rationally to negative signals my body gives off” (TN204).

By not hiding myself, not letting other people’s opinions of my life get to me and trying to live my life, as the woman I wish to be. (TN209)

It was also important for participant’s health and wellbeing to not to let other people’s rejection of them affect them, and to develop love and acceptance for themselves: “acceptance and loving my whole being” (TN120).

Other ways in which people reported taking care of themselves included: maintaining a balance of hormones by following their treatment regime, taking vitamins and medication, and seeing doctors and therapists regularly as ways in which they took care of themselves. Some participants also mentioned seeing other health professionals such as naturopaths, acupuncturists, chiropractors, and dieticians, and a number said that group therapy played a role in their well-being.

Other ways of sustaining health and well-being: “Occasionally singing really loudly and very badly out of tune. It makes me smile” (TN71); “take Government organisations to legal reviews” (TN107); “manage my gender dysphoria by expressing myself in the home” (TN293); “laugh a lot” (TN30); “love outrageously” (TN93).

While, on the whole, respondents were positive about what they did and could do for their health and well-being, a few reported negative responses: “I do not have good health or much wellbeing” (TN183); “can’t” (TN125).

Section 6

Health service use and experiences

Transitioning - the masculinising or feminizing of one's body - is an important part of the transgender experience. For transgender people, health issues associated with gender and transitioning are multi-faceted. Transitioning can be complicated medically and requires substantial information-seeking as well as involving lengthy and often difficult series of negotiations with health services. The standard process of transitioning is long, complicated and expensive. There is, typically, a mandatory trial period of two years living full-time in the target gender while receiving hormone therapy and concurrent psychiatric assessment (Murray, 1997). The process involves interaction with a range of professionals across many disciplines, including psychiatrists, psychologists, endocrinologists, gynecologists, plastic surgeons, urologists, general practitioners, speech therapists, social workers, nurses, sex therapists, and a chaplain or spiritual advisor (Walters, 1997). Relating to health services can be a difficult experience for people who are transgender, as their gender identity is often revealed or scrutinised. However, participants report that, when done appropriately, interaction with the medical community is a profoundly legitimating and positive experience.

Regular doctor

General practitioners play an important role in providing and coordinating medical care (general and specialist), as well as ongoing support and counselling for transgender people (Meese, 1997). Four out of every five participants reported that they had a regular doctor (82.1%). Participants were more likely to have a regular doctor if they were older ($\chi^2(2) = 8.44, p = .015$). Of the participants reporting a regular doctor, 83.4% had had a check up in the last 12 months

Other health services used in past 12 months

Respondents used a wide range of health services in the previous 12 months, with a small proportion accessing services that are related directly to being transgender, e.g. speech pathology, gender presentation services (Table 9). Hospitals had been accessed by 15-20% of participants in the past year and a minority had used number of other specialist services to varying degrees.

The most commonly accessed health service was a mental health professional, used by almost half the sample. An equivalent rate of use of psychotherapy by transgender people was found by Mathy (2001) who reported that, in a sample of 73 transgender people living in North America, 53.4% had used a psychotherapist. This level of use is not surprising given the prevalence of depression in the sample, and that counselling/psychotherapy is typically required before an individual undergoes sex reassignment surgery. Proportionally more participants who were assigned female at birth had accessed a counsellor, psychologist or psychiatrist than those assigned male at birth (61.3% and 42.9% respectively; $\chi^2(2) = 6.33, p = .012$). It was also found that 18 of the 19 participants who had used a speech pathologist, were assigned male at birth. Speech pathology is used by transgender people to gain a sex appropriate voice, e.g. to masculinise or feminize the voice, and this is an important part of being accepted in a new gender (McNeill, 2006). Assigned females generally achieve masculinisation of the voice through hormone treatments. Similar treatments for assigned males, however, have less impact on voice pitch and so they often access speech pathologists to feminize their voice. Additionally, it may also be more difficult for transgender women to 'pass' with a deep voice than for transgender men with a high voice.

When asked what other health service had been used by participants, the most common was an endocrinologist (listed by 12 participants), a specialist doctor involved in hormone treatments. Given that accessing endocrinologist was not directly asked about and that hormone treatments are widely used by transgender people this is likely to be an underestimate of the number who had seen an endocrinologist in the past year.

Private health insurance

Half (50.7%) of the Australian respondents had private health insurance, a level identical to the rate for the general Australian population reported in the Australian National Health Survey (ABS, 2006b). In comparison, few New Zealand participants had insurance (13.0%). In general, cost of private health insurance seemed to be a limiting factor : 66.4% of all participants who did not have insurance said they would like to have it but could not afford it. Accordingly, respondents with a higher income were more likely to have private health insurance than those with lower (below \$40,000) incomes ($\chi^2(3) = 20.78, p < .0005$).

For those participants who had Private Health Insurance, the majority (57.1%) indicated that their choice of a private health plan was unrelated to gender issues, 15.1% said it had influenced their choice a little, 27.7% said it had influenced it a lot. Of those who said they had Private Health Insurance, just over half (51.3%) said that they had used private health insurance for a gender-related matter.

One third of participants who did not have private health insurance cited a reason other than cost for their decision. Some of whom said that they did not have it because they worked in the public service and received free medical care, were on a pension, or felt that they were in good health and that Medicare was adequate for their needs. Another common reason for not having private health insurance was a belief in a universal system of healthcare. While some could afford private health insurance, and felt that they would benefit from it, they did not want to “send the wrong message to the Government” (TN05).

Other reasons that participants gave for not having private health insurance included: they would receive as good care in the public health system; they did not think the benefit they would gain justified the cost; not trusting insurance companies or the private health system to deliver good quality care; difficulty finding ones that would suit them due to the absence of coverage for transgender health procedures; and having other more pressing financial commitments.

Some participants indicated that they intended to take up private health insurance at some point, but had not got round to it. One participant did not want to join as they would have to pay more than if they joined earlier, and had had surgery in Thailand which would not have been covered anyway.

Others had more particular reasons:

Paying insurance is me betting that I'll be sicker than average, and claim more than I paid. This is not a bet I want to win, so I won't make it, thanks. (TN211)

Table 9
Health Service Use in the Past Year

Health Service	Total	
	N	%
Counsellor/psychologist/psychiatrist	120	47.4
Dentist	109	43.1
Hospital – inpatient	52	20.6
Hospital – outpatient	47	18.6
Hospital – accident/emergency unit	40	15.8
Sexual Health Clinic	40	15.8
Physiotherapist	34	13.4
Chiropractor/Osteopath	32	12.6
Speech Pathologist	19	7.5
Trad. Chinese Practitioner, etc	16	6.3
Naturopath	14	5.5
Gender presentation services	12	4.7
Kinesiology	7	2.8
Other	38	15.0

Note. Multiple responses possible

Experience with health services

Participants described their best and worst experiences with a health practitioner or health service in relation to being transgender. If they had not consulted a particular health service or practitioner about transgender health issues, but had wanted to, they were asked why they had not done so. Participants were also given the opportunity to comment on the changes that they would make to health services if they could.

For many respondents, the best experiences in the health system involved encounters where they felt accepted and supported by their practitioners. They valued practitioners who showed empathy, and were understanding, compassionate, and professional. Professionalism was often linked to a non-judgmental attitude, and to a respect for patients' gender identities. This respect was conveyed through the appropriate use of pronouns, use of patients' chosen names, and making an effort to change medical records to fit with gender identities. Participants experienced these as "positive affirmations" of their gender (TN129), and it allowed them to feel like "everyday, 'normal' (people)" (TN262), in the often difficult process of consulting health services about transgender health issues.

It was common for participants to be met with a degree of curiosity and surprise in their encounters with health services. This could range from "just the odd raised eyebrow, nothing serious" (TN18), to feeling like "a bit of a novelty or freak show" (TN262). Some participants preferred it when practitioners seemed to be "oblivious" (TN25) to their transgender status, or when they "didn't even bat an eyelid" (TN04) upon learning about it.

Respondents' worst experiences with health services usually involved encounters where they were met with hostility. These ranged from instances where participants sensed discomfort, contempt and resentment, to occasions of being refused treatment, laughed at, ridiculed, and met with outright displays of disgust. Examples included "being told that (she was) the filthiest most perverted thing on earth" (TN11), while another's was being told that he "needed to find god not hormones" (TN132). For some, prejudice and contempt came to be expected. Sometimes participants were grateful simply for the absence of explicit displays of these: "Most males in the health service try not to show their distaste for my condition, and I appreciate that" (TN73).

Attending sex specific medical clinics that were discordant with participants' gender identities was a difficult experience for many. Some people avoided using these services altogether. The experience could be made even more difficult by medical staff who did not respect participants' gender identities. For one participant, the negative experience with a health service that stood out was "having a hysterectomy, being (in) a gynaecological ward...and (the) staff 'she'ing (him) (TN81)". Medical staff could also disaffirm a person's gender identity by using the wrong name, and could sometimes be flippant about confidentiality, for example "calling out the wrong (former) name in a waiting room full of people" (TN24).

A number of participants said that they had never spoken to health professionals about transgender health issues and others said that they were often reluctant to disclose their transgender status with practitioners when being treated for health problems. Fear of being "stereotyped and boxed" (TN105), pathologised, labelled, judged, stigmatized, met with hostility and ignorance, were some of the reasons that people gave. These fears were sometimes based on the experiences of other people, or on an individual's past experiences with health services. One woman explained her reluctance to use a health service, saying:

Fear of the health system. After bad experiences I'm scared to use it because I know it's not really there for me. (TN289)

Discomfort about having to expose one's genitalia was a common theme in the data, both in participants' accounts of their reluctance to use health services, and in descriptions of participants' best and worst experiences with health services. Practitioners who were sensitive to the difficulties that transgender people face in health care settings, and who recognized participants' unease over medical check-ups, were valued greatly. One participant who felt self-conscious about baring parts of himself said that he felt at ease with his plastic surgeon who he found to be "professional and respectful" (TN24). Another said this of his general practitioner:

She realises I have big issues relating to female health issues. Pap Smear, breast check, EWW. She does everything she can to put me at ease. Whilst having yucky pap thing still calls me sir! Love it. (TN132)

Practitioners were greatly appreciated if they were knowledgeable and experienced in transgender issues, and if they were sensitive to gender diversity and to the difficulties that transgender people face in health care settings. Of course, knowledge about appropriate hormone treatment and surgery is also important. Many participants, however, found that their doctor had little experience in treating transgender people, and needed to gain new skills in order to take them on as patients. This situation was not necessarily experienced negatively. While some people wished that their doctors had been taught how to treat transgender patients in medical school, and not need to be educated by their patients, others were happy to have open-minded doctors who 'learned with (them)' (TN127), and who showed an interest in transgender issues.

Some participants enjoyed being an "equal partner" (TN166) in the doctor-patient relationship, "involved in the process rather than just being told what to do" (TN69). They liked practitioners who respected the transgender patient's own knowledge about their body, and trusted their ability to make their own decisions about what they wanted. For one participant, her best experience with a health service was the first time her "views on (her) gender (were) accepted as authoritative" (TN211).

My psychiatrist treated me like a rational adult and didn't make me go through various silly hoops. (TN85)

Participants reported on whether health services and practitioners gave them the opportunity to express their views on the services that they received. Most (51.7%) said that they did, just over a quarter (27.4%) said that they did not, and a significant proportion (20.9%) said that they did in some instances but not all. Many participants noted that they would express their opinions whether or not they were given the opportunity: “Try and stop me!” (TN27), one person said.

Other participants noted that this approach was not always possible, especially when doctors acted as gatekeepers who controlled access to hormone treatments and surgery. To make the process easier for themselves, some participants limited how expressive they were of their opinions, as not to do so was “at (one’s) own peril” (TN225).

Participants were also acutely aware of needing to meet certain criteria in order to qualify for hormone treatment and surgery. Many people felt that they were required to “fit a textbook description” (TN176) of what a transgender person should be, and then were made to “jump through hoops”, a commonly used phrase in the data, before treatment was approved.

Remove the Harry Benjamin Standards of Care and replace with a check list that isn’t designed round a set of hoops to jump through. (TN55)

For many, using health services for transgender health issues involved presenting themselves in particular ways in order to fit into stringent gender categories that did not necessarily reflect the way they experienced their gender identity. Some participants expressed a frustration over being constantly “pigeonhole(d)..into only either male or female” (TN227) in the health system. They encountered doctors who had “quite old-fashioned views about masculinity and femininity” (TN04) and found that their way of dressing, for example, was “judged” according to what people of a particular gender “(wore) in the 50s” (TN106) rather than what they wear today.

Participants reported feelings of anxiety over whether they would meet the criteria for treatment; some reported making an effort to only say what they thought was in line with expectations of a transgender person:

Many people I’ve spoken to are too scared to say anything that doesn’t fit “the standard story” because they’re worried they’ll be denied services (which is understandable). (TN04)

I have on occasion censored aspects of my experience for the fear of being denied treatment. (TN21)

Participants pointed to a need for a more complex understanding of gender in the health system. Many cited this as one of the things they would change about the health services that they had accessed. Participants argued that practitioners needed to be aware of the “diversity of gender identities” (TN21) and to recognize that “transpeople are a diverse bunch of people with diverse needs” (TN22).

The process of being diagnosed with a Gender Identity Disorder was fraught. It often meant participants allowing themselves to be defined in ways than ran contrary to their sense of personal esteem and worth, yet they were dependent on such a diagnosis as one of the “hoops” that they needed to clear. In this way, participants could be simultaneously supported and undermined by the health system:

One can feel intimidated by just having to go to health system ‘cause transgender gender is not a sickness, yet western medicine can imply otherwise if a trans person becomes dependent on it for survival reasons (TN98)

Participants’ comments about diagnosis painted a complex picture. For some, being “finally diagnosed as gender dysphoric and being prescribed hormones” (TN232) was a significant and happy milestone. These descriptions complemented the stories of other participants who struggled to have health professionals take them seriously. Participants related encounters with practitioners who refused to help them because they “didn’t believe in transgenderism” (TN163), or who thought that their transgenderism was a “fetish or obsession” (TN269). Some participants also had to justify their decisions to use hormones to doctors who did not think that wanting to change their bodies was a good enough reason to be on hormone therapy.

Participants also challenged the presence of Gender Identity Disorder in the Diagnostic and Statistical Manual of Mental Disorders IV, arguing that gender diversity should be seen as a natural form of human variance rather than as a psychological disorder. One participant, however, argued instead for a re-conceptualisation of gender dysphoria as a “genetic birth defect”. A physiological explanation could provide a concrete rationale with greater practical purchase for participants in a biomedical health system, and this was reflected in participants’ earlier comments about the need for hormonal treatment and surgical intervention to be recognised as medically essential. One person’s hope was for:

...private health funds and government to recognise the treatment for gender dysphoria as being a very real, medical condition!!! (TN262)

The process of assessing whether someone met a transgender or transsexual standard that qualified them for hormone treatment or surgery was experienced as a degrading experience for some participants. They felt interrogated, exposed, and humiliated by “invasive questions” about their bodies (TN206), and could feel like their lives were being “ripped to pieces by (their) psychiatrist” (TN77). In contrast to the experiences of participants who felt that they had some control over how they were defined, these participants felt “grilled and mistrusted and attacked” (TN140).

I had an appalling psychiatrist as was his replacement at his clinic. All they wanted to know about was my sexual practices and fantasies. They were not interested in anything else. To the extent that I was asked about what positions I took in sexual conduct, whether I enjoyed penetration and specifically what kind, and whether I lay face up or face down when masturbating. (TN162)

In these instances, participants felt that their individual needs were not taken into account, and that specialists could be “more interested in (a client’s) ‘gender dysphoria’” than in the person who they were treating (TN26). They felt that doctors were more focused on “mak(ing) sure that (their) life experience matched that of the ‘typical’ FtM” (TN199) rather than working out what the best treatment would be for their patients as individuals.

I felt like I was being put through a ‘tranny factory’. (TN199)

Adhering to diagnostic criteria alone could create a mismatch with the treatment that was offered, and a participant’s readiness to undergo treatment or their inclination to at all. As the data that we present later in this report will show, participants varied in terms of how much hormone treatment or surgery they wanted, when they thought these interventions were needed, and whether they thought these were necessary at all. In fact, one of the reasons that participants gave for not using a health service for transgender issues at all was feeling that they did not need to pass as either male or female. Paying attention to individuals’ diverse needs was important in ensuring that patients got the treatment that was right for them, and at the right time in their lives.

Age was one of the criteria for accessing treatment that, used outside of the context of participants’ lives, could lead to unsatisfactory outcomes for participants. It was important for participants to be able to access treatment when they needed to, but not to be rushed into it when they were not yet ready.

One participant, for example, felt that he had been prematurely pushed into hormone therapy by his GP when he turned 18 (TN153). Other participants experienced difficulties in gaining access to treatment that they required. It was frustrating for participants who were ready to transition to be denied treatment because they were too young. One participant’s worst experience was having to wait until she was 18 and watching her body become “disfigured right before (her) eyes” (TN52). Another young participant who was of legal age, but still considered too young by her doctor, said:

I have found (the) clinic to be ageist and very vague when I have asked questions. Every appointment I have the psych goes on about how young I am. This really bothers me. I am legally an adult and have not made decisions about my gender quickly at all. (TN86)

As important as it was for participants to have their experiences taken seriously, it was also important for them not to be over-defined by them. A focus on a patient's gender dysphoria or transgender status could eclipse other important aspects of their health and well being. While it was important for health professionals to be aware of the context in which they were treating their patients, participants noted that doctors needed to also be “aware that not all medical problems stem from gender issues” (TN127):

...I was referred to a different psychiatrist who took a more holistic approach to my issues. He treated my depression as a separate issue from being trans and gave me a lot more confidence that living as male was right for me as an individual, and not just because I fit a set list of diagnostic criteria. (TN47)

Rapport between the doctor and patient was important in ensuring that participants received the treatment that was right for them. Once rapport was established, participants' input was respected, and their individual needs were more likely to be taken into account. Some participants made choices about which health services to use. Some of those who had not had a “worst experience”, said that this was because of their conscious decision to see health practitioners who they knew were sensitive to transgender issues. They chose practitioners that suited them, and if they came across someone who did not, they would move on. One woman, for example, stopped seeing a sexual health physician who “did not credit (her) with knowing about hormones and (her) body”. Instead she saw her GP with whom she was “able to discuss everything related to (her) hormone regime” and arrive at decisions together (TN181). Another participant “always sought professional healthcare and psychotherapy” as to not do so was “asking for trouble” (TN178).

I haven't really had a good experience - everything I've used is through [institution], and I've had to use them because they were the only alternative, not because they were in any way a good option. (TN255)

It was ideal for participants to be able to choose services that worked for them, as this could go a long way to ensuring that they were able to obtain suitable care. In reality, however, this was out of reach for many. Cost of services, the lack of public funding, and the scarcity of relevant services in some areas were the main barriers to receiving appropriate treatment. Participants also commented on the scarcity of health services for transgender people in the public system, commonly reporting long waiting periods for accessing services. This situation kept some participants from accessing these services altogether.

Anything through the public system takes far, far, far, far too long, being asked to wait well over a year for a simple first consult is ridiculous and insulting. In order to get anything done, it was necessary to go private, which is prohibitively expensive. (TN284)

Participants expressed a strong desire for sufficient transition-related health care to be made available through the public system, including procedures that were often considered “peripheral” in the health system, such as cosmetic surgery and electrolysis. These were seen as essential for some participants to present well as their chosen gender:

These costs should be covered by Medicare or you'd best get used to paying them the pension for the rest of their lives since they will never fit in to society without them. (TN10)

The Financial aspect of Transition has driven many of my Friends to Suicide.... There But for luck go I... But I have the Stockpile of Pills waiting for adequate motivation. (TN245)

For some participants, accessing services was an effort. This was particularly so for those who lived away from major cities. One participant hoped for more flexibility in the provision of transgender health services because travelling from Tasmania to Melbourne when particular services were only available on certain days required a significant effort. Another suggested:

Transition-related health care needs to be much cheaper. (I live in Western Australia and there are few services available under the public health system. Psychiatrists and endocrinologist must be accessed privately). (TN05)

Many participants said that one thing they would change if they could was peer involvement in transgender health services. Participants felt that “proper trans community consultation” (TN22) might contribute to a more complex, experience-near understanding of transgender identities and their relevance for the health care of transgender people. It would also complete health professionals’ gaps in knowledge about suitable hormone treatment and surgery. Based on their experiences with health services, some participants also felt that they would have been more comfortable consulting transgender counsellors and health professionals.

Trans that have gone before me have a wealth of knowledge as they have tried and failed or succeeded in lots of things. More notice needs to be taken of them. (TN253)

The issue of gatekeepers who determined who was able to access surgery was raised. One participant suggested the need for more than one gatekeeper to ensure that individual differences did not determine whether or not one was able to access suitable treatment:

When your entire life is in the hands of one person, with whom you might not get along, it can be very frightening and traumatic. (TN185)

For some participants, the presence of these gatekeepers made them reluctant to use certain health services at all for fear that they might interfere with one’s “right to self determination” (TN166). Just as there were participants who had not had bad experiences, there were participants who said that they were “still waiting” (TN206) for something they could call their “best experience”, and that “there (hadn’t) been any good bits so far” (TN222), “Get back to me in a year or so, if I haven’t suicided by then” (TN222), “I would change society first” (TN95).

Information and support

Two thirds (66.7%) of participants reported that they had received enough satisfactory information about their gender issues from health practitioners/services.

Participants explained where and how they got information and support about gender-related health, well-being, and treatment. The most important source of information for participants was the Internet, which included email groups and online forums, and online communities of transgender people, and websites of ‘out’ transgender people. For most people, this was one of a few resources that they drew on, but for some, the Internet was seen as the only real source of information, and these participants experienced a severe lack of services and information “on the ground” (TN222).

Other significant sources of information and support included health services such as gender clinic, GPs, psychiatrists and counsellors, other transgender people, transgender organisations and support groups such as the Seahorse societies, journal articles and books.

Section 7

Hormone treatment

Helped with positive self-image, confidence, feeling of “normality” - and I’m way cuter now :). (TN176)

For many transgender people, hormone treatments are the first step in the process of transitioning and are often followed by surgical procedures. For others, taking hormones will be the only type of medical treatment they ever have. Hormone treatments for transsexuals involve substituting the sex hormones of an individual's assigned sex with those of the opposite sex. For male to female transsexuals this means taking estrogens, and in some case anti-androgens (to stop the production of male hormones), while for female to male transsexuals treatment means taking testosterone. Such treatments are used for two purposes: to reduce or eliminate secondary sex characteristics of an individual's assigned sex, and to induce those of their new sex. Not all secondary sex characteristics will be eliminated or obtained, and the extent to which these goals are achieved vary from person to person. Treatment with hormones is also suspected to influence mood, however there is only limited data on these effects at present (Slabbekoorn, van Goozen, Gooren, & Cohen-Kettenis, 2001) Once the gonads (e.g. testicles or ovaries) are removed, sex hormone therapy is necessary for the remainder of the individual's life to avoid side-effects of hormone deprivation (e.g. Osteoporosis).

Use of hormone treatments

In response to a question on whether they had ever used hormone treatment for gender-related reasons (eg. oestrogen, anti-androgens, progesterone-based hormones, testosterone, and/or oestrogen blockers) almost three quarters (73.1%) reported that they had. Of the 26.9% who had not used hormone treatments, almost half (45.5%) did not intend to do so in the future, around a third (36.4%) said that they were going to use hormones in the future, and the remainder (18.2%) were not sure.

Those who had undergone hormone therapy were given the opportunity to comment on both the positive and negative aspects of treatment; those who had not were asked whether they intended to in the future, and what their reasons were for their decisions. There were a small number people who expressed complete satisfaction and reported taking to hormone therapy “like a duck to water, with no problems whatsoever” (TN11), and a small number who reported only the side effects of hormone therapy. Most participants reported both positive and negative aspects to hormone therapy.

The positive aspects that participants reported were mainly concerned with bodily changes, and the feeling of well-being that followed these changes. In many instances, participants described an overwhelming satisfaction at having their body correspond to the way that they had always felt:

The pleasure in having my body starting to conform to my thoughts, with the growth of hair, breasts, skin softening and other regions reducing. At this stage negatives have not entered or impacted on my journey. The delight in being out in the world declaring my feminine self to the world.” (TN157)

Similarly, for the participants who had not yet undergone hormone therapy but planned to in the future, treatment was thought of as a means to bring their bodies “in sync with (their) minds” (TN11). These participants looked forward to particular bodily characteristics such as breasts, softer skin, or facial hair, which would contribute to a more female or more male appearance that would allow them to drop the “façade” (TN18). For participants who had undergone treatment, being able to ‘pass’, or indeed, to no longer have to worry about passing as the sex or gender that they were, was a welcome result.

The negative aspects of hormone therapy that participants reported included side-effects of treatment such as headaches, migraines, nausea, allergic reactions, and digestive problems, as well as longer term effects on their health such as liver disease, high cholesterol, and cardiac problems. Hormone therapy could also bring about other undesirable changes in participants’ bodies. While most experienced an overarching delight in their new appearance, this was also sometimes accompanied by less desirable changes such as a loss of muscle definition, weight gain, the development of cellulite for some participants, and acne and balding for others. Some changes were experienced as simultaneously positive and negative. One participant, for example, was pleased with the decrease in upper body muscle mass, but cited the resulting reduction in upper body strength as a negative aspect of this physical change (TN266).

Many participants who had had hormone therapy felt that it was a necessary part of their lives, and likewise, respondents who intended to go on hormone treatment saw it as an essential part of their future: “I feel it’s more than me wanting or needing to start taking hormones, it’s simply a must if I’m to live this role effectively” (TN200). Many argued that it was essential and “medically requisite” (TN215); one participant described increasing the level of testosterone in his body as “treatment of Transsexuality” (TN155). Many of these participants could not see a viable future in their bodies as they were:

My future as female would have been very bleak and I could only see myself survive under a heavy dose of anti-depressants for the rest of my life. (TN79)

These sentiments, however, were not shared by all participants. A small number, who had decided not to go on hormone therapy, did so because they did not feel that it was necessary for their well being. One participant thought about it as a possibility in the future, but said:

I am happy with my transgenderism at this point of my life. As I get older I may decide to take my transgenderism further with hormones. (TN78)

For most participants who had hormone therapy, there was a sense of things having fallen into place, with one’s body, emotions, and thoughts coming into alignment. Participants described “clarity of thought that (they) didn’t have before” (TN181), and noted changes in the way that they experienced emotions that better fit their mental processes. One participant said: “...I no longer have feelings that don’t go with my thoughts...my feelings now match the things I think” (TN284).

While changes in the way participants experienced emotion could sometimes take time to get used to, they were often thought to be a positive aspect of transitioning. Some participants described an appreciation for their “increased emotional depth”:

I find it is much easier to be emotionally available, and also find I am able to discuss my emotions and express my emotions in a physical way much easier than I could before starting hormone therapy. (TN266)

A change in sex drive was another commonly cited side-effect of hormone therapy. Some participants reported a significant increase in libido, others a significant decrease. While some did not like these changes, as with the changes in emotion, many felt these to be fitting too. For example, participants described a “decrease of male sexual function” as a positive result of treatment (TN266), and wondered “why anyone would want an erection” (TN85). One participant also reported a simultaneous increase in “female desire” (TN252).

The physical and emotional changes that participants experienced brought about an enhanced sense of well-being, and sometimes improved mental health. Some participants found that hormone therapy reduced their depression and suicidal thoughts. Many described feelings of happiness:

I am happier than I have been for years. I also have an inner peace that had escaped me prior to starting hormones. (TN159)

Overall feelings of well-being, however, could sometimes also be accompanied by mood swings, anxiety, and lethargy for some participants, and irritability, agitation, and difficulty concentrating for others. For most, these were inconveniences that could be managed within the largely positive context of transitioning. A few participants, however, described significant mental and emotional disturbances. One participant described hormone therapy as “an emotional rollercoaster ride” involving “huge lows and an urge to harm myself often” (TN245). Others described the mood swings as “pretty freaky” (TN14), and wished that they had been informed of the possibility of this occurring. For some, hormone therapy actually brought on depression and suicidal thoughts, particularly in the early stages of treatment.

Participants described going on hormone therapy as their “second puberty” (TN90), and one participant noted that:

A transsexual requires treatment as though they are redoing puberty, not treatment as though they are post-menopausal women. (TN225)

Having support during these changes was important to participants. One participant who tried “doing this on (his) own (and) chose not to talk to anyone about (his) experiences”, came off the hormones as he was “not quite ready” for the “speed of changes” and thought that it was important to “talk things through” (TN161). Participants’ doctors had different ideas about how quickly transitioning should happen. Some doctors put participants on hormone regimes that would mimic the normal process of adolescence, while others allowed this to happen more quickly. One participant described having “developed secondary female body characteristics very quickly, in a matter of a few months which...was a little too fast” (TN17), while another was frustrated that his endocrinologist “traditionally puts people on oral T (Panteston) and then very low levels of Sustanon to mimic the length of time it takes someone to move through male puberty” while “other endos here are more open to moving people onto full-strength injections much quicker” (TN171).

Many people described a process of adjusting to the effects of hormone therapy. Side-effects such as nausea, migraines, headaches, and lethargy were more marked early on, and often subsided once the individual’s body had become used to the treatment. A participant who had been on hormone therapy for twenty years, reported no longer experiencing adverse effects, but remembers a range of side-effects initially (TN96). Achieving a balance of hormones that was right for the individual was also an issue that came up frequently, and participants often expressed frustration at the absence of standard dosages for hormones. Others, however, described this as a process of discovering what worked for them. One participant, for example, found that “oestrogen patches are okay” but felt unhealthy when using testosterone blockers (TN41). Quite often, this process involved a dialogue between doctor and patient to manage side-effects and work out a regime that worked for the individual

Initially I had an allergic reaction to Spironolactone that caused a number of problems, some of which were cardiac and required admission to hospital. I have since switched to Androcur, which apart from occasional fatigue has worked well. I have had no problems with oestrogen, and am pleased with the effects thus far. I have experimented with micronised progesterone (in the hope of improving breast growth), but that exacerbated an anxiety disorder. (TN05)

Finding a balance of hormones was thus a dynamic process that required participants' reflexive involvement in their treatment. Once a balance had been achieved, and respondents had found a system that worked for them, it was difficult when hormones became unavailable, or were taken off the Pharmaceutical Benefits Scheme (PBS) as was the case with Primogyn Depot:

I have always endeavoured to keep my hormone levels as stable as possible. However this can sometimes be difficult when certain pharmaceutical companies pull certain HRT products without consulting people who depend on them. (TN126)

Hormones become part of some individuals in ways that made coping with changes difficult. The right hormones were said to "complete" them, while hormones that they wanted to reduce the effects of were experienced as "poison in (their) veins" (TN16). This was especially the case for people who had been on particular hormones for a long time. Changes to the hormones available through PBS were described as "very hard physically and emotionally" (TN97) by a participant who had been on Primogyn Depot for twenty years. Participants had to go through the process again of finding the right treatment, and this presented an inconvenience: "I found...having my blood oestrogen levels drop very low, going through blood tests again till a correct dosage is found, a real pain as the previous worked very well..." (TN163).

Participants also expressed concern about the long term effects of hormone therapy, and its potential toxicity, some deciding not to go on treatment for this reason. One participant who would only start hormone therapy because it was required for surgery said:

At the moment in Victoria it seems impossible to get top surgery without first being on testosterone. I find this pretty ridiculous, as I would rather get top surgery asap, but I'd take my time deciding whether I want to stick a whole batch of synthetic hormones in my body. (TN38)

Other participants who had tried synthetic hormones and experienced adverse side effects, opted for, or were interested in exploring the possibility of, taking natural hormones. One participant who had experienced depression when an "unknowing doctor prescribed progestins", switched to a natural progesterone instead and expressed satisfaction with the results, while another who also had trouble with depression was "researching the possible benefits of using Natural Progesterone alongside Estriol to bring balance" (TN185).

Health concerns were a common reason for opting not to go on hormone therapy. Of the participants who said they did not intend to start such treatments, many indicated a desire to do so, but could not because of the health complications that this presented. A participant who had an existing stroke risk due to atrial fibrillation reasoned that it was "no good being a dead tranny" (TN117). Age was a common barrier to going on hormones, with some participants reporting that hormone treatment would be "too dangerous" at their ages. One participant hoped to be able to use hormone treatment in the future, but had the Hepatitis C virus and wanted to be clear of it before attempting hormone treatment, a known risk of liver damage.

Participants expressed frustration about the lack of information about other potential long-term effects and risks involved in going on hormone treatment. One participant noted:

No specialist has given me adequate information about the effects of hormone replacement therapy. One study in Holland gave a very bleak statistical outcome for transsexuals on hormone therapy, but specialists here seem to brush off the risks. (TN41)

The difficulty in accessing information about side effects, risks, and suitable treatment regimes was a common theme. Participants expressed a wish for doctors to be better informed about how to treat transgender people, suggesting regular bulletins for doctors with updates about hormone treatment and its application to transgender patients. Some participants expressed frustration at being put on treatment regimes that were based on research conducted with genetic females or genetic males, and pointed to the need for a better understanding of the specific health needs of transgender people.

The physical side-effects and risk of hormone therapy were not the only negative aspects of treatment that participants reported. While some participants were happy with the changes in their bodies and about the way they felt about themselves, the changes in their appearances had an impact on their relationships. One participant who started hormone therapy said: “I started to develop as hoped and had to stop because of concerns about my children who live with me and my employment” (TN276).

The potential disruption to participants’ social worlds was an important factor in the decision not to go on hormone therapy. Hormone therapy was thought to have the potential to jeopardize aspects of their lives such as family relationships, careers and income, and relationships with significant others. Participants who had made the decision to hold off on treatment, did so for reasons such as fearing they would lose their partners if they “fully transitioned” (TN160), feeling they were “constrained by work” as their “drive to succeed and have an income was strong” (TN91), or feeling that they “could not expose (themselves) to ridicule in (their) current life” (TN170).

Going on hormone therapy was a vulnerable time for many, and having social support was important for participants. Lack of support was thus also an important factor in the decision not to have treatment. One participant who had been living as a woman for a while, said that while she has “wanted to start hormones since (she) was around 12 years old”, she “never had the confidence/social support to do so” (TN200).

Financial concerns were another important factor in the context in which participants experienced hormone treatment. Some participants described the cost as a significant burden; it was a barrier for some of the participants who had not gone on hormone therapy. While treatment could be described as a “luxury” they could not afford (TN15), it was more often described as a necessity that they did not have access to, or experienced difficulty accessing. Having treatment covered by PBS sometimes required being officially recognised as a particular sex, which usually involved having had some treatment to begin with. The alternative was to have oneself categorised in particular ways that participants did not always welcome:

I am concerned about the cost of hormones. I am now recognised as female by the HIC, but prior to this I would pay for Androcur privately because I did not want to be prescribed under the “deviation of sexual drive in men” indication. This was very expensive. (TN05)

For some people, hormone therapy was a major life decision that despite its appeal for them, would pose significant challenges that they were not equipped to deal with. Many did not feel that they were at a stage in their life, or in the context that would support them through this stage of transition:

No, my life is hard enough as it is, and I decided many years ago (15) that it is better for me to just present as a woman, not have SRS or go down the hormone path. (TN61)

My life is so messed up that it wouldn't help right now. (TN192)

Going on hormone therapy was overall a very positive experience for many participants, but its significant side effects needed to be managed. The context in which participants underwent these changes was important, and while a negative experience with hormone therapy did not override the feeling of congruence that participants felt in the changes that they experienced, the context in which these happened were significant in their health and wellbeing:

Firstly I should point out that I was in a country town in NSW and felt that support services were inaccessible, so I tried to embark on transition by myself. I started with regular doses of natural substance that was high in phytoestrogens, until my breasts got started. Then I ordered estradiol and an anti-androgen on the internet and used them with minimal GP supervision for 9 months. My body and brain grew further out of synch with my social role and I tried to seek support and stop hormones which precipitated a nervous breakdown and loss of employment. The hormones were wonderful in their effects but I was taking them in a poor context. (TN293)

The move through variation in mood to a sense of general contentment following hormone treatment, is expressed by these two participants:

In the first few weeks, I had a few days of feeling a bit down. This worried me a little, but it passed very quickly and as my breasts started to swell and the nipples became tender, I seemed to gain the most self satisfying feeling of being at peace and my self confidence has grown to a level that I cannot remember ever having had. I am so content and happy. (TN195)

For the first year my Depression disappeared and as my body changed so too did my personality opening up more and being more socially accepted by my peers. Now, under three quarters of the way through my 'second puberty', life has it's ups and downs, but generally I live a happy and content life, if not the perfect one. (TN90)

Hormones and self-reported health and well-being

For participants assigned male at birth, there was a trend indicating that those who had ever used hormone treatments reported a lower score on the SF-36 general health perception than those who had never used such treatments. For participants assigned female at birth, the opposite pattern was observed, whereby those who had used hormone treatments reported a higher score on the SF-36 than those who had not (68.25 and 52.28, $t(60) = 2.99$, $p = .004$).

When similar analyses were conducted with the general health ratings, and ratings of health since the last year no differences between groups were found. Furthermore there was no relationship between the use of hormone treatments and either well-being or depression.

Non-prescribed hormones

In addition to hormone treatment, 13.1% participants had used non-medically prescribed hormones or supplements for gender-related reasons (e.g. body-building supplements, tribulus). Use of non-medical hormones or supplements was not associated to whether respondent's had used prescribed hormone treatments or their annual income.

A range of analyses indicated that for respondents assigned male at birth, those who had used non-medically prescribed hormones or supplements reported poorer physical and mental health than those who had not. Scores on the general health subscale of the SF-36 were lower for those who had used non-medical hormones (52.04 and 67.56, $t(184) = -3.47$, $p = .001$). Additionally, those who had used non-medical hormones were more likely to be currently depressed (64.0%) than those who had not (37.1%) ($\chi^2(1) = 6.47$, $p = .011$). The causal direction of these relationships is unclear: it could be that poorer physical and mental health resulted from taking these items, or it could be that those with poorer health were more inclined to take these. Interestingly, these findings were not repeated for participants whose assigned sex at birth was female, and none of the different ratings of physical or mental health were associated with having ever taken non-medically prescribed hormones or supplements.

Section 8

Surgery

As part of transitioning, surgery is sometimes performed on genitals, breasts and other physical features. While not considered the final stage of transitioning, as there is usually a period of adjustment post-surgery, surgery is often viewed as the central and major step in an individual's journey to transition. In Australia, surgical procedures for transsexualism have been performed since the 1950s (Collyer & Heal, 2002). However access to surgery remains limited and it is predominantly performed in Sydney and Melbourne, while in New Zealand services are even more restricted.

Increasingly, studies have found that surgical interventions result in positive outcomes for transsexuals across a range of domains, including psychologically, socially, physically, and sexually (Smith et al., 2005). Extensive screening processes, psychological therapy and staged levels of treatment prior to surgery (e.g. hormone treatment, real life test) are used to prepare the individual for the surgery and minimise the chances of regret after irreversible surgical procedures. Although disappointment after surgery has been reported to occur (Barrett, 1998; Rehman et al., 1999), satisfaction is generally high and few transsexuals report regret after such procedures (Lawrence, 2003; Olsson & Moller, 2006). As such, surgery in combination with hormone therapies is considered to be therapeutic and the 'treatment of choice' for transsexuals (De Cuypere et al., 2005).

Surgical procedures

Respondents were asked to indicate whether they had undergone any surgery that was gender related from a list of 15 surgical procedures. Many different terms have been, and are, used to collectively refer to these procedures. The term 'gender affirming' surgery was used in the survey after consultation with the transgender community. Participants, however, referred to surgery using a range of different names including: "gender correction surgery" (TN262), "gender reassignment surgery" (TN 26) or "GRS" (TN185), "genital corrective surgery" (TN182), "sex affirmation" (TN11), "sex change" (TN97), "Full SRS (sexual reassignment surgery)" (TN57). The terms used to refer to surgery are considered by many in the transgender community to be very important as they reflect meanings around gender and sexual identity. For example, when participants asked if they had had any additional types of 'gender affirming' surgery two participants responded:

It is actually sex affirmation... it is my female sex I am affirming by surgical and hormonal modification. Surgery cannot change my (psychological) gender unless, perhaps, I have a lobotomy! (TN8)

Sex Affirmation Surgery. Sex Affirmation Surgery. Sex, not Gender. Please get it right. Please try and pay attention. (TN11)

The majority of respondents had not had any form of surgery, while 39.1% respondents reported having had some form of surgery. A similar proportion of assigned males had had surgery as assigned females (39.3% and 38.7% respectively). Table 10 presents surgery by sex assigned at birth.

For respondents who were male on their original birth certificate, surgery that involved genitals was the most frequently reported type of surgery. The construction of a vagina from a penis (vaginoplasty) was the most common procedure performed, followed by cosmetic genital surgery and orchidectomy (removal of the testicles). The rate of orchidectomy reported in this sample is likely an underestimate, as only 10 of the 48% (20.8%) who had a vaginoplasty reported having an orchidectomy as well. It would be expected that removal of testicles would have occurred in those who had a vagina created. Of those who had not had a vaginoplasty, 7.7% (11) had had an orchidectomy, which may indicate that some persons undergo this procedure prior to, or instead of, having vaginoplasty (Reid, 1996). Non-genital surgical procedures such as nose reshaping, breast implants, facelifts, brow or eyelid surgery were less commonly reported.

Table 10
Surgery by Assigned Sex

Procedure	Sex on original birth certificate			
	Male		Female	
	N	%	N	%
Vaginoplasty (construction of a vagina from a penis)	48	25.1		
Cosmetic Genital Surgery	25	13.1	1	
Orchidectomy (removal of testicles)	21	11.0		
Rhinoplasty (nose reshaping)	19	9.9		
Breast Implants	19	9.9		
Tracheal Shave	10	5.2		
Chin surgery or facelift	10	5.2		
Brow or eyelid surgery	8	4.2		
Vocal pitch surgery	1			
Chest Reconstruction			16	25.8
Mastectomy (removal of breasts)	1		15	24.2
Hysterectomy and bilateral salingoophorectomy (removal of uterus and ovaries)			11	17.7
Phalloplasty (construction of a penis)			1	
Metoidioplasty (creation of a penis from the clitoris)			1	
Liposuction	6	3.1	3	4.8

Note. Multiple responses possible

For those with female on their original birth certificate, chest reconstruction, mastectomy and removal of the uterus and ovaries were the most common procedures. One person had a procedure to create a penis, reporting having had both a phalloplasty and metoidioplasty. Liposuction was used at a similar (low) rate by participants regardless of sex assigned at birth.

Overall, assigned males were more likely to report surgery to their genitals (e.g. having a vaginoplasty) than assigned females (e.g. having a metoidioplasty or phalloplasty). This may reflect the longer history of the availability of genital surgery for the transitioning of assigned males than for assigned females. It is not surprising that for assigned females mastectomy, chest reconstruction and removal of the uterus and ovaries are more common than surgery to create a penis, as these procedures are routinely performed in non-trans populations and have good surgical outcomes.

Participants were asked to indicate any additional surgical procedures that they had undergone. Four respondents indicated they had hair removed (usually by electrolysis), while three indicated hair advancement or transplant. Three had had surgery to increase lip fullness and one had had feminizing dental work. Four respondents who had had a vaginoplasty indicated that they had additional related procedures - clitoroplasty (3), labiaplasty (3) and vulvoplasty (1). It is likely that other respondents who had received a vaginoplasty also had received the same or similar procedures, but had not indicated them. Two participants indicated they had undergone nipple reconstruction. Finally, one respondent, who had a phalloplasty and medioplasty, indicated he had also received testicle implants and an erection device.

Of the 39.1% of respondents who reported having had one of the procedures, the majority reported only having one or two procedures (71.7%), and only a minority (four respondents) reported having six or more procedures (Figure 7). That is, of the respondents that had had surgery, most indicated only having had a few procedures.

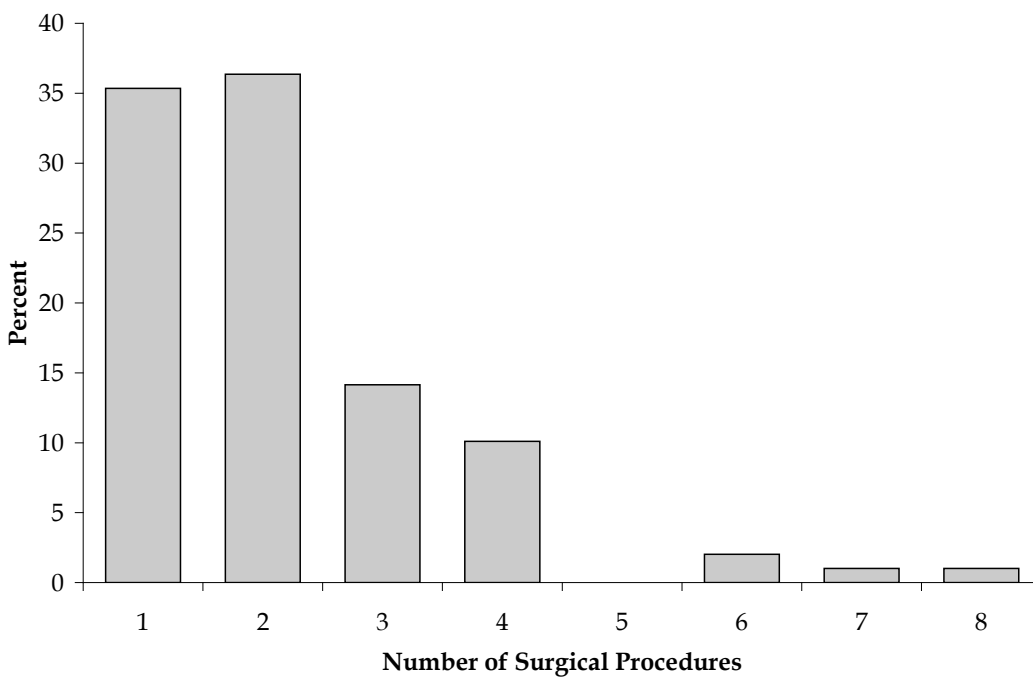


Figure 7. Of Those Who had Surgery, the Number of Surgical Procedures

Where surgery was performed

Participants were asked about where they had had surgery. Participants reported going to both private and public hospitals, and it was clear that the presence of specialists was a large factor in determining where participants went for surgery. Some participants experienced difficulties in obtaining treatment where they lived, and travelling interstate for operations, usually to cities like Melbourne and Sydney, was common. Seventeen participants indicated that they had undergone surgery overseas. Fifteen participants indicated that they had travelled overseas to get surgery (fourteen to Thailand and one to Singapore), and two had surgery prior to moving to Australia (one in New Zealand, one in England). All of the participants who had travelled to Thailand reported that they had positive experiences due to the quality of the surgeons and the level of care provided. Several participants noted that travelling overseas for surgery can be complicated: it requires additional planning in regards to obtaining temporary passports that have an altered gender designation (e.g. female when assigned sex is male) to avoid difficulties exiting and entering countries.

Prevalence rates of transsexualism are usually calculated by counting the number of such surgical procedures performed in a country and then dividing by the population of that country. Given this, it is important to recognise that a number of Australian and New Zealand transsexuals travel overseas for these procedures. That is, prevalence estimates that do not take into account of surgery that is performed overseas will likely result in an underestimation of the rates of transsexualism in both Australia and New Zealand.

Age and surgery

Participants who had had surgery were older than those who had not had surgery (this was the case regardless of the assigned sex of participants). Overall, those less than 30 years of age were less likely to report having had surgery (14.8%) than those in older age groups (45.1% and 57.7%) (Figure 8, $\chi^2(2) = 21.33, p < .0005$). This is not surprising given that to undergo surgery is a lengthy process that spans many years and can incur considerable cost.

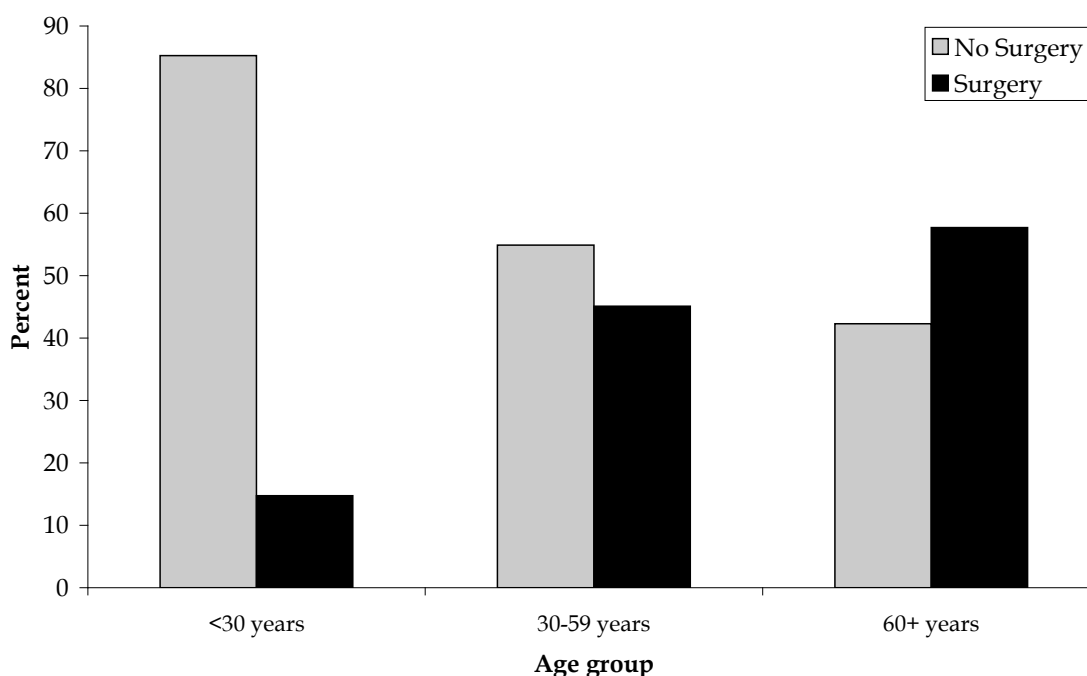


Figure 8. Surgery by Age Group

Surgery and hormone use

Taking hormones is an almost universal requirement before undergoing any gender related surgery. Almost all participants (98.0%) who had some form of surgery had used hormone treatments (Figure 9, $\chi^2(1) = 51.13, p < .0005$). Of the respondents who had not had any form of surgery, the majority (57.1%) had used hormone treatments.

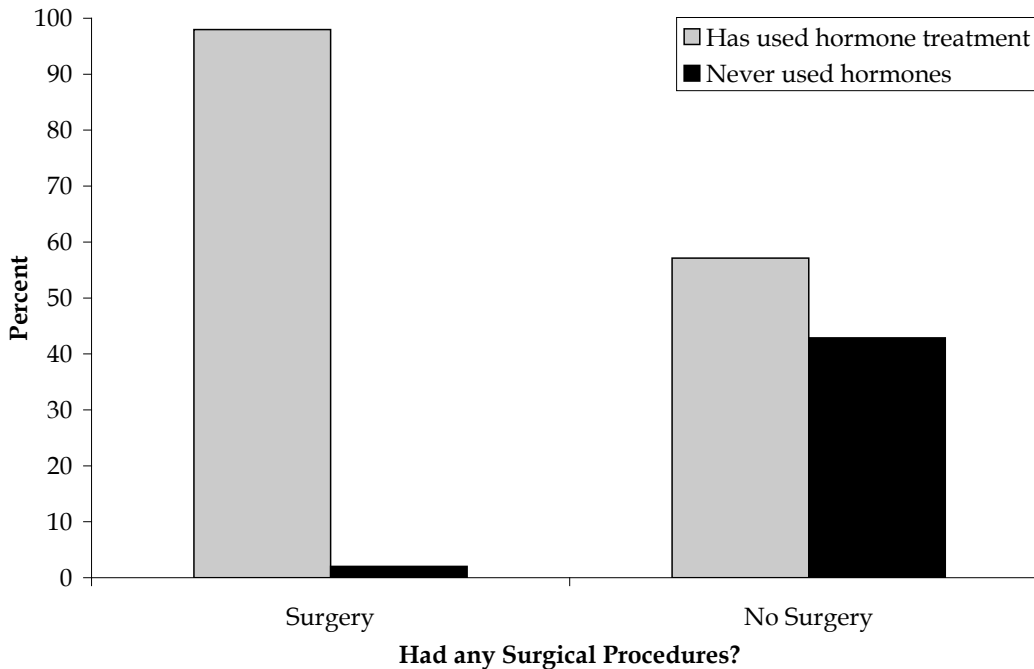


Figure 9. Surgery and Hormone Treatments

The experience of surgery

Respondents who had undergone surgery were asked to provide details about where they had the surgery, what the costs of surgery were, what barriers, if any, they had experienced, and to comment on both the positive and negative aspects to their experience of surgery.

As with hormone therapy, participants often described a deep sense of satisfaction, feelings of relief and completeness with having a body that they have felt to be right for them. Participants said they had “cried with happiness” (TN08) at discovering they were “finally the correct shape” (TN163), and reported more confidence and an “improved...self image” (TN10) at being able to “pass”.

Surgery was a real turning point for me... I finally felt completely comfortable in my skin. (TN24)

For most participants, this experience also came with a significant amount of pain, and for some, ill effects and complications of surgery. While these were manageable for most, for a number of participants, the complications that resulted from surgery presented substantial problems that needed to be managed both immediately post surgery, and for some time afterwards.

Participants named a variety of barriers to obtaining surgery. These included work, family and study commitments, differences in laws regarding surgery in different states if participants moved while still transitioning, the small number of specialists who could perform such surgery, and the resulting need to have to travel interstate or overseas if surgery was not available where they lived. Minimum age at which surgery could be performed was also a potential barrier, and one of the reasons that participants gave for travelling overseas for surgery.

While a small number of Australian participants reported that they had the cost of surgery covered exclusively by Medicare, many participants had purchased private health insurance to cover additional costs, or to fund their surgery completely. Consistent with this, analysis of quantitative data indicated that having private health insurance was associated with having surgery for respondents who had male on their original birth certificate ($\chi^2(1) = 6.65, p = .010$). That is, respondents assigned male at birth were more likely to have had surgery if they had private health insurance (49.4%) than those who did not (29.9%). There was no association between private health insurance and surgery for respondents with female on their birth certificate. Some Australian participants, who had full Medicare cover for their surgery, reported having other conditions that provided an alternative rationale for surgery, such as cryptorchidism for orchidectomies, and endometriosis for hysterectomies.

For most participants, the most outstanding barrier to surgery was cost. This was a major factor in people's decision making about whether to have surgery, and how much to have:

I need more done to make my vagina functional but can't afford it. I also would like some face surgery but it is prohibitively expensive. (TN08)

It also influenced the extent of the surgery that they could have. One Australian participant, for instance, was able to access surgery through Medicare, which meant that she was "unable to have more than 5 cm of vaginal depth" (TN183). While the quantitative data indicated that there was no association between income and whether some had had surgery or not, participants' financial positions and whether or not they had health cover determined how much surgery they could have, and what compromises they had to make to have procedures that they felt they could not do without. Participants for whom money was not a barrier said that for them, "cost was never the major consideration" (TN253), while other participants who were less well off reported that the "cost was exorbitant" and that they "no longer own a car and do not expect to be able to own a house again anytime soon" (TN88).

Medical professionals could also present a barrier to participants' ability to access surgery. While many people described their doctors as having been supportive of their choices, some participants' doctors refused them surgery because they did not share the participants' perspectives on the necessity of certain surgical procedures.

Participants also had to have a recommendation from a psychiatrist in order to have surgery. This process of gaining approval was commonly described as being slow, but most people acknowledged that it was necessary and valuable, and did not see it as an obstacle. For those who had difficulty in obtaining a recommendation for surgery, however, this was cited as a major barrier. The small number of available mental health professionals presented a barrier if rapport between the provider and client was not established. One participant, for example, contained his dissatisfaction with the service he was receiving in order to have his psychiatrist sign off on the surgery, but said that his refusal to continue to see this psychiatrist afterwards "will almost certainly jeopardise (his) ability to access other GRS procedures in the future" (TN22).

Participants often expressed strong feelings about the financial and procedural barriers that they faced in accessing surgery they felt was essential. There was a sense of frustration with the perceived inequity between accessing certain surgical procedures for transgender and transsexual issues, and for other health reasons:

I was told that I had to get a psychiatrist to sign off on the surgery, despite the fact that any bio-woman can get her breasts remodelled, enlarged, reduced, or even removed (as some women are now to reduce risks of breast cancer) just because she wants to. (TN180)

One participant found it "offensive" that cosmetic procedures for some conditions could be claimed on Medicare, but not to "correct...gender presentation" (TN10) and another wondered "how come some bastard can smoke and drink themselves to a heart attack and have full medical treatment on Medicare and (she was) forced to leave home and work overseas to earn enough to pay off surgery for a condition (she) did not create". (TN88)

For the participants who had undergone some form of surgery, the procedures were often seen as a necessity rather than a choice. A few participants even described surgery as life-saving in the way that it had increased their well-being and eliminated their thoughts of suicide.

My surgery GRS was very professionally and caringly done and has saved my life as I was often suicidal before. (TN09)

Participants frequently cited their experiences with medical staff in their descriptions of the positive and negative aspects of surgery. There was a mix of participants who reported bad experiences with medical staff at hospitals, and those whose interactions with medical staff were positive. Some participants found the experience to be “the most...fruitful encounter with the medical fraternity in (their) life” (TN166), valuing medical professionals who were “respectful of (their) transness and pronoun choices”, or who behaved with “kindness” and had “a good bedside manner” (TN198). Negative experiences included hospital staff treating their patient “like a freak” (TN06).

One of the reasons that people gave for travelling to Thailand for surgery was that Thai surgeons were thought to be more experienced than surgeons in Australia or New Zealand due to the number of operations they perform. Thai medical staff was also seen to be better equipped to deal with transgender and transsexualism issues. One participant who had travelled to Thailand for surgery said:

I had no problems whatsoever. My result is incredible. I was treated with the utmost in love and compassion by all the clinic and hospital staff. An extreme contrast to how I have been abused, insulted, brutalised, mistreated and refused treatment by the Australian public hospital system. (TN11)

Some participants expressed frustration at the absence of services for transgender people where they lived. One participant from Western Australia felt that local doctors and other health professionals were not interested in treating transgender and transsexual people. Her experience was that transgender and transsexual people there “have no real support base” (TN39). The fact that participants had to travel for surgery was also sometimes seen as a negative side of undergoing surgery. These participants were often disadvantaged because they did not have their family and friends around to support them, and it could also limit the outpatient care that they could receive after surgery; participants had to weigh the benefit of this care against the cost of their stay in the city they had travelled to for treatment.

Postoperative care was an important concern for many people after surgery as participants needed to manage pain, ill effects, and the psychological impact of surgery. There were a small number of participants who experienced serious complications such as vaginal fistulas, infections, loss of sensation, and scarring. Others also experienced feelings of grief and loss after surgery, and one participant experienced a loss of short-term memory, an inability to solve complex problems, and depression.

While severe experiences were limited to a small number of participants, most people had to deal with them to some extent. The most substantial issue for the majority of participants was the physical pain and discomfort that followed surgery. The presence of supportive health professionals, family members, and friends, was extremely important during this time, and could make a difference in how pain was managed.

Surgery was great, even if it was initially painful. The staff at the hospital were really good. The worst part was coming home and moving back into the community where I lived. Lucky to have so many good, close friends who took most of the brunt of my change and didn't put me down. (TN81)

Participants who lacked such support cited it as a difficulty that they experienced undergoing surgery. For one participant, the experience was mostly positive, and the “only downside...was doing it all on my own even at home after returning home after hospitalisation” (TN58). A number of participants expressed dissatisfaction with their treatment after surgery, having been “sent home with drip bags full of blood and pus” (TN180), “sent home on the bus (alone)”, and needing to look for a community nurse themselves (TN06). The management of surgical wounds was also important for participants. One participant said:

I wasn't given much information about care after the event and part of my neo-vagina closed over, reducing the length to about 25%. (TN129)

Although a number of participants experienced ill-effects of surgery that overshadowed any positive result, for most, surgery was acknowledged to have been a difficult experience, but one that was seen to be worth the pain and discomfort. Participants sometimes expressed this with images of struggle and eventual accomplishment:

For me the experience was like being pregnant: the waddling walk, difficulty getting up and down, wind, headaches, tiredness, constipation, and the joy of new life; mine. (TN181)

Mastectomy was very painful but I would do it every year to be free...I didn't scar as badly as I thought I would and was prepared for. The scars that I do have I wear triumphantly. Like initiation scars worn by some natives as a passage to manhood. (TN67)

Well-being and surgery

Respondents whose assigned sex at birth was male, and who had any type of surgery, were more likely to report better well-being than those who had not had any surgery (Figure 10) ($\chi^2(4) = 10.22, p = .037$). In particular, 24.0% of those had surgery were 'extremely happy' compared with 8.6% of those who had not had surgery. A similar pattern was seen for assigned females (Figure 11) but this effect was not significant.

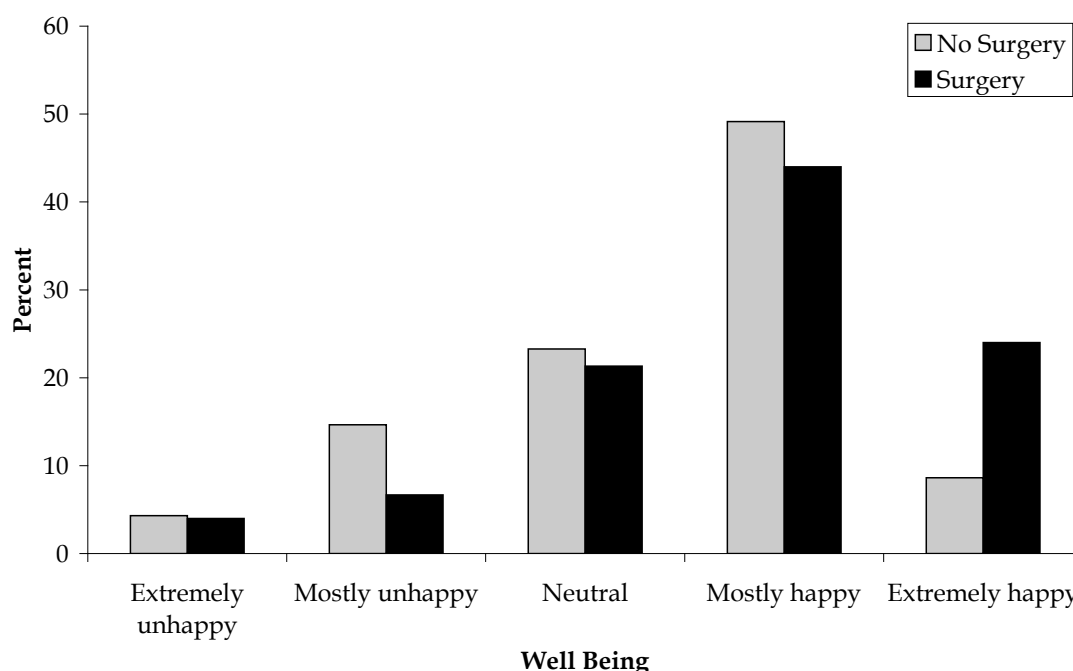


Figure 10. Wellbeing and Surgery of Respondents with Male on their Original Birth Certificate

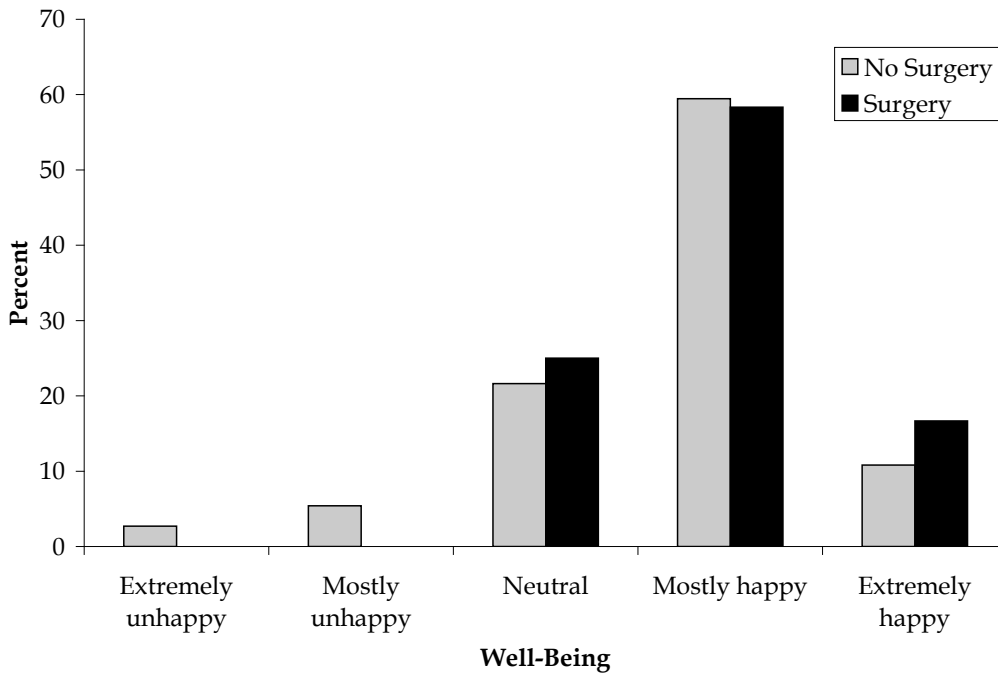


Figure 11. Well Being and Surgery of Respondents with Female on their Original Birth Certificate

Self-reported health and surgery

Assigned males who had had a vaginoplasty reported better health (ie. higher scores) on the SF-36 than those who had not had this procedure (71.31 and 63.56 respectively, $t(186) = -2.23, p = .027$).

Non-surgical/non-hormonal body modification practices

Non-surgical or non-hormonal body modification or practices (e.g. corseting, chest binding) had been used by 41.6% (101) of respondents. This was more common for assigned females (74.6%) than assigned males (31.0%) ($\chi^2(1) = 34.96, p < .0005$). There was no relationship between income and the use of these practices. Similar to surgery, those with male on their birth certificate, respondents aged less than 30 years were less likely to have used these practices (11.1%) than those aged 30-59 years (36.1%) or those aged 60 years or older (36.0%) ($\chi^2(2) = 6.50, p = .039$).

Experience of non-surgical and non-hormonal practices

Participants were asked to comment on their experiences of non-surgical or non-hormonal body modification.

Chest binding, which involves the wearing of a piece of clothing to reduce the visible size of one's breasts (i.e. flattens the chest), was a common practice for respondents who were assigned female at birth. It was often a substitute for a mastectomy and chest reconstructive surgery if participants could not afford these, or as way of exploring identity without the permanence of surgery. For some, it was merely an inconvenient prerequisite that would qualify them for an operation, given their psychiatrists would only approve surgery if they had been binding for a specified length of time. For many, binding was a way for people to feel more comfortable about their bodies and their appearances, and for some, a means to help them to pass as males.

(Binding) does a LOT for my self confidence and body comfort to have the appearance of a flat chest. (TN33)

This came with significant inconvenience, involving a high level of discomfort that was especially pronounced during summer. In many cases it caused pain, and could make breathing and movement difficult. Some participants also reported injuries to ribs and backs.

Chest binding is crap - it is hot, uncomfortable, and looks suspect. (TN93)

There was a limit to the effectiveness of binding. Some participants found it to be unsatisfactory because they had large breasts, and other found that it could not “contour (one’s) chest as one would have liked” (TN128). Participants also saw it as potentially revealing, and were fearful of being found out. Some described being hyper-vigilant, limiting their intimacy with partners, avoiding certain sports, and taking care by only using disabled change rooms, for example.

Thus, it was acknowledged that while it had its benefits, binding as a body modification practice posed significant bodily and psychological discomfort:

Mastectomy should be provided to all f2ms asap as a matter of good physical and psychological health and enabling people to get on with their lives as functioning members of society, but it isn't. (TN76)

I do what I need to to fit into where I believe and feel so strongly I belong and if that means I have to bind my breasts each day then I will , ... it's uncomfortable and just another reminder of who you are and don't want to be tho. (TN260)

Some participants who had mastectomies were happy to no longer have to practice chest binding, and were glad not to have to worry about their breasts “giving (them) away” (TN24).

A small number of transsexual men mentioned other body modification techniques such as the use of penile prostheses and simulated facial hair, as well as learning how to walk, stand and sit in a more ‘masculine’ way.

Some of the techniques practiced by transsexual women included electrolysis and laser hair removal, corsets, waxing, eyebrow shaping, taping penises and scrotum, using fake breasts, and hip padding. These practices “felt right” (TN227) to participants and were experienced as “affirming” (TN109). Like chest binding, they came with a significant amount of discomfort and pain, particularly corseting, which “puts a lot of pressure on internal organs sometimes making them ache” (TN66), and electrolysis:

You want pain? You need to know about determination in moving toward the gender in which you need to live. It's the prize winner - Electrolysis. By FAR the most painful of any procedure. (TN178)

For some participants, the benefits of certain techniques also came with inadequacies in the absence of more permanent surgical procedures:

The positive effects were that I could come close to a convincing silhouette of a genetic female. The negatives effects were knowing that the appearance was not permanent and extremely unhappy to remove the garments. (TN232)

Quite often, practices such as these were stand-ins for more permanent modifications, and inconveniences that were essential in the meantime. One participant was “looking forward to not needing them after surgery” (TN284). Electrolysis, however, was considered an essential gender related procedure for transsexual women, even if it was painful, and many were frustrated by how expensive it was.

Section 9

Changing Documentation

Such a great feeling when I had it done, I have just got my passport done after three years post-op and it is the best feeling ever. (TN16)

Half of respondents (50.6%) reported that they had tried to amend public documentation to reflect their current gender identity. A range of different types of documentation were mentioned by participants and are listed in Table 11.

Table 11
Types of Documentation Respondents Had Tried to Amend

Type of documentation:	
Bank accounts	Insurance details
Birth certificate	Medicare card
Car registration	Naturalization papers
Citizenship certificates	Passport
Council rates	PO box details
Credit cards	Police security checks
Drivers license	Superannuation
Electoral details	Tax file number
Gun licenses	University records
House title	

When attempting to change documentation, participants dealt with a wide range of public and private organizations, and those mentioned by participants are listed in Table 12. It is clear that having documentation reflect the preferred gender is crucial to a sense of personal and identity recognition. Experiences and outcomes varied, and even within the same organization there appeared to be different practices, leading to different experiences and degrees of difficulty and frustration.

Table 12
Organisations Dealt with when Changing Documentation

Organisations dealt with:

- Australian Electoral Commission
 - Australian Tax Office
 - Financial Institutions (Banks, Credit Card Companies, Superannuation Funds), Public companies (e.g. Telephone companies)
 - Government Departments (e.g. Department of Birth Deaths and Marriages, the Department of Foreign Affairs and Trade)
 - Health Insurance
 - Local councils
 - Medicare
 - Police
 - Post offices
 - Social security (e.g. Centrelink)
 - Telephone companies
 - Transport department and associated organizations (e.g. Vic Roads and the Road Traffic Authority)
-

The changes made (or attempted) were mostly to do with changing an ‘M’ to ‘F’, ‘Male’ to ‘Female’ (or vice versa), or the changing of a name. There were several participants who had attempted other modifications. For example, a New Zealand participant had the gender designation removed from their passport and changed to a ‘-’. Another participant stated:

I wanted to get the words “previously registered in another name” removed from my birth certificate after I had GRS. Why? Because when I have had to present it for employment I get asked what was your previous name, which was a male name, and basically it would give away my gender. (TN256)

For gender or sex to be changed on documentation, often the individual is required to show evidence of having had a related surgical procedure and no change can be made until surgery has been performed. In line with this, almost 90% of participants who had undergone surgery (any of the types asked about) had also made attempts to change documentation (Table 13). A quarter of participants who had not undergone any surgical procedures had also made attempts to change documentation. This indicates that a person’s desire to have their current gender identity reflected on documentation is not dependent on whether someone has had gender related surgery.

Table 13

Attempts to Amend Documentation to Reflect Current Gender Identity by Having Had Surgery

Have you tried to amend documentation to reflect your current gender identity?	Have you had any surgery?			
	Yes		No	
	N	%	N	%
Yes	88	88.9	39	25.7
No	11	11.1	113	74.3
Total	99	100.0	152	100.0

Many participants indicated frustration at not being able to change their gender or sex on their documentation unless they had had surgery, particularly given the cost and other barrier of gender related surgical procedures.

I've had a legal name change, but am disappointed that the New South Wales government requires I undergo surgery to recognise my gender. I think diagnosis from one or perhaps two psychiatrists should be enough to amend sex on one's birth certificate, as it makes things very difficult when using a birth certificate with a female name which states male gender. (TN279)

I feel the Department of Births Deaths and Marriages should amend the law to allow people with transsexualism to be recognised as their correct sex regardless of if they have been unable to obtain surgery or not since money is the prohibiting cause. (TN76)

I want to change my passport to say male, but they won't let me till I've had chest surgery or a hysterectomy.... fuckheads!!! (TN102)

I have been refused since I have not had phalloplasty and therefore they said I have not had "sexual reassignment surgery". I was able to change my name by Deed Poll, but the certificate they gave me had in HUGE LETTERS "Registered sex: FEMALE". So it was very difficult and intimidating taking this around to officially change my name. Even now, 8 years after I changed my name, I am still required to produce this document and now it causes even more hassle because I pass completely as male and am showing a piece of paper that says I am a woman. (TN180)

I successfully applied for both a birth certificate and a change of name document from 'Births Deaths and Marriages' department in N.S.W. and then a driver's licence and Medicare card and had no problems whatsoever. Although my new name is on the government documents (i.e. Birth certificate and change of name certificate) it saddens me to know that until I have S.R.S. my gender will always be shown as 'male'. (TN282)

Overall, participants' experiences of changing their documentation were dependent on what information they wanted to change (e.g. name, or sex), whether they had undergone surgery, what documents and records they were trying to amend, as well as the idiosyncrasies of particular individuals and institutions.

In some instances, the process had been largely unproblematic for participants, even though it could involve "a bit of mucking around" (TN178), and could be "overly and unnecessarily complicated" (TN20). It required organisation and effort, but as long as they "filled in the right forms", and had the "correct supporting documents" handy (TN178), the outcome was mostly positive. In other instances, the process was more drawn out; sometimes taking years before the correct changes were registered, or else ending in refusal.

Changing one's name on documents appeared to be a relatively straightforward exercise for most people, although some participants encountered difficulties with particular banks, credit card and telecommunication companies. A number of participants also reported instances where they believed that the changes to their personal information on public records had been accepted, only to find that their old name continued to show up when they made insurance claims.

It was particularly common for participants who had successfully changed their names to report a time-lag in the accompanying change of title. Participants reported having to contact institutions several times before their mail was addressed with the appropriate title, and one participant reported finally leaving his telephone company because "they could not get it right" [TN12]. In some instances, institutions flatly refused to change participants' titles until they could prove that they had undergone surgery:

My bank has outright refused to stop addressing my mail as 'Mr' until I can provide them with either an updated birth certificate or a letter from a surgeon saying I have undergone GRS. (TN176)

Participants appreciated it when their mail was properly addressed even though they had been unable to change their sex on their documents:

I changed my name, then obtained a new birth certificate. It was easy and pain free. Even the letter to me from the Department of Internal Affairs confirming the change had taken place was addressed to 'Miss' rather than 'Mister', which I felt was thoughtful, and showed it wasn't merely a form letter. (TN284)

Changing Documentation and the Place of Surgery

Changing one's sex on official documentation was more difficult than changing one's name. Participants' legal status as transgender people was constructed around whether they had had surgery. Participants could only change their sex on their birth certificates if they could prove that they had undergone surgery, and that they were not married. Having an amended birth certificate was the key to having most other documentation changed to reflect the individual's gender. Most participants who had been able to obtain amended birth certificates were able to easily change their passports, driver's licences, as well as their information with other institutions and government bodies such as Medicare and Centrelink.

In some cases, a medical report stating that a person was taking the steps towards having gender reassignment surgery also allowed participants to make changes to some documents such as drivers' licences. In some instances, participants were able to obtain temporary passports that allowed them to travel easily as the gender that they were presenting. Two New Zealand participants noted that they were able to obtain passports that stated their gender as "-" while they remained pre-operative. Both were happy with this compromise, one commenting that the "the system works" (TN107).

While an amended birth certificate made things much more straightforward for some participants, others who were not able to obtain one had some degree of success in changing their personal information with various institutions. This appeared to be largely dependent on the willingness of particular individuals within these institutions to bend the rules. For example, one participant noted:

I had to fight Centrelink to accept my gender because I do not have a birth certificate (I am pre-op) that represents my identified gender. It took lots of pleading and bursting into tears (literally) until someone sympathetic finally took my side, broke the rules and just made the change. (TN176)

Participants also had innovative ways of getting what they wanted when the “direct and honest way” proved fruitless. These included “feigning innocence and pretending (the agency had) made a silly mistake” to change one’s sex on social security documents (TN188), opting for the non-gendered title “Dr” after failing to have gendered titles removed from paperwork, and adding one’s feminine name as an additional cardholder on one’s credit card. Some participants also found effective ways of dealing with government clerks, realising that they were more cooperative if you “tell them what to do” instead of asking them whether it is possible for something to be done (TN251).

Experiences of discrimination

Generally there were no problems with having my documentation changed other than the embarrassment of actually having to do it. (TN28)

For some participants, the experience of having documentation changed was an uncomfortable and sensitive process to begin with even if it went smoothly. However for some participants, it could also involve outright ridicule or an unsubtle curiosity that led to embarrassment. Participants related experiences that included being continually addressed as “Sir” even though the individual was “dressed as a female” (TN55), clerks speaking more loudly than they needed to in a waiting room full of people, the staff at an organisation where a participant was getting documentation changed “all (coming) out one by one to have a look”, and being told that they could:

...change (their) title from ‘Ms’ to anything (they) liked, including ‘Sir’, ‘His Royal Highness’, ‘Prince’, ‘Duchess’ etc, but...not...(their) gender designation”. (TN22)

For one participant, attempting to have his documentation reflect his gender had been a “stressful and painful” process (TN164).

There were also participants who reported positive experiences in trying to amend their documentation. These involved encounters with staff that made it a point to make the participant feel comfortable. One participant, for example, was appreciative of a staff member for being “very supportive and just treating (him) as a normal guy” (TN68). Another said:

... when I was out of work and at the unemployment office...a lovely lady who was a Justice of the Peace took me aside and told me that I could change my name and she could do that for me. For which I was grateful, not fun standing in queues when your name is called out loud as a boy or man. (TN95)

Participants who had been able to successfully change their documentation experienced this as affirming of their gender. Participants described it as the “best feeling ever” (TN16), and felt that having their documents legally changed meant that “no one (could) question” their status as their preferred gender (TN179). On the flip side, being unable to change their sex on their birth certificates, and continuing to receive mail address to “Mr Jane Doe”, for example, could be equally disaffirming.

I have been refused since I have not had phalloplasty and therefore they said I have not had “sexual reassignment surgery”. I was able to change my name by Deed Poll, but the certificate they gave me had in HUGE LETTERS “Registered sex: FEMALE”. So it was very difficult and intimidating taking this around to officially change my name. Even now, 8 years after I changed my name, I am still required to produce this document and now it causes even more hassle because I pass completely as male and am showing a piece of paper that says I am a woman. (TN180)

Participants often expressed a sense of hopelessness, especially when they did not have the means to have surgery. One participant who had not had surgery, nevertheless tried to have her sex on her birth certificate changed. She also tried to amend her bank and tax information but continued to receive mail addressed to “Mr”. She could not have surgery because she was “all out trying to keep a roof over her head and food in the cupboard, (let) alone trying to save for gender affirmation surgery” (TN191).

I am unable to change my most important identification to reflect my true gender identity until I have an operation. I personally feel that is discriminatory as gender identity is based on much more than anatomy. (TN91)

Participants also felt discriminated against knowing, for instance, that the change of their gender on their passports was “merely a gesture by the Federal Government and does not confer any right to marry in one’s true gender” (TN27). One participant felt discriminated against when she was had her gender changed on her birth certificate, and was “hailed into a private booth and told that this does not give (her) the right to marry” (TN126).

Consequences of being unable to change documentation

The inability to change their documents naturally had consequences in participants’ lives. Participants noted that the mismatch between their documents and their gender presentation could “incite discrimination” (TN110) as it prevented them from being able to pass. When they travelled with incongruent passports, it could leave them open to “questioning and searches that (they) would otherwise not be subjected to” (TN45), and a number of participants reported experiences of being harassed at airports. This affected participants’ sense of safety:

...when travelling overseas and your picture is feminine, but the passport is stamped ‘male’...it can turn a simple ‘stamp and move on’ procedure into a ridicule and trans-phobic encounter...even putting your well being or life in danger. (TN110)

When participants were living publicly as their preferred gender, they were aware of the fact that their public documents that wrongly listed their sex had the potential to out them. One participant said that her “biggest fear is of the curiosity of people I don’t know or trust” (TN133). While she said that her fear had been “so far, unfounded”, it still “persists as a fear”. For others, the possibility of being outed was a very real threat. This was particularly so when participants applied for jobs that required security clearances. One participant who had undergone surgery but was unable to have her birth certificate changed because she was still legally married, said:

Every time I apply for a job or for a security clearance, my full history is revealed because I am a man according to my most fundamental document of identification. (TN08)

Some participants who were able to change their birth certificates had similar problems as their new certificates noted that they had been “previously registered in another name”:

...when I have had to present it for say employment, I get asked what was your previous name, which was a male name. Basically it gives away your gender. (TN256)

Some participants suggested thresholds other than surgery, such as psychiatric diagnosis or hormone treatment, for document change.

I think diagnosis from one or perhaps two psychiatrists should be enough to amend sex on one’s birth certificate... (TN279)

All my documentation has attempted to be changed with varying success. Drivers licence, Medicare card, electoral role, bank account all fully changed. Birth Certificate and Centrelink records Name change but they will not change the gender. Educational certificates varying degrees of success. (TN163, has had hormone treatment but not surgery)

In one case, a participant did not proceed to citizenship because of what was considered to be too onerous bureaucratic processes:

I tried to alter my aust citizenship certificate to my new name as it was too embarrassing (and inaccurate) to show the original one - they wanted detailed information on my surgery and hormonal treatment as well as confirmation of gender identity change for the longer term. I have refused to do for the sake of bureaucracy and subsequently renounced aust citizenship. (TN128)

Section 10

Stigma and discrimination

Changing sex at times brings out the worst society has to offer (TN233)

Transgender people frequently experience harassment and stigmatization, and violence due to their gender identity. Lombardi et al. (2001) reported in a sample of 402 transgender people in the United States that 59.5% had experienced harassment or violence as a result of their gender identity, around a quarter had had a violent incident and almost 40% had experienced discrimination in the workplace. Experience of violence or discrimination by transgender people can also lead to secondary problems due to their gender identity being exposed, such as losing jobs or being denied promotion.

Personal experiences of stigma and discrimination

Participants were asked to identify circumstances where they had been discriminated against on the basis of gender issues (Table 14). Of participants, 87.4% had experienced at least one listed form of stigma or discrimination. It seemed to be experienced equally by transgender people regardless of which sex they were assigned at birth. For respondents residing in Australia, there were no differences in the reporting of stigma and discrimination for participants from metropolitan and from rural areas.

Social forms of stigma and discrimination were the most common, with around half of participants reporting being verbally abused, socially excluded, or having rumours spread about them. A third had been threatened with violence. A similar level had received lesser treatment due to their name or sex on documents, as well as been refused employment or promotion. Almost a quarter had been refused services in other areas, while one in five had been threatened to be 'outed'. Physical attacks were reported by 19% of participants, a similar level reported discrimination from police, and 15% had things thrown at them. Refusal of bank finance was experienced by 15%, while housing had been refused for 12% of participants. Obscene mail and phone calls, and damage of personal property were experienced by 11%. Sexual assault and rape had been experienced by around 10% of respondents. Hate mail and blackmail were reported by less than 10% of the sample. Only 5% of participants reported that they had had custody of their children revoked due to gender issues. It is unclear, however, the number of participants overall in the sample who had children; thus it is likely that the proportion of respondents who had had custody revoked is much higher.

Table 14
Experience of Discrimination or Stigma on the Basis of Gender Issues

Type of Discrimination or Stigmatisation	Total	
	N	%
Direct personal insults or verbal abuse	135	53.4
Excluded socially or ignored	120	47.4
Rumours spread about you	120	47.4
Threats of violence or intimidation	85	33.6
Received lesser treatment due to issues regarding name/sex on documents	82	32.4
Refused employment or denied a promotion in an existing job	80	31.6
Refused services in other areas	68	26.9
Threats to 'out' you	53	20.9
Physical attack, or other kind of violence	47	18.6
Discriminatory treatment from police	45	17.8
Obtaining bank finance has been made difficult or refused	38	15.0
Had objects thrown at you	37	14.6
Refused housing	31	12.3
Sexual assault	29	11.5
Obscene mail or telephone calls	28	11.1
Deliberate damage or defacing of personal property	27	10.7
Rape	25	9.9
Hate mail or graffiti	21	8.3
Custody of your children was reviewed or revoked	13	5.1
Blackmail	12	4.7

Participants were asked if there was anything else that they wanted to tell us about stigma and discrimination associated with their gender identity and presentation.

A number of participants said that they had not experienced any discrimination because, in their view, they were able to pass successfully as the gender that they were presenting. They were able to “look, sound and act” like their preferred gender (TN284), which allowed them to only disclose to people that they trusted.

“Work(ing) extremely hard” to pass so that they would not be a “noticeable transsexual” (TN10) was thus one of the ways in which participants tried to avoid discrimination, although this was not always easily done. The period in which people were transitioning, for example, could be a particularly precarious one. For one participant, the experience had been one of “daily and relentless” stigma and discrimination, as his appearance at the time did not “fit one or the other gender box” (TN103). Other people were less successful in passing because they did not naturally have the body type or facial structure that would allow them to do so, and they could not afford to have cosmetic surgery:

People can hide their sexuality (GLB) but it is very difficult to hide your former sexual identity when procedures like facial feminisation are denied to you because of the cost. (TN08)

For some participants who could not easily pass as their preferred gender, their strategy to avoid discrimination was to present androgynously. While people chose to present androgynously for other reasons as well, for some participants, it increased the likelihood that they would pass, allowing them to avoid “social scrutiny” (TN245).

I still feel discrimination in all levels of society. I feel I need to present androgynous to feel comfortable in public. (TN126)

One participant decided that she “(could) never be a woman” and was happy being a “tranny”. She chose to “maintain a somewhat male image” but wore lots of jewellery and diamonds which people read merely as eccentricity (TN195).

For the participants who eschewed gender binaries and presented androgynously, or who decided not to have surgery, some experiences of discrimination came from other transgender people. These participants pointed to an attitude among people who had undergone surgery, or were intending to, that surgery was “de rigeur” (TN13):

I am unsure if I want SRS and there are a number of transsexual people who believe that I should not be able to get a birth certificate or passport with a female gender marker. This makes me sad. (TN05)

This conveyed an onus on them to do all they could to be acceptable to society. Indeed, one participant who had undergone surgery and who was able to pass well said that she felt “pity for those who do not wish to be passable and yet complain about social stigma directed towards them” (TN197).

Transgender people have been the least accepting and most confronted about my androgynous gender. (TN211)

Another way in which participants avoided stigma and discrimination was to keep their gender identities to themselves, or to only express them in private, and in safe spaces. In these instances, they had assessed that to present in their preferred gender as their public selves would have repercussions on their relationships with family and friends, as well as having consequences for their employment. Such fears were born out in the experiences of other participants whose transitioning or coming out had resulted in rejection from people close to them, or who had lost of jobs and employment opportunities. Going “full-time” and making a “public” transition could thus prove a major disruption in their personal and professional lives:

I once was a well established lawyer. Coming out meant divorce, taking lesser jobs and being fired after I said I want to go 'full time'. (TN288)

People were “sent to Coventry” by their spouses and children (TN73), and even had their young children taken away from them. For one participant who was transitioning later in life, losing a wife of 45 years in the process, most of the discrimination she had encountered had been from family members.

Family members of participants could also become the target of discrimination:

My whole family suffers. My step son has left school at 15yo without completing Yr 10 due to bullying against him. (TN162)

For one woman, it was imperative that her transgender status remain private and she did all she could to pass in order to protect her children from potential stigma and discrimination:

I never talk about it (my history) really unless I feel someone needs to know. I'm lucky enough to pass well which, I believe, makes life a lot easier for me and my kids...who live with me. (TN185)

The workplace

People commonly experienced discrimination in the workplace. In this context, coming out and living as one's preferred gender was considered by some as potentially "disastrous" (TN196) for careers, particularly for transgender women working in traditionally masculine jobs such as the police or defence force. For some, gaining and maintaining employment was thought to be the "largest hurdle" that transgender people faced. Passing completely as their preferred gender, or keeping it private, was often thought to be crucial:

Many (transgender people) I know are only men during work hours. (TN87)

Job applications were complicated when, for example, someone was applying for a job as a female, but "all (their) qualifications (were) male" (TN55). One participant who had submitted job applications as a person in transition, found that most of them were ignored. On a more positive note, however, she said:

I am currently awaiting the outcome of an interview where I reached the shortlist as an M/F in transition. (TN43)

As was reported in relation to changing documentation, even if participants were able to pass well, and had managed to change crucial information about themselves, their sex assigned at birth could be revealed in the job application process through security checks, or through statements on new documents that stated that they had been previously registered otherwise. Participants noted that equal opportunity and anti-discrimination legislation was difficult to apply, in practice, and that in many instances, they could never know for certain if they had been discriminated against based on gender identity:

It is sometimes impossible to tell whether one has been discriminated against for reasons of reassigned gender. I was once denied a job interview despite being better qualified and having more experience than those who were interviewed but I cannot be sure this was based on my reassignment...(TN27)

My employment was terminated in July of this year after I indicated I wished to transition. It was indirectly via a restructure exercise and the reasons furnished were that I was not a "team player" and that I did not fit into the culture of the employer...I've never had a negative outcome or lost a case. (TN43)

Some participants had to depend on hostile employers to provide proof of employment, and this sometimes determined whether or not they would be able to "pass" in their future employment. One participant who had been dismissed because of her transgender status said:

...the Minister/Department refused to alter my name on my record of service and refused to issue a record of service with my gender listed as female. (TN88)

While there were participants who reported positive experiences in the workforce, the experience of fear significantly affected the working lives of many participants. For example, a participant, who was about to start transitioning, left a job because she was "too frightened to tell the people that (she) worked with" (TN176); another who had successfully transitioned was making plans to resign from a high level position. He perceived that the sector in which he worked would be intolerant of a transgender person, and he was exhausted from the constant fear of being found out (TN93).

Participants also sometimes feared for their physical safety in the workplace, should they be "discovered":

I pass very well in day to day life, but I still fear being outed in work situations. I often work in isolated areas, where bathroom facilities are non-existent, and I have yet to find a way to stand and pee that works whilst wearing jeans or overalls and that doesn't require trouser removal. Of course, I worry that someone will catch me out if I squat, and often there aren't any bushes anyway - just a fencepost. This is a major issue for me, as the people I work with aren't very tolerant, and it would be really easy for me to have an "accident" or just disappear, even. (TN04)

Others have had very different experiences. For example,

My work has been absolutely fantastic - I actually got congratulatory emails after the "coming out" announcement was made. I think it's all in your own attitude - if you feel good and comfortable about yourself and are open and honest with others it generally will go well. (TN33)

Fear for safety

Fear was a common theme in participants' comments about their experiences of stigma and discrimination, not only in relation to their work. This fear was often based on past experiences, the experiences of their friends, or just an awareness of general attitudes towards transgender people, and the way in which they are portrayed in the media. Participants said that they sometimes feared for their safety, and that even what they considered a "relatively minor incident" of verbal abuse (TN117) could provoke a "fear of what might be" that is greater than what actually happens (TN166). This sense of fear could be all pervasive, one participant noting that "no matter where you are or how you are acting, you're always at risk" (TN200). Another even said that she imagined that people in her environment "might have liked to have arranged for me to be murdered" (TN203).

Even when participants were confident of being able to pass relatively seamlessly, there was also the fear that they could potentially be outed by people who knew about their past. Participants had to work out when or whether to tell people that they were transgender, particularly potential partners:

I have had men interested in me up to the point of discovering my past. All have walked at that point. It takes a special man to accept that sort of past. (TN178)

Generally I suss out the situation and if I feel safe/supported, then I will disclose. (TN28)

One participant described the need for negotiating issues of privacy and confidentiality as "a huge chess game" and an experience of "liv(ing) in fear of being exposed and ridiculed" (TN170).

A similar "chess game" is played when participants work out how to present in a way that is safest for themselves:

I'm never sure whether I'm more safe acting more 'masculine' (and being read as an effeminate/gay boy), or being more feminine (and being read as a bi/dyke girl). When I'm with my partner (who ids as male/masculine), I sometimes act more 'feminine' so we aren't called faggots by groups of teenagers on the train. (TN38)

Stereotypes and discrimination

Participants also commented on the stereotypes of transgender people which effected people's reactions to them, and accounted for many of their experiences of discrimination. They perceived that there was a general attitude in society that transgender people were "perverts or sex offenders" (TN230), "child predator(s)" (TN286), "prostitute(s) and junkie(s)" (TN289). Participants also commented on the role of the media in popularising these stereotypes of transgender people by portraying them in a "negative light" (TN221):

at times its sucks you feel the weight of the world against u..when u read the papers or when u see news about a trans person its always "disqualified" or transexual murderer never transsexual winner or our aussie tg does us proud.. trans is always painted in media circles as negative... (TN256)

Some report that discrimination as a transgender person is compounded by other strands of discrimination.

I feel that as Aboriginal and a sistergirl, we face more discrimination and stigma than non-Aboriginal trannies. We have to deal with our own communities attitudes and values, not alone deal with the broader community. I have noticed that living in a large city, I face some form of discrimination at least 3 to 4 times a week. (TN191)

Depression and Stigma/Discrimination

Not surprisingly, there was a clear relationship between experiencing discrimination/stigma and depression (Figure 12). Respondents who had experienced a greater number of different types of discrimination were more likely to report being currently depressed (as measured by the Prime-MD). For example, 10% of those who had not experienced any of the listed types of discrimination were depressed, while just over 60% of those who'd experienced 10-12 types of discrimination were currently depressed.

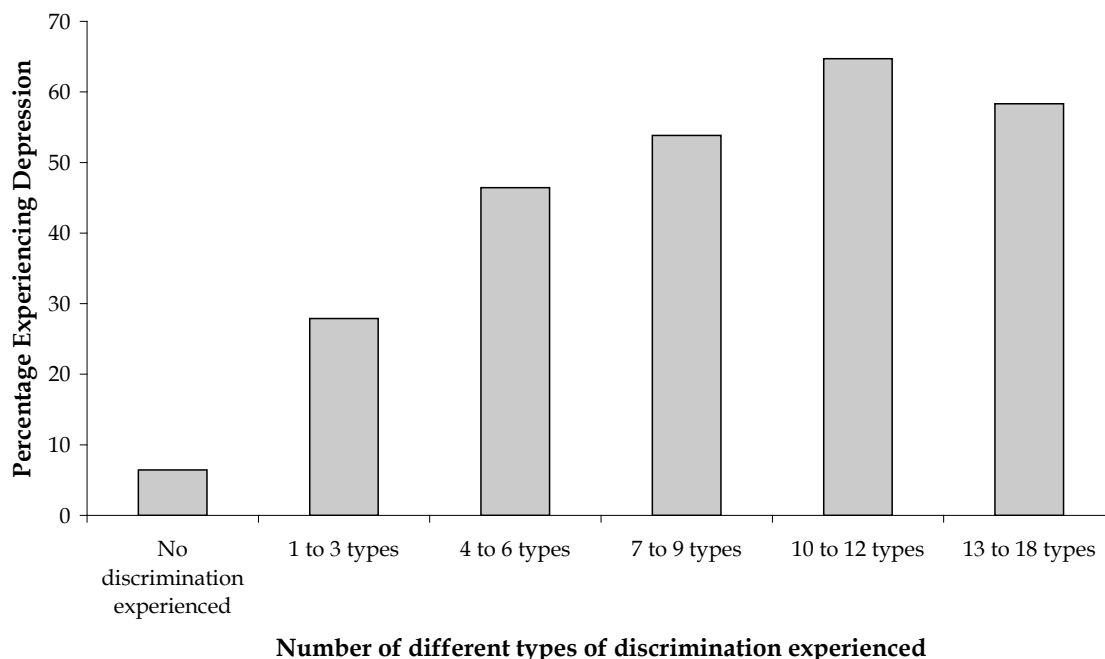


Figure 12. Experience of Discrimination and Depression

Modifying behaviour

Almost two-thirds (64.4%) of participants reported modifying their activities due to fear of stigma or discrimination. This is a similar level to that reported by the total Private Lives sample (67.3%). For Australian participants, modification of behaviour was reported at equivalent levels regardless of what state they were living in, or the location (metropolitan or rural) of their residence.

Of those that reported modifying their behaviour, the most common sites were in social settings and at work, the least common was at home (Table 15). Assigned females were more likely to report modifying their behaviour in social settings ($\chi^2(1) = 3.83, p = .050$) and when using public toilets ($\chi^2(1) = 19.91, p < .0005$).

Table 15
Sites of Modified Daily Activity Among Those Who Do

Site of Modified Behaviour	Sex on original birth certificate			
	Male		Female	
	N	%	N	%
In social settings	83	66.4	30	83.3
At work	74	59.2	23	63.9
When using public toilets	48	38.4	29	80.6
With your family	61	48.8	14	38.9
At home	34	27.2	9	25.0
Other	32	25.6	8	22.2

Note. Multiple responses possible

Modification of behaviour and depression

The proportion of participants modifying their behaviour did not differ according to what sex was on their original birth certificate. It was found, however, that for respondents with male on their original birth certificate, those who modified their behaviour were more likely to report being currently depressed than those who did not modify their behaviour (Table 16, $\chi^2(1) = 15.17, p < .0005$). No association was found, however, when the same analysis was conducted on participants with female on their original birth certificate.

Table 16
Modifying Daily Activity Due to Fear of Stigma and Depression Among Respondents with Male on their Original Birth Certificate

	Does fear of stigma or discrimination cause you to modify your daily activities?			
	Yes		No	
	N	%	N	%
Depressed	62	50.8	13	21.0
Not Depressed	60	49.2	49	79.0
Total	122	100.0	62	100.0

A relationship was observed between depression and the modification of daily activities due to fear or stigma (Figure 13). It was found that the greater the number of places in which a person reported that they modified their behaviour, the higher the likelihood they were currently experiencing depression (as measured by the Prime-MD). For example, of those who did not modify their daily activity, 20% were currently depressed; of those respondents who modified their behaviour in five of the six sites around 60% were currently depressed.

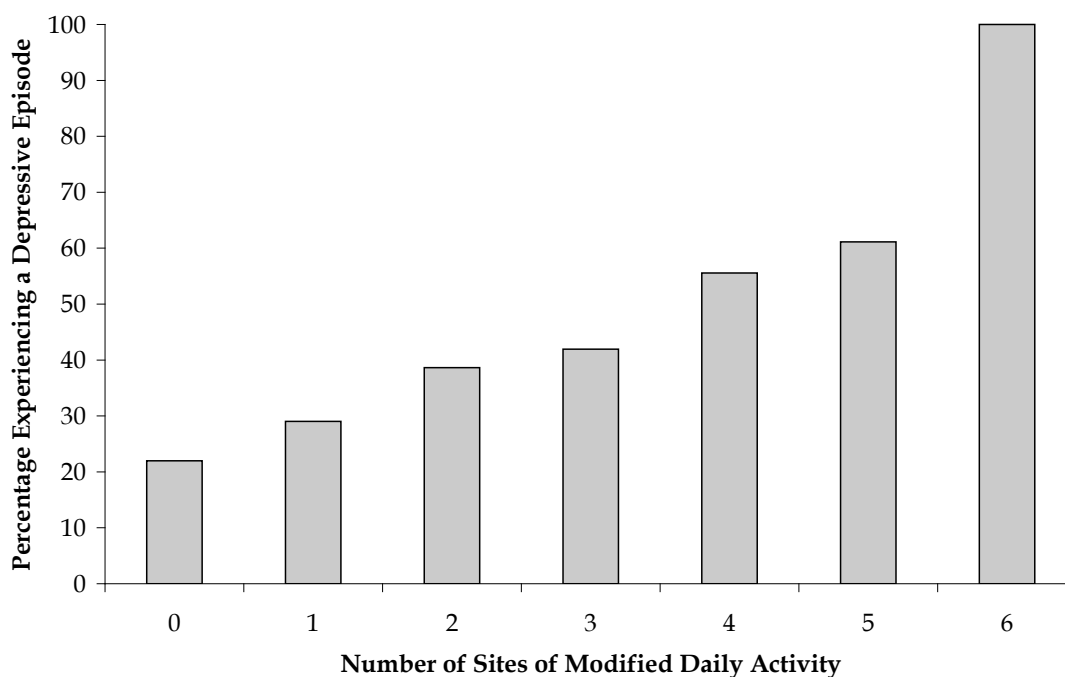


Figure 13. Relationship between Depression and Modifying Behaviour Due to Fear of Stigma and Discrimination.

Intimate partner violence

Partner violence was reported by 16.1% of participants. There was a trend for those who had an assigned sex of female at birth to be more likely to have experienced intimate partner violence (Table 17) ($\chi^2(1) = 3.10, p = .078$). However, the data do not allow us to know the sex or gender of the person who committed the violence.

Table 17
Have You Ever Experienced Intimate Partner Violence?

	Sex on original birth certificate			
	Male (%)		Female (%)	
	N	%	N	%
Yes	26	13.8	14	23.3
No	163	86.2	46	76.7
Total	189	100.0	60	100.0

Contact with police

Almost a fifth (18.2%) of participants said that when they had experienced a criminal offence, they had reported it to the police. Of those who did report it to the police, 34.8% said that when they had they were not treated with courtesy and dignity.

Section 11

The lived experience: recognition and negotiation

There is no one-size-fits-all experience for transgenders, any more than there is for any other class of humanity. (TN27)

While I'm technically "Transgender" or "Transsexual", or whatever the proper term is this week, I've never really identified as such. (TN284)

At the end of the survey, participants were given an opportunity to comment generally on their gender identity and gender presentation. The responses came in a variety of ways, situating experiences of the health system, formal processes, and stigma and discrimination, within the context of their overall lives. These comments reflect the diversity of ways in which people live transgender lives. The comments also demonstrate the situated nature of these differences: participants reported their negotiation of personal and professional relationships, as well as the medical system, in dealing with issues of privacy, intimacy, and notions of "truth" about themselves. The responses are grouped here under three broad themes: negotiating public and private selves; negotiating transition; and negotiating recognition in the health system.

Negotiating public and private selves

Participants differed in how they chose - or were able - to live their gender identities openly, as well as the time of life at which they 'came out' or started 'transitioning' (if they did at all).

Some participants described themselves as being "out", indicating that they were living a different sex to that assigned at birth. Others, however, saw themselves as living "in stealth" (TN228). One participant self-identified as "generally man, male, etc" in most day-to-day situations, but more readily "transman, transguy" in the queer community (TN04). In certain contexts, for example, one choose to "present as a man", and in others, "a transgender woman" (TN204).

For some participants, the only option was to live their gender "part-time": for instance, going out on weekends as themselves, but maintaining the appearance of their assigned sex during the working week. Others only expressed their gender in the privacy of their own homes. Sometimes, this was shared with the people that they were close to, and they were able to cross-dress "freely at home without fear from family and friends" (TN120). Others reported that they were only able to experiment with their gender presentation when they were by themselves.

When someone was living as their preferred gender, presentation was an important way in which participants controlled who had access to information about them. Being able to pass seamlessly as their preferred gender was critical for some participants. As we have shown above, participants' life situations had an impact on how essential "presenting well" and being "passable" were. For many it was not only a question of self-actualization, but also an issue of being able to function successfully in society, particularly in their employment. Being able to pass well could also have implications for their safety and, as some people's experiences reported earlier indicate, the safety of people close to them.

Many factors perceived as being beyond a person's control, such as access to treatments or natural physical characteristics, determined how well they were able to present as their preferred gender. Even then, one's appearance and adeptness at "doing" one's preferred gender was not always sufficient to guarantee one's capacity to pass in all situations. Struggles with formal regulation over documentation – which participants have demonstrated can determine social status in a fundamental way - had the constant potential to "out" them at critical moments.

I have tried to be just male but that doesn't seem to work...as my female side keeps on 'oozing out'... (TN292)

Participants often frustrated comments about the difficulties in accessing hormone therapy, gender affirmation surgery, and cosmetic procedures. These illustrated the significant impact that lack of access could have on the aspirations of people who wished to pass seamlessly as their preferred sex, especially if they did not naturally have the body type or features that allowed them to do so without treatment. It also illustrated the stress at being denied what are seen as essential treatments.

Passing perfectly was not necessarily everybody's aim. For one participant, passing was less a matter of presenting perfectly as one's preferred gender, and more a matter of achieving a good-enough presentation that did not "challenge (people's) concept of gender enough for them to question it" (TN182). For others, appearing bi-gendered or androgynous was their way of challenging gender binaries. A 49 year old 'transwoman' actively involved in GLBTI lobbying, and using hormone therapy for desired physical changes in her body, said:

I probably look like a middle-aged, long-haired MtF. I don't affect a high voice or attempt to pass - it's part of my approach to working politically and socially for acceptance and celebration of diversity in society. (TN100)

Gender identities were not necessarily reflected in the ways that people presented. A person who self-identified as "bi-gendered" reported facing more discrimination when dressing androgynously, and found that it was "safer to pass fully (wig, boob & makeup)" (TN117). On the other hand, as reported earlier, presenting androgynously was a way that some chose to "pass" realistically, avoiding discrimination when one was not able to present effectively as one's preferred gender. This allowed some participants to express their gender identity in a way that did not draw unwanted attention to themselves.

For participants who only cross-dressed privately, this could be a way of 'testing the waters' and fine-tuning their ability to pass before committing to life as their preferred gender. A 54 year old transgender person who had been cross-dressing for 18 months said:

I live by myself and cross-dress almost every night at home. I am becoming quite passable - I have just purchased a hair-piece that blends in well with my own long hair which I get coloured by my transgender friendly hairdresser. (TN121)

Nevertheless, this participant was hesitant to "(venture) out in society" for "fear of verbal abuse and ridicule". Even when participants were living as their preferred gender, they negotiated complex hierarchies of relationships in which decisions about disclosing their transgender status had to be made. If their transgender status was something only to be shared with close friends, they had to decide who they would tell, at what point, and to assess the potential consequences:

Still don't know who to come out to when meeting new people. I find it mostly a problem socially. I rarely need to talk about it at work because I pass well. But I think it is important for a partner to know about it in an intimate relationship. (TN129)

Several participants reported that it was particularly difficult to decide when to come out within a relationship. Others reported that finding a partner was one of the most difficult aspects of living a transgender life. For others still, it was easier to form relationships with other transgender people; and some chose not to enter into relationships where self-disclosure was necessary.

The worst thing about that is knowing that in order to keep my secret I will ultimately be alone forever. But I don't think I have any other option. (TN164)

Negotiating transition

As was to be expected, participants reported that taking the decision to transition was a most difficult one. The process necessitated complex negotiations within different relationships, social, familial, and intimate. It was, however, also a joyful time for many, and an essential step in arriving at a point where they were able to feel comfortable in themselves. Transitioning that involved hormone treatment or surgery brought for some feelings of completeness, well-being, and satisfaction, despite the physical discomfort associated with this experience. It was also reported as an exciting time for some, involving a degree of playfulness, experimentation, and creativity in the ways in which gender identities could be explored, and an opportunity to “completely re-invent yourself” (TN178).

Regardless of the experience of transitioning, it was most often a turbulent time, and participants indicated that that it involved a substantial disruption in the lives they had built around their assigned gender. This was particularly the case when transitioning happened later in life, as it had for many participants.

When I finally acknowledged GID and came out the following happened: (a) divorce (b) loss of friends (c) loss of employment. I wish I could say the truth sets you free. (TN43)

I was born a male with female gender identity. I have lived a Christian life as a male for 53 years and provided for my family. I am now a 56 year old single female who has made a new life without the ones who matter most to me, simply because they cannot come to terms with what I have had to do to survive. (TN114)

Fear of discrimination prevented some participants from expressing themselves openly and caused them to postpone transitioning. A 45 year old participant was “still living a predominantly male life just going out fem on the occasional weekend”, realizing that transitioning was “a long and tuff lifestyle change” (TN161).

Many participants described a long history of ignoring their feelings about their gender, trying to live as their assigned gender, before finally deciding to come out or transition. Quite often, people finally arrived at a point in their lives where living as their assigned gender became unbearable. This group of participants described coming out and transitioning as matters of necessity and survival, rather than choice. This quite often involved a crisis such as a major depressive episode or a breakdown, including suicide attempts. For most of their lives, they could not see a future in which they would have been able to express themselves in a way that reflected their gender.

Some participants who had come out “found [that] family issues [were] the hardest” (TN18). While transgender people often develop their own supportive friendship circles on whom they depend, they can less accurately predict the responses of “loved ones” who sometimes “simply (didn't) understand” (TN18). Others were pleasantly surprised by the support that they were given when they eventually decided to ‘come out’ as a transgender person, and begin the process of transitioning:

I have really enjoyed my transition over the past 5 years only wish I could have done it a lot sooner my 2 daughters are very supportive during and after the transition. (TN248)

A common view expressed by those who had 'transitioned', was that they wished that they had started the process earlier in life: one, for example, wishing they had "done something...years ago, like 40 years" (TN195). A female participant who had almost come out when she was 16 but decided not to for fear of being "kicked out of home", found herself at age 30 "just [wanting] it all done" (TN283). Another participant acknowledged that with "early education and diagnosis" she would have "transitioned as a teenager". Now, she was at a point in her life where she was trying to "manage (her) gender dysphoria without transitioning, as it seems untenable to do otherwise" in her current life (TN293).

Being unable to come out could have far reaching effects on participants' well being. A 40 year old transsexual who was hoping to go on hormone treatment, and who had tried non-surgical body modification, could not see a way to come out in her preferred gender to her family or at her workplace. She said:

The feelings of being female rule nearly everything I do. I have terrible sleep problems and at times go for a week or so on 1 hour sleep per night. This is the times that I become most depressed. Wondering how can I ever live as a female without hurting my family and being ridiculed by those around me. (TN196)

Negotiating recognition in the health system

I would like to get funding somehow to have the gender reassignment surgery, before I'm too old. (TN169, age 43)
I just want some form of autonomy over my body, and I hate that the health system doesn't let me have that. It's really disempowering, and needs to be changed. (TN38)

Medical treatment, of course, was an important component of transition for most participants. Hormone therapy, and, for a smaller number of participants, gender affirmation surgery, were implicated in ways in which participants thought about their gender identities. Participants' comments suggest that experiences with the health system involve a bargaining process, negotiating a way through questions of access to treatment, gatekeepers, questions of the essentialness of treatment, and definitions about themselves imposed by the health system.

For some, medical interventions were important events around which a sense of gender identity changed. An 18 year old participant on hormone treatment once saw herself as transgender, but felt that she was "just a girl now" (TN279). Another participant saw gender affirmation surgery as a key part of his gender identity:

I am currently waiting for surgery for chest reconstruction so my transition is not yet complete. My gender identity will probably change and I will probably later identify as a male with a transsexual history. (TN69)

Medical intervention could also present a disruption in the ways in which participants identified and performed gender.

The period of my life during/straight after transition was very difficult because at the same time as my gender identity was getting sorted and I liked my body changes etc, I suddenly had to discover how not to be a dyke anymore - an identity which I was very very attached to. (TN180)

The impact of the medicalisation of transgender lives was reported as being supporting in some ways, and de-legitimizing in others. For some participants, surgery was not the most important thing in itself, but the necessary step towards the desired recognition that came with an alteration to formal documentation, which was only possible on the basis of surgical reassignment. Others found that it was empowering to refuse to be pathologised, by seeing oneself - as one participant did - as “a normal girl, with an annoying, disfiguring & emotionally painful birth defect between (her) legs” (TN284) that a surgical procedure could fix. In this approach to transgenderism, the problem of a body that did not match one’s gender identity was likened to other common, and far less stigmatized physical complaints:

Let us look forward to a time when it is just another procedure, as unremarkable as childhood diseases, or procedures like heart bypass and transplant surgery, which were also new and remarkable procedures in the recent past. (TN27)

When participants experienced gender in ways like this, the lack of access to gender affirmation surgery presented a considerable problem for health and well being. For some, hormone treatment and surgery was described as being their ‘salvation’, and essential for their lives. This was evident in the trauma that participants experienced when they were denied access to such treatments. Whilst TN284 (quoted above) was never “‘mistaken’ for a guy”, she felt that “gender presentation (was) the easy part” of being transgender and the “painful birth defect” loomed large.

Some participants expressed a contradiction in seeing their current body as essential to who they were, while at the same time desiring to make changes to it:

I also do yoga to keep my mind, body and spirit as whole, which kinda conflicts with surgery and harming the body, for the sake of fitting in and feeling like no-one will stare at you if you have breasts and a beard.. (TN98)

I'm a lot happier now than I used to be and more likely to survive a long time. I am however disappointed that gender seems to be so boxed in socially that even as a nice looking woman, once people find out I used to be male, they define me by my previous maleness and use the wrong pronouns, even if they never knew me as male. (TN55)

Section 12

Last words

One participant identified three social and political domains where change was needed, and where the voices and positions of transgender people need to be heard:

I hope it [the TranZnation survey] has some influence on the lawmakers, the medical world and the general population. (TN10)

At the same time, another thought that the survey itself had been too oriented towards the medical:

i perceive my own and others' gender diversity through a post-modern lens and i found this survey to be quite medical model oriented. i would like to see more affirmation of gender diversity using queer theory to create spaces for people to explore and express their gender identity, practice and desire/fantasy without having to engage in the medical discourse. (TN101)

The common response to completing the survey appeared positive. As an example, this participant positioned research as one of the ways of fostering recognition of transgender people and their life issues.

i think it [the TranZnation survey] is a positive step to help the transgender community get some of the issues we face in to the public forum and hopefully some respect from the wider community as a whole in our quest to live a complete life in our respective gender roles. (TN110)

Even if research outcomes are seen as positive, completing the TranZnation survey may have incurred some emotional cost.

Once again I have had to confront my issues.....I'll stop crying soon. I sincerely hope that this helps make someone else's gender journey easier. (TN170)

... Remembering some (even minor) events can be quite emotional - experiences of harassment, threats etc. Completing the survey has, in itself, been a challenging experience. (TN176)

Here are two slightly ambivalent responses:

I was reluctant upon reading the goals of the organisation [Australian Research Centre in Sex, Health and Society] conducting this survey. TG folk do not have any more to do with sexual disease than the "general" community - probably less as it is difficult finding partners. That aside, I felt it was an opportunity to participate in the gathering of knowledge to the betterment of future people with Gender issues. I thank you for that opportunity. The "recap" was healthy. (TN178)

[The TranZnation survey] seems to dwell on the negative a bit, like the whole tranny thing is a traumatic ordeal. Mostly for me it's been fun and my friends and people i work with think it's cool and the idea of it being a problem doesn't come into it. (TN199)

This note of friendliness and fun continues in the final Last Word, which captures the forward looking and friendly tone which often shone through in this study:

I love to talk about how things have changed, with me and the general attitude of "the public". Imagine getting on a train & going to the city shopping 20 or more years ago. The cops would be called and probably beat you up. I hope attitudes continue to improve. (TN195)

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