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GENDER IDENTITY AUSTRALIA

THE HEALTH CARE EXPERIENCES OF PEOPLE WHOSE GENDER IDENTITY DIFFERS FROM THAT EXPECTED OF THEIR NATALLY ASSIGNED SEX

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We begin by acknowledging the sovereignty of the Kaurna people, the First Nations people upon whose land we as authors and non-indigenous Australians live and work.

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Executive Summary

The two surveys reported here, undertaken in 2012 and 2013, highlight both diversity and homogeneity. With regard to diversity, the report celebrates the many differing ways Australian people whose gender identity differs from that expected of their natally assigned sex experience their gender. In so doing, it encourages acknowledgment of this diversity, and recommends that service provision moves towards a model that recognises diversity as its starting place.

With regard to homogeneity, what tended to group our respondents together were the effects of cisgenderism. Specifically, we use the two categories 'male assigned at birth' (MAAB) and 'female assigned at birth' (FAAB) in many sections of this report to highlight that what often differentiated people's experiences were health care professionals' apparent responses to participants' natally assigned sex. In other words, the diversity between respondents highlighted above tended to disappear when it came to accounting for experiences with healthcare professionals who, it would appear, at times were responding to a presumed distinction between people FAAB but who now identify with a different gender identity, and people MAAB but who now identify with a different gender identity. What seemed to determine experiences with healthcare professionals was in many instances assigned sex, and this, we suggest, is a product of cisgenderism (a claim we expand on at length in the overview).

Of the significant differences we found when comparing the two surveys, people MAAB were older, were more likely to have had surgery, and were more likely to have had more positive experiences with mental health professionals. In comparison, people FAAB reported slightly higher levels of positive mental health than did people MAAB. In general, we found that for those people who desired sex-affirming surgery, having had surgery was related to higher levels of positive mental health. Those who were in relationships, were parents, and/or felt more connected to the general community all reported higher levels of positive mental health.

The report also outlines both negative and positive experiences amongst respondents in relation to mental and physical health professionals, and as such highlights both what works well, and what requires improvement.

Importantly, the findings reported here echo previous similar surveys from the UK, Canada, the US, and of course the first Australian study documented in the *TranZnation Report*. Together these findings highlight not only the multiple forms of marginalisation experienced (and the subsequent need for better service provision), but also the strengths and resiliencies shown. We can only imagine how improved outcomes would be if cisgenderism both within healthcare and in the broader community did not occur.



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Overview

Over the past decade increasing attention has been paid to the health care needs and experiences of people whose gender identity differs from that expected of their natally assigned sex in societies where it is presumed that having a penis makes one male (and thus one is expected to identify with, and act according to, what is deemed to be male), and that having a vagina makes one female (and thus one is expected to identify with, and act according to, what is deemed to be female).

The research documented in the present report builds on previous research on the health care experiences of this diverse population of people by focusing on three related issues:

1) How people whose gender identity differs from that expected of their natally assigned sex understand the identity categories they use in regards to both gender and sexual orientation,

2) The diverse experiences of people whose gender identity differs from that expected of their natally assigned sex in terms of

engagement with healthcare professionals and experiences of mental and physical health, and

3) The sense of connectedness to community and its possible mental health correlates experienced by people whose gender identity differs from that expected of their natally assigned sex.

As documented in this report, whilst the findings in relation to the first issue demonstrate the diversity of identifications experienced by people who responded to the call for participants, the findings in relation to the second issue demonstrate relative homogeneity.

What we found, in essence, was that whilst there was great diversity amongst respondents in terms of how they described their gender identity and their sexual orientation, this diversity tended to largely disappear (at least at a statistical level) when we sought to identify trends in terms of responses to variables included in the surveys we administered. Specifically, the primary categorical differences that we identified were arguably

related to assigned gender and age (and their intersections).

In other words, the primary statistically-significant finding in terms of differences between respondents was identified when we compared respondents who were assigned female at birth but who now identify with a different gender identity, and respondents who were assigned male at birth but who now identify with a different gender identity.

This category (of natally-assigned sex) as the primary site of difference amongst the respondents is both intuitive and problematic. It is intuitive in the sense that normative societal expectations about gender result in highly differing experiences between people assigned male and people assigned female, regardless of their current gender identity. In other words, what is *expected* of people assigned male is clearly differentiated from what is *expected* of people assigned female, and this is exacerbated by the binary nature of this distinction.

Overview

People who are natively assigned as either male or female are expected (and indeed are schooled) to act in ways deemed appropriate to their assigned sex. This means that regardless of current gender identity, we all experience coercive gendering as deemed appropriate to our natively-assigned sex. Diversity across families and social location aside, there is relative homogeneity in terms of what is expected of people assigned male and people assigned female, and thus those people who are assigned male at birth within a given society where binary gender categories exist will experience themselves being gendered *by others* in relatively similar ways, as will people who are assigned female at birth. In this sense it is intuitive to say that there are differences between people on the basis of the expectations made of their natively assigned sex.

A second reason why it is intuitive that we found a primary difference between respondents in terms of their natively assigned sex is that, for people whose gender identity differs from

that expected of their natively assigned sex, research repeatedly finds high levels of discrimination. This discrimination, however, is not uniform. Rather, it is differentiated by natively-assigned sex, such that people who are assigned male at birth but who now identify with a different gender identity experience discrimination that differs in content and form from that experienced by people who were assigned female at birth but who now identify with a different gender identity.

These differences are the product of normative gender expectations as outlined above, which are restrictive to both males and females, but which are enforced in differing ways. Masculinity, for example, is held in societies such as Australia as emblematic of power and dominance, and thus people assigned as male are expected to act as such. People who are assigned male at birth but whose gender identity differs from this assignment challenge the norm of masculinity, and are subject to violence aimed at punishing what is seen as their gender transgression (such as

physical abuse).

In terms of femininity, people who are assigned female at birth are expected to be the opposite of powerful and dominant (this is how the male-female pairing as a binary works – one is expected to be the opposite of the other). For people female assigned at birth but whose gender identity differs from this assignment, they may be subject to violence that attempts to forcibly reassert their assigned sex (such as rape, a crime most commonly directed towards people female assigned at birth).

Importantly, and in noting these differences, our intent is not to simply reinforce the male-female binary. Rather it is to highlight the power of gendered norms, and the force that sex assignment carries.

This point about the repetition of norms brings us to the problematic nature of our findings, namely that in emphasising natively assigned sex, our findings may potentially operate to repeat the forcible assignment of gender norms upon our

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respondents. The reason why we utilise the categories of male assigned at birth (MAAB) and female assigned at birth (FAAB) in much of this report, however, arises from the second issue that this report addresses, namely experiences with healthcare providers.

Whilst the first issue that this report addresses elaborates the diversity amongst our sample in terms of gender identity and sexual orientation, the second issue addresses, in essence, how our respondents are treated by the healthcare providers they engage with, and this appears to be differentiated largely on the basis of professionals' responses to respondents' natal assigned sex. This, of course, is a complex claim, and one that cannot be adequately addressed in this overview: our claim needs to be unpacked alongside the presentation of the findings to highlight the nuanced nature of the findings.

What can be stated here, however, and drawing upon the work of Ansara and colleagues (2010; 2012;

2013), is that what appears to unite the data we have on experiences with healthcare professionals are the effects of cisgenderism. As Ansara notes, cisgenderism as a term describes more accurately than does the term 'transphobia' the misgenderings that occur when it is presumed that the natal assignation of sex on the basis primarily of external characteristics (i.e. genitalia) is both appropriate, and aligns with a person's own sense of themselves as a person (in a context where sex is presumed to equate to gender, and where all people are expected to have a sex and a gender within a two sex and two gender system).

Cisgenderism as a term, then, captures both the violent responses outlined above to people whose gender identity differs from that expected of their natal assigned sex, as well as critiquing the broader meaning-making system in which binary notions of sex and gender are produced, and the multiple forms of marginalisation and discrimination that arise from this system.

To apply the concept of 'cisgenderism' to our findings, then, is to suggest that the differentiation we have identified between the healthcare experiences of people FAAB and people MAAB is a product of cisgenderism within the healthcare professions. That people are treated differently on the basis of professionals' readings and expectations of their gender presentation (and its relationship to their natal assigned sex) is thus very much about cisgenderism, much more than it reflects any kind of 'truth' about the validity of sex assignation or the appropriateness of enforcing gender norms on the basis of sex assignation. The truth it does reflect, then, is how cisgenderism occurs, and how this has very real effects in the lives of many of our respondents.

Importantly, however, we use the word 'many' above to denote that whilst the findings we report are statistically significant, they are not homogeneous. In other words, just as there were a diverse range of ways in which our respondents described their gender identity and sexual

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orientation, so too were there a diverse range of experiences with healthcare professionals.

Also important is the fact that a small number of our respondents had managed to access health care professionals who themselves identified with a gender that differs from that expected of their natively assigned sex. For some people this was overwhelmingly positive, whilst for other people their experiences were similar to those had with healthcare professionals whose gender identity was cisgender (in this instance referring to individuals whose gender identity conforms – broadly speaking – to that expected

of their natively assigned sex).

In sum, then, what we hope this report demonstrates is both heterogeneity and homogeneity: heterogeneity in terms of diverse accounts of gender and sexuality and diverse experiences with healthcare professionals, and homogeneity in terms of the marginalizing effects of cisgenderism.

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Method

The findings presented in this report draw on two online surveys open to Australian residents, undertaken in 2012 and 2013. The first utilised the terminology 'people who were female assigned at birth but who now identify with a different gender identity'. A total of 78 people completed this survey. The second utilised the terminology of 'people who identify as transgender women'. A total of 110 people completed this survey. These two differing terms were used on recommendation from community members consulted prior to the commencement of the research.

Other than the terms outlined above, no specific definitions were given in regards to gender identity or sexual orientation, and thus people who completed the surveys in some way saw their experiences as applicable to these two terms whilst, as outlined in this report, providing their own specific definitions of what the terms meant.

Other than the opening screens for each of the surveys, which differed in

terms of the terminology outlined above, both surveys were identical.

The first two screens of each survey asked for demographic information about self-defined gender identity, self-defined sexual orientation, relationship status, age, cultural background, whether or not the respondent had children, the importance of other people's perceptions of their gender identity, current housing situation, educational history, employment status, and income bracket.

The subsequent sections of the surveys focused on whether or not respondents had attended appointments with a range of healthcare providers (such as general practitioners, sexual health clinics, pharmacists, and speech pathologists) and their experiences with each of these providers. Experiences were rated on a scale where 1= Very negative, 2= Negative, 3= Neutral, 4= Positive and 5= Very positive.

Respondents were then asked if they had accessed a counselor, psychologist or psychiatrist, and were again

asked to rate their experiences, and were also invited to make comment about their experiences.

Respondents were then asked if they had undertaken sex-affirming surgery, and if so, respondents were asked about their satisfaction with the information provided to them, the support they received, and any perceived discrimination.

Respondents were also asked to indicate if they had received a diagnosis of 'gender identity disorder'/'gender dysphoria', if they were currently taking hormones, and if they had been diagnosed with a mental disorder.

Further screens in the surveys asked respondents to rate their physical health overall and their mental health overall, on a scale where 1= Very bad, 2= Bad, 3= Neither good nor bad, 4= Good and 5= Very good.

Respondents also indicated if they felt they belonged to a community specific to their current gender identity, and then rated their sense of community

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connectedness, in addition to rating their sense of connectedness to the general community. The first of these utilised a 13-item inventory adapted from the Sense of Community Scale. Similarly, the rating of connectedness to the general community utilised an 11-item inventory again adapted from the Sense of Community Scale. For each of these inventories respondents rated a list of statements, such as 'Being a member of this community makes me feel good' and 'Members of this community care about each other'.

All data were analysed utilizing either SPSS 17 or NVIVO. The former was used to generate tables, bar charts, and all statistics included in this report. The latter was used to undertake content analysis of open-ended responses.

Throughout the following sections of this report we provide basic information about relevant statistics produced from the data. We acknowledge, however, that the language we use may not be familiar to all readers, hence we now provide a brief summary of the specific terms we make reference to.

Key terms used to describe the data are means (M) and standard deviations (SD). The mean is equivalent to the average, so when we say that across all the people who completed a particular scale, the mean was 3, this means that the average response was 3.

The standard deviation tells us a bit more about how to interpret the mean. The standard deviation reports how widely responses diverged from the mean. So if the standard deviation for responses to a scale is 1.5, this indicates that the majority of responses ranged 1.5 points above and 1.5 points below the mean.

Sometimes the standard deviation will be large, such as when we report the mean and standard deviation for age. For example, the mean age of a sample might be 35, and the standard deviation might be 15. Standard deviations are always provided in the same unit as the scale. Given the unit for age in this example is years, a standard deviation of 15 in this hypothetical example means the ages of the majority of the participants varied between 15 years above the mean, and 15 years below the mean.

It is also important to note the scale that is represented by the mean and standard deviation. For example, in some of our scales 1 = very negative, 2 = negative, 3 = neither negative nor positive, 4 = positive, and 5 = very positive. So if the mean for responses to a question that used this scale was, hypothetically, 2, and the standard deviation was .75, that would mean on average that people responded with 2 – negative – but that some people rated a bit higher (2.75, so almost neutral), and some people rated a bit lower (1.25, so almost very negative).

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Demographics

In this section we report the demographic data (other than in regards to gender identity and sexual orientation, which are covered in the next section). Given our discussion in the overview about the complexities of treating our respondents as either MAAB or FAAB, in this section we instead refer to comparisons between the first survey and the second survey, as this is a more correct representation of our respondents.

As we noted in the previous section, 78 people completed the survey intended for people ‘female assigned at birth but who identify with a different gender identity’, and 110 people completed the second survey intended for ‘people who identify as transgender women’.

In places in this section the demographic variables are reported in terms of both surveys combined. This is because with some variables responses were very similar across both surveys. For other variables we report the differences between the two surveys.

In terms of cultural identity,

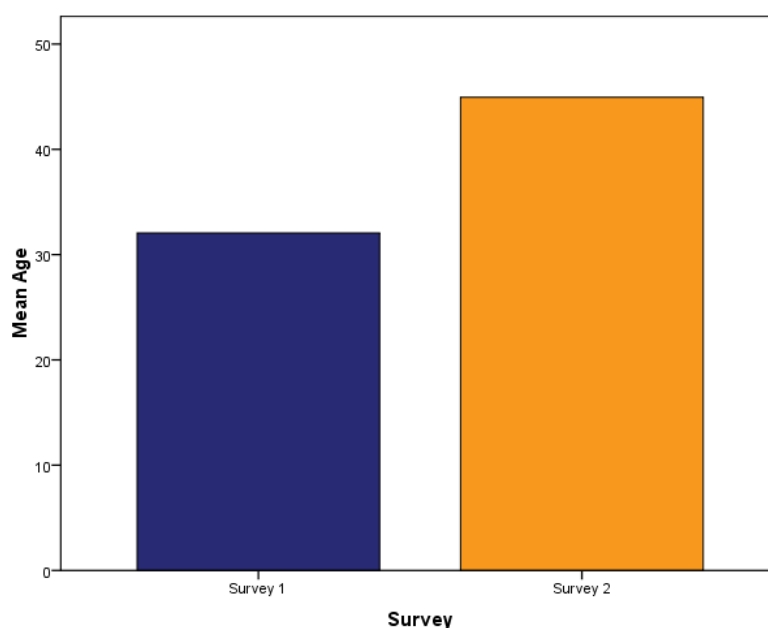
almost all respondents (94%) identified in some way as white Australians. People used terms such as ‘white’, ‘Anglo’, and ‘Anglo-European’. 3% of all respondents identified as Indigenous. 2% of all respondents identified as Asian. 1% of all respondents identified as Middle Eastern.

In terms of place of residence, most of the overall sample lived in a large city (82%). The remainder of the overall sample indicated that they lived in a regional town or area.

In terms of where people lived, the following table shows the distribution of the overall sample in terms of state or territory:

State/Territory	Percent
Victoria	27
New South Wales	25
Queensland	15
South Australia	10
Western Australia	10
ACT	5
Tasmania	5
Northern Territory	3

The bar graph below shows the average age of respondents from each of the surveys. There was a



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statistically significant difference between these two surveys, such that people who completed the first survey were overall younger than people who completed the second survey. This mirrors findings from the *TranZnation Report* (Couch, Pitts, Mulcare, Croy, Mitchell & Patel, 2007)

In terms of income across all respondents, the following table shows the percent of people in each income bracket:

Income Bracket	Percent
\$0-\$6000	19
\$6001-\$34000	35
\$34001-\$80000	34
\$80001 +	12

In terms of educational level, the following table shows the percent of people across both surveys who had completed one of four different types of education as their highest level of education:

Education Type	Percent
High School	20
Trade/Diploma	35
Undergrad	28
Postgrad	17

The following table reports the differing types of employment people were

engaged in across both surveys:

Employment Type	Percent
Casual	10
Part Time	12
Full Time	40
Student	9
Retired	20
Unemployed	9

In terms of relationships, there were differences between the two surveys. In regards to people who completed the first survey, 47% reported being single. The remaining 53% reported being in some form of relationship (this included defacto, engaged, married, or a polyamorous relationship).

In terms of the gender identity of respondent's partners in the first survey, 43% of people in a relationship said their partner was a cisgender female, 25% said their partner was a cisgender male, 14% said their partner was a transgender male, 10% said their partner was a transgender female, 3% said their partner was genderqueer, and the remaining people had a number of partners with a range of genders.

In regards to people who completed the second survey, 53% reported being single. The remaining 47% reported being in some form of relationship (this included defacto, engaged, married, or a polyamorous relationship).

In terms of the gender identity of respondent's partners in the second survey, 53% of people in a relationship said their partner was a cisgender female, 15% said their partner was a cisgender male, 14% said their partner was a transgender female, 10% said their partner was a transgender male, 5% said their partner was genderqueer, and the remaining people had a number of partners with a range of genders.

In terms of children, 17% of people who completed the first survey said they were parenting at least one child. All but two of these parents had given birth to their child/ren prior to transitioning. The remaining two had become parents through their current cisgender female partner giving birth.

In regards to people who completed the second

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survey, 27% said they were the parent of at least one child. All but one of these parents had been involved in the conception of the child prior to transitioning. The remaining person had become a parent post-transition through foster care.

In terms of Centrelink benefits, 32% of the overall sample were in receipt of a Centrelink payment. These included 15% of the overall sample receiving Disability Support Pension, 10% receiving Newstart, 5% receiving Youth Allowance, and 2% receiving parenting payment.

We also asked participants if they were currently taking hormones, if they had previously received a diagnosis of 'gender identity disorder' (now known as 'gender dysphoria'), and if they had undertaken sex-affirming surgery.

Of the people who completed the first survey, 57% were not currently taking hormones and 43% were. 50% had previously received a diagnosis of 'gender identity disorder' and 50% had not. 46% had undertaken some form of sex-affirming surgery and 54% had not.

Of the people who completed the second survey, 55% were currently taking hormones and 45% were not. 60% had previously received a diagnosis of 'gender identity disorder' and 40% had not. 42% had undertaken some form of sex-affirming surgery and 58% had not.

We also asked participants about the importance of other people's perceptions of their gender identity. There were no significant differences between the two surveys. On average respondents across both surveys rated the importance of other people's perceptions as 3.94 (SD=1.21), on a scale where 1= Very unimportant, 2= Unimportant, 3= Neutral, 4= Important and 5= Very Important.

In terms of relationships between demographic variables, we found a number of interesting correlations. People across both surveys who were older reported caring less about other people's perceptions of their current gender identity.

Across both surveys, the older people were, the higher their income.

People who were parents were older (M=50.84, SD=11.69) than were people who were not parents (M=33.48, SD=11.42) across both surveys.

We would note here that the significant differences between particular groups reported in the following sections are the key significant differences identified. No significant differences were identified between most of the demographic variables outlined in this section and responses to questions about experiences with healthcare professionals (i.e., there were no significant differences in responses on the basis of state/territory of residence, income, education, employment type, or location of residence).

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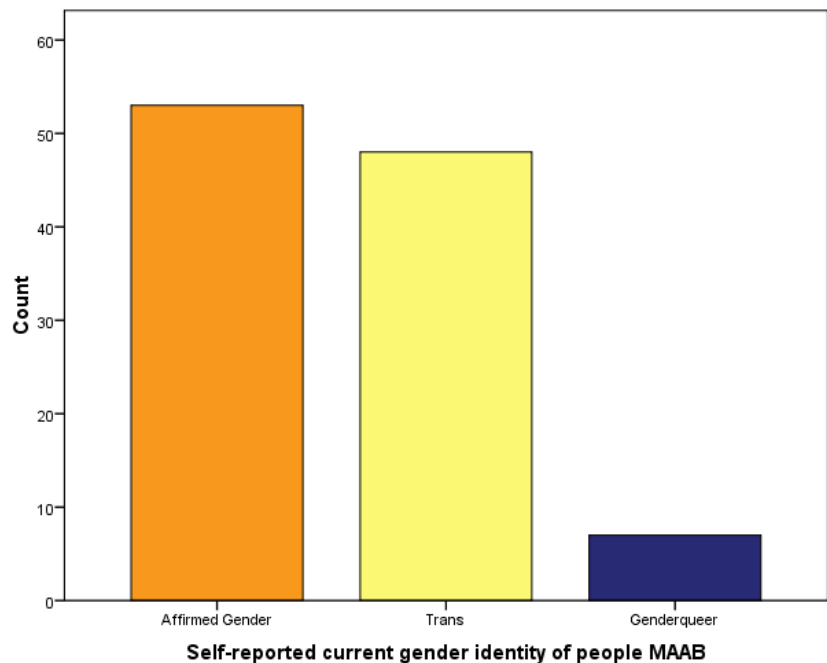
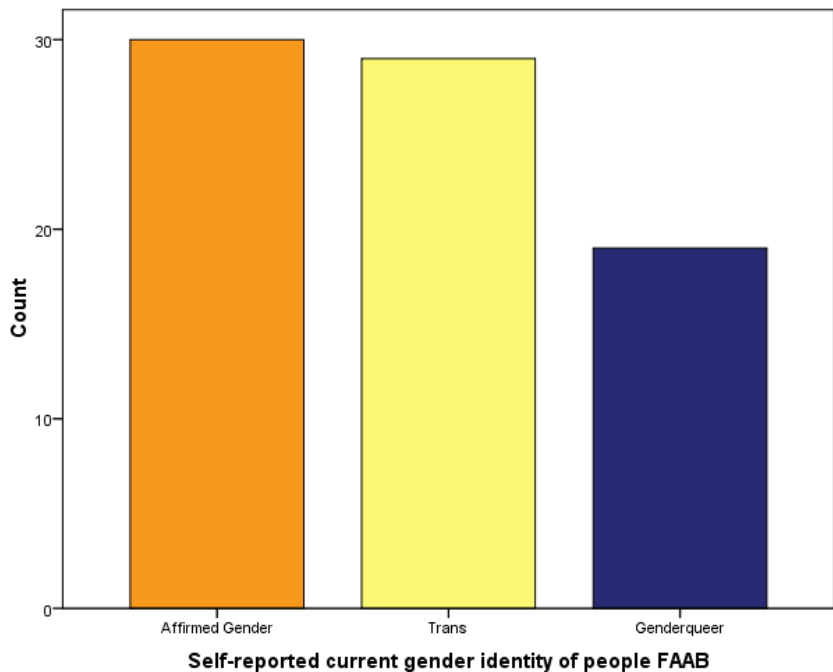
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Gender Identity and Sexual Orientation

Rather than providing a list of possible responses from which respondents could choose in regards to their gender identity and sexual orientation, we opted to include a text box for each question, leaving it to respondents to utilise the terms most appropriate to them. As might have been expected, responses tended to cohere around existing identity categories. This is intuitive, given whilst gender categories can be reworked or refused altogether, most people experience some injunction to describe themselves in gendered terms (indeed, an injunction we repeated in asking people to describe their gender identity and sexual orientation), and most people resort to terms commonly used in their community.

The tables presented on this page and the next indicate the distribution of people from each of the surveys in terms of their self-attributed gender identity and sexual orientation.

There was a significant difference between people FAAB and people MAAB in terms of current gender identity, and also in terms of sexual orientation.



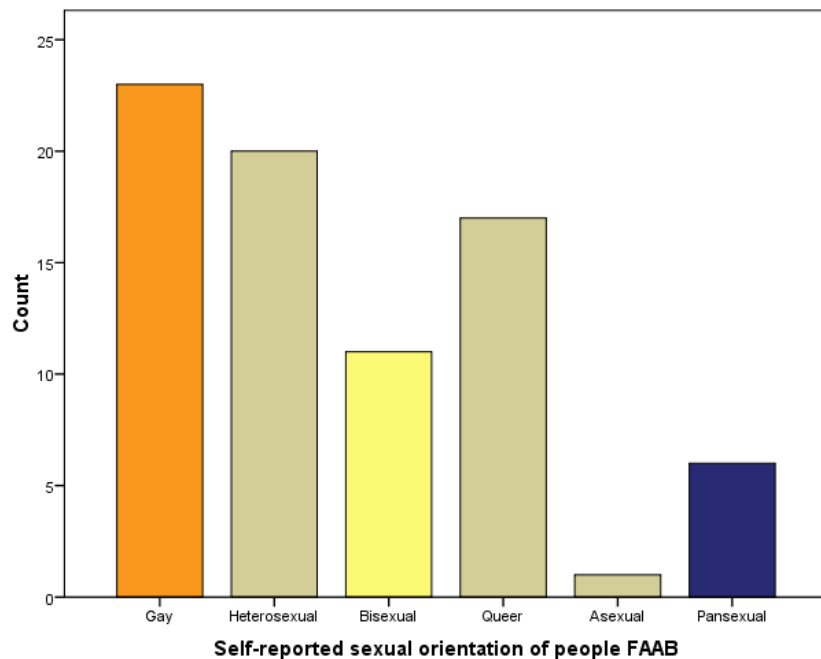
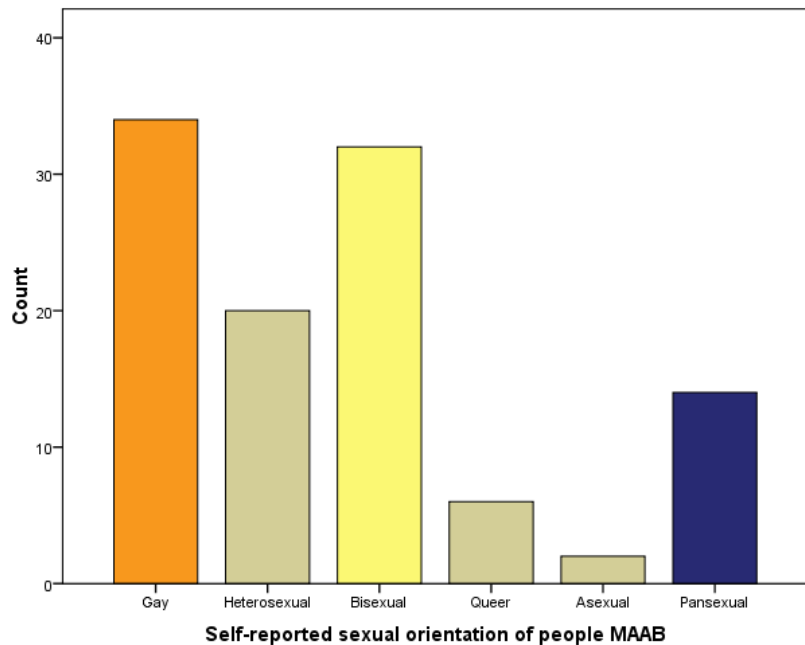
Gender Identity and Sexual Orientation

People FAAB were significantly more likely to identify as genderqueer in terms of their current gender identity than were people MAAB.

People MAAB were significantly more likely to identify as bisexual in terms of their sexual orientation than were people FAAB.

People FAAB were significantly more likely to identify as queer in terms of their sexual orientation than were people MAAB.

In terms of how people described their current gender identity, the table over the page highlights differences between people who defined themselves by their affirmed gender, as transgender, or as genderqueer.



Gender Identity and Sexual Orientation

Current Gender Identity	Comment (assigned gender)
Affirmed gender	<ul style="list-style-type: none"> • I am a woman, I identify legally, socially and in every other way as a woman (MAAB) • I have always thought of myself as a female since I was 4 years of age (MAAB) • I am a male, able to live with and contribute to my community in a positive way (FAAB) • I have always felt male for as long as I can remember. I want to be acknowledged that way (FAAB) • I have had reassignment surgery, and live in my preferred gender of female. I am just a normal member of my community now, a woman (MAAB) • Describing myself as female means I should have been born female in the first place (MAAB) • I am a male person (FAAB)
Transgender	<ul style="list-style-type: none"> • I think it is important to acknowledge that the majority of my life I've lived and presented as male and it is still an important part of who I am and how I got here. For me the nature of transition is important to my story and place in society so I don't plan to shy away from acknowledging that (MAAB) • I feel that talking publically about being trans is important, and I will never deny it as my identity (FAAB)
Genderqueer	<ul style="list-style-type: none"> • I am both male and female (FAAB) • I identify sometimes as a woman but nearly never as a man (MAAB) • I identify somewhere between femininely genderqueer and identifying wholeheartedly as a transgender woman. Slightly genderfluid, but a definite lean to the feminine side (MAAB)

Experiences with Mental Health Professionals

In this section we outline our findings in terms of how participants spoke about their interactions with mental health professionals, as well as the relationship between people's self-reported mental health and other variables on the surveys. Where applicable we disaggregate these findings by naturally assigned sex. As we noted in the overview, this is not without its problems, but given much of what participants experienced appeared to be about the effects of cisgenderism, then it seems appropriate to acknowledge that the services people receive are often shaped by how other people perceive their gender identity (even if we acknowledge this shouldn't be the case).

The main reason why we use the two categories FAAB and MAAB in this section and the next is because when we tested for differences within each of these categories in terms of differences in self-reported gender identity and sexual orientation, we found no significant differences between any of the groups (i.e., affirmed gender, transgender or gender queer in regards to gender

identity, and heterosexual, homosexual, bisexual, pansexual or genderqueer in terms of sexual orientation) and any of the other variables within the surveys. This doesn't mean that there weren't differences between individuals. What it means is that statistically there were no differences between any of these groups. Where we did find significant differences were in terms of whether an individual completed the first survey or the second survey, their age, and whether or not they had undertaken sex-affirming therapy. It is these differences that we focus on in this section and the next.

51% of the people in the first survey had accessed a counselor, 48% had accessed a psychologist, and 65% had accessed a psychiatrist. Numbers were higher in the second study in regards to accessing mental health care professionals, with 72% having accessed a counselor, 78% having accessed a psychologist, and 82% having accessed a psychiatrist. Rates of access were not mutually exclusive, with many

participants accessing two or all three of the mental health professional categories.

In terms of engaging with counselors, psychologists and psychiatrists, people MAAB reported overall higher ratings than did people FAAB, and this difference was statistically significant.

In terms of counselors, the mean score for people MAAB in terms of their overall experience was 3.92 (SD=1.25), so just below a rating of 'positive'. People FAAB on average rated counselors 2.03 (SD=1.25), so 'negative'. In terms of both surveys combined, 29.3% of respondents rated their experiences with counselors as 'very negative', 16.2% rated their experience as 'negative', 12.7% as 'positive', and 7.9% as 'very positive'

In terms of psychologists, people MAAB on average said their experience was just below 'positive' (M=3.97, SD=.98). People FAAB again on average rated their experience with psychologists much lower, at 2.22 (SD=1.14), so just above 'negative'. In terms of

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both surveys combined, 23.2% of respondents rated their experiences with a psychologist as 'very negative', 16.2% rated their experience as 'negative', 24.2% rated their experience as 'positive', and 15.2% rated their experience as 'very positive'.

In terms of psychiatrists, people MAAB on average rated their experience as just below 'positive'

(M=3.65, SD=1.25). People FAAB again rated their experience lower, with an average rating of 2.73 (SD=1.25), so just below 'neutral'. In terms of both surveys combined, 22.9% of respondents rated their experience as 'very negative', 23.7% rated their experiences as 'negative', 16.9% rated their experience as 'positive', and 12.7% rated their experience as 'very positive'.

Of note was the fact that age was a significant predictor of people's experiences with mental health professionals, such that older people tended to have better experiences than younger people.

We considered the fact that perhaps the differences we found in terms of natally assigned sex were a product of age, given, as we outlined in the demographics section,

Participants who completed the first survey	Participants who completed the second survey
EXPERIENCES WITH COUNSELORS	
<p><i>Younger Participants</i> (n=6 negative and 2 positive comments)</p> <ul style="list-style-type: none"> • There is a lack of basic understanding needed to tackle trans issues. It took me two full paid sessions just to explain it to her. • Educating my counselor about gender was not only really annoying but a waste of my sessions. 	<p><i>Younger Participants</i> (n=4 negative and 2 positive)</p> <ul style="list-style-type: none"> • The counselor was freaked out, and more or less told me I was mad. • The answer provided by the counselor was to remain distracted from my desire to become a woman.
<p><i>Older Participants</i> (n=4 positive and 2 negative comments)</p> <ul style="list-style-type: none"> • She was totally affirming and supportive. • Counseling helped me get through the attempt to get a diagnosis of GID, which was stressful and traumatic. 	<p><i>Older Participants</i> (n=8 positive and 3 negative)</p> <ul style="list-style-type: none"> • A counselor is in my opinion a vital part of the transitioning process, and mine made everything else bearable. • The right counselor who is across trans issues makes the world of difference.

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respondents who were MAAB were on average older than respondents who were FAAB. To check this we ran statistical tests that controlled for age (so basically cancelled age out as a possible difference). Even when we did this, the differences we outlined

above in terms of people MAAB having better experiences with counselors, psychologists and psychiatrists than people FAAB remained.

To highlight these differences we now provide

tables that outline a selection of comments made by respondents in regards to each of the three mental health professions surveyed, broken down by naturally-assigned sex and age.

Participants who completed the first survey	Participants who completed the second survey
EXPERIENCES WITH PSYCHOLOGISTS	
<p><i>Younger Participants</i> (n=6 negative and 1 positive)</p> <ul style="list-style-type: none"> • My psychologist didn't take my decision to transition seriously enough, held me back heaps, was not trans aware whatsoever. • Having to educate a professional who does not understand gender issues can lead to a sense of feeling unheard and that can have carry-on blocking effects to the effectiveness of treatments. 	<p><i>Younger Participants</i> (n=4 negative and 2 positive)</p> <ul style="list-style-type: none"> • The psychologist I was forced to see was awful. • Lack of definite information, inefficient, caused lengthy delays in treatment.
<p><i>Older Participants</i> (n=2 positive and 0 negative)</p> <ul style="list-style-type: none"> • Was very helpful and allowed me to look at the concerns from different angles. • Again minimal knowledge, but asked lots of open-ended questions and came on the journey of understanding with me. 	<p><i>Older Participants</i> (n=6 positive and 2 negative)</p> <ul style="list-style-type: none"> • He made me feel like a person and understood how I was feeling and empathised with me which gave value to my life and made me feel that my life was worthwhile not a failure. • Was very helpful in encouraging me to come to terms with myself, was quite good at dealing with the lack of adequate information available to them, and was very good in empowering me to deal with an abusive relationship.

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Participants who completed the first survey	Participants who completed the second survey
EXPERIENCES WITH PSYCHIATRISTS	
<p><i>Younger Participants</i> (n=5 negative and 1 positive)</p> <ul style="list-style-type: none"> • My experience was rather traumatic and I was constantly subjected to ridicule and had to work hard to prove myself as trans. • He ritualistically talked about my body in ways that was shaming, and treated my chronic pain as psychosomatic. 	<p><i>Younger Participants</i> (n=3 negative and 1 positive)</p> <ul style="list-style-type: none"> • The guy was a complete moron, seriously how many years and how much money spent for these quacks to hang a shingle and practice psychiatry. • Horrible gender stereotyping. Offensive descriptive language. Inappropriate questioning and details asked for. Offensive assumptions such as variant sexuality.
<p><i>Older Participants</i> (n=5 positive and 2 negative)</p> <ul style="list-style-type: none"> • She was professional, helpful, and knowledgeable. • My psychiatrist was a caring, humane practitioner. 	<p><i>Older Participants</i> (n=6 positive and 2 negative)</p> <ul style="list-style-type: none"> • He was thorough, kindly, and very good at getting me to discuss all aspects of my life. • Very knowledgeable and professional.

The comments provided in these pages echo findings from previous research (e.g., Couch et al., 2007; Benson, 2013; Bess & Stabb, 2009; Speer & McPhillips, 2013), in that positive experiences were marked by caring, knowledgeable and responsive engagements, whilst negative experiences were marked by having to educate the professional, feeling pathologised, gatekeeping, and the use of

inappropriate and/or misgendering language. Refusal of treatment was not something that many of our respondents reported, but for some older respondents who had attempted in the past to access support from mental health professionals, they had indeed been denied services.

In an attempt at further explaining the differences between participants in

terms of experiences with mental health professionals and the variables of assigned sex and age, we hypothesised that having had surgery may also be related to outcomes. We made this hypothesis on the basis of the fact that, given gatekeeping was a concern for many of the participants, those who had 'passed through the gate' and undertaken their desired surgery might have been in general more positive about

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mental health professionals than those who were still in the process of negotiating with professionals to secure their support for surgery. Statistical tests suggested both that participants who had undertaken surgery were older ($M=44.27$, $SD=13.268$) than were those who had not ($M=36.14$, $SD=14.016$), and that participants MAAB were more likely to have undertaken surgery than were participants FAAB. These results appeared to accord with the pattern already identified, namely that age and gender were predictors of outcomes. Yet interestingly surgery status was not predictive of experiences with any of the mental health professional groups, even when controlling for age or gender.

Self-Reported Mental Health

As we noted in the method section, respondents were asked to rate their current mental health on a scale where 1= Very bad, 2= Bad, 3= Neither good nor bad, 4= Good and 5= Very good. Overall across both surveys the average self-reported mental health rating was

3.54 ($SD=1.12$), meaning that on average people rated their mental health slightly above neither good nor bad.

Those who had undertaken surgery reported higher levels of positive mental health ($M=3.87$, $SD=0.99$) than did those who had not undertaken surgery ($M=3.30$, $SD=1.16$). This finding replicates that found in a 2012 UK survey of trans people (McNeil, Bailey, Ellis, Morton & Regan, 2012), and a 2010 Canadian survey of transgender men (Rotondi, Bauer, Scanlon, Kaay, Travers & Travers, 2011), and in the first Australian study (Couch et al., 2007), all of which found that wellbeing increased after surgery for those who had undertaken sex-affirming surgery. With regard to the present study, it is important to note that the difference between these two groups (had surgery or not had surgery), whilst statistically significant, is still relatively small, with both groups having an average rating of mental health within the scale response of 'neither good nor bad'.

Interestingly, we also asked

people if they wanted to have surgery in the future. Those who said they didn't want surgery reported higher levels of positive mental health ($M=3.89$, $SD=0.99$) than did those who wanted surgery ($M=3.30$, $SD=1.16$). Again, the differences here are relatively small, but were statistically significant.

What this suggests to us, then, is that for people who desire surgery, not being able to undertake surgery (for whatever reason) may be detrimental to their mental health. For people not interested in surgery, having not had surgery did not necessarily impact upon their mental health.

We also found a significant relationship between how important participants considered other's perception of their gender identity, and their self-reported mental health, such that being more concerned with other's perception was related to lower levels of self-reported mental health. This is intuitive given other people's *negative* perceptions are likely to impact upon an individual's mental health negatively.

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We also found a significant relationship between age and mental health, such that older people reported more positive mental health than did younger people.

Interestingly, we didn't find a significant relationship between natal assigned sex and mental health. Given the significance of age, however, we ran tests that controlled for age. When we did this we found a significant relationship for natal assigned sex and mental health, such that people FAAB at birth reported higher levels of positive mental health than did people MAAB.

We found no significant relationship between having received a diagnosis of 'gender identity disorder' (as it was known when most of our participants sought a diagnosis) and an individual's self-reported mental health, even when controlling for age.

Similarly, we found no significant relationship between having been prescribed hormones or not and self-reported mental health, even when controlling for age.

We also found no significant relationship between respondents' ratings of the importance of other people's perception of their gender identity and ratings of experiences with any of the mental health professionals.

Finally in regards to self-reported mental health, we found that across both surveys, those who were in a relationship reported higher levels of positive mental health ($M=3.83$, $SD=1.07$) than those who were single ($M=3.12$, $SD=1.15$). Similarly with regard to being a parent, those who were a parent reported higher levels of positive mental health ($M=3.96$, $SD=0.97$) than did those who were not parents ($M=3.32$, $M=1.15$). Again, whilst these differences were statistically significant, they are relatively small differences.

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Experiences with Physical Health Professionals

Our findings in regards to experiences with physical health professionals in some ways mirror those from the previous section, but also differ, especially with regard to the significant differences noted in the previous section in regards to natively-assigned sex.

We found no differences between the two surveys in regards to ratings of general practitioners, speech pathologists, sexual health clinicians, and pharmacists.

Looking at each of these professions across both surveys, people rated their experiences as good or close to good overall. Speech pathologists were rated the highest (M=4.09, SD=1.42), then sexual health clinicians (M=3.88, SD=1.51), pharmacists (M=3.82, SD=1.38), and general practitioners having the lowest rating (M=3.74, SD=1.47), though again it is important to note that all of these averages other than for speech pathologists are within the range of 'neutral'.

In terms of discrimination, overall the four professions on average were rated as showing some discrimination. The highest

rating for discrimination was for general practitioners (M=1.70, SD=1.22), with slightly lower ratings for sexual health clinicians (M=1.65, SD=1.29), pharmacists (M=1.56, SD=1.04) and speech pathologists being rated closer to 'no discrimination' (M=1.21, SD=0.92). We would note that the scale for this item was 1=No discrimination, 2=Some, 3=Neutral, 4=Often and 5=Always.

There were no significant relationships noted between any of the survey variables and sexual health clinicians, speech pathologists or pharmacists.

There were, however, significant relationships between some survey variables and general practitioners. In terms of experiences, we found that those who reported greater comfort in engaging with general practitioners reported higher levels of positive mental health, as did those who felt more respected by their general practitioner.

Conversely, those who reported higher levels of discrimination from general

practitioners reported lower levels of self-reported mental health.

Participants who felt they spent more time educating general practitioners reported feeling more discriminated against, and less respected.

Over the page we include example comments made about general practitioners (comments were not provided about the other three professions). We report the number of positive and negative comments made (it should be noted that not all participants provided a comment).

Experiences of Sex-Affirming Surgery

In terms of experiences with surgery, people who were MAAB and who had surgery (42.05% of all people MAAB) reported more positive experiences of surgery (M=4.27, SD=0.89) than did people FAAB who had surgery (43.24% of all people FAAB), who reported much more negative experiences (M=1.66, SD=1.09).

People who were MAAB

Experiences with Physical Health Professionals

and who had surgery reported more positive experiences of post-surgery care (M=4.34, SD=0.68) than did people FAAB who had surgery (M=1.84, SD=1.16).

These differences possibly reflect the differing availability of surgeries for people MAAB as compared to people FAAB, with the latter group reporting less availability and less satisfaction with phalloplasty (though this may be changing, see chapters in Cotton, 2012).

People who had surgery and who felt they received an optimal amount of information about the

surgery from their surgeon prior to the surgery reported they felt more in control of their decisions about surgery.

Comments about experiences of surgery are provided over the page. Again, these are grouped into positive and negative experiences, and not all participants made a comment.

Participants were asked to rate how much they felt they had spent on surgery (if they had undertaken it). Those who had surgery reported an average rating of 3 (the category this represented being between \$1000 and \$5000).

Experiences of Physical Health

In terms of relationships between different variables related to physical health care, those who had undertaken sex-affirming surgery reported higher levels of positive physical health (M=4.00, SD=0.90) than did those who had not undertaken surgery (3.10, SD=0.98).

There was no significant difference between groups in terms of physical health on the basis of natal assigned sex, a diagnosis of 'gender identity disorder', or having been prescribed hormones.

EXPERIENCES WITH GENERAL PRACTITIONERS	
POSITIVE (n=35)	NEGATIVE (n=62)
<ul style="list-style-type: none"> I have been lucky to have positive experiences with GPs (FAAB) They have been sympathetic and provided me with useful referrals (FAAB) I have always been treated with the utmost respect by GPs (MAAB) My GP is great and I couldn't ask for better (MAAB) 	<ul style="list-style-type: none"> Both of the GPs I have seen were clearly transphobic (FAAB) Most seem very ignorant of trans issues (FAAB) I had an experience with a GP so negative I attempted suicide (FAAB) So many have little knowledge and expect us to do the work (MAAB) I have experienced discrimination and ongoing poor care from GPs (MAAB)

Experiences with Physical Health Professionals

EXPERIENCES OF SURGERY	
POSITIVE (n=15)	NEGATIVE (n=45)
<ul style="list-style-type: none"> Nearly all my experiences have been overwhelmingly positive (MAAB) The Thai doctors are amazing and way ahead of anything in Australia (FAAB) I have fond memories of my experience (MAAB) My surgery went well and I had no complications (MAAB) 	<ul style="list-style-type: none"> There are few opportunities in Australia and few good surgeons (FAAB) I have been expected to shower and use toilets intended for those of my nataly-assigned gender (FAAB) I didn't get the mastectomy I wanted, instead I got a boob job, which made me suicidal (FAAB) The assistant kept calling me he instead of she.(MAAB) I was not warned of the possible scarring and am very unhappy with the outcome (FAAB) Unpleasant experiences with staff using the incorrect pronoun (MAAB) Some staff have shared my information without permission and it can be embarassing (FAAB)

Overall across both surveys the average rating of physical health was 3.78 (SD=0.96), so in the range of 'neither good nor bad'.

It is notable that the 'positive' experiences noted in the comments above are primarily of competent service provision – participants were happy with the transformation of their bodies. There was also an

emphasis on positive reports amongst those who had surgery in Thailand.

Negative reports, by contrast, tended to focus on the actual interactions with staff, rather than on the surgery outcomes themselves, though there were still accounts of poor outcomes. Surgery options within Australia were

almost uniformly depicted as negative, onerous, involving gatekeeping and no public health cover.

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Sense of Community

The final main area of interest in the two surveys related to sense of community, both to a community related to participants' current gender identity, and to the general community.

People who completed the first survey on average rated their sense of connection to the general community as 27.60 (SD=9.35), out of a possible score of 55. People who completed the second survey on average rated their sense of connection to the general community as 22.48 (SD=14.64). On average, then, both groups reported a low sense of connection to the general community.

In terms of statistical differences, we found that those who rated their sense of connection to the general community higher also rated their mental health higher.

Those who were parents reported a stronger sense of community with the general population (M=40.57, SD=8.98) than did those who were not parents (M=27.36, SD=9.40)

We also asked people whether or not they felt affiliated with a specific community related to their current gender identity. 60% of people who completed the first survey said yes to this question. 77% of

people who completed the second survey said yes to this question.

In terms of how they rated their sense of community with a community specific to their current gender identity, those who completed the first survey on average rated their sense of community as 45.60 (SD=11.12) out of a possible total of 60. People who completed the second survey on average rated their sense of community to a community specific to their current gender identity as 45.50 (SD=14.15). Both groups thus reported a strong sense of connection to a community specific to their current gender identity.

There was no significant relationship between self-reported mental health and connection to a community specific to current gender identity.

Recommendations

Clearly the findings presented in this report suggest a number of areas requiring improvement in terms of service provision to people whose gender identity differs from that expected of their natal assigned sex.

Most important is the need for better training of *all* mental and physical health care professionals. Such training must move beyond the simplistic categorisation of all people whose gender identity differs from that expected of their natal assigned sex into one group, and instead to recognise the diversity of experiences of gender identity as outlined in this report. Similarly, such training must recognise how cisgenderism occurs differently dependent on natal assigned sex, and that this reflects cisgender norms rather than necessarily inherent differences between groups of people.

We emphasise the word 'all' above, as whilst services specifically targeted at the populations of people surveyed for this report might be desirable for some people, for other people

they may not be desirable, or even if desirable may not be available (i.e., for people living outside large cities). This would suggest, then, that this is an entire workforce issue, rather than focusing solely on people who already provide services. To 'do no harm', as is the remit of mental and physical health professionals, thus requires the training of all such professionals to provide adequate and respectful services at all levels to people whose gender identity differs from that expected of their natal assigned sex.

Another important point that requires service change is in relation to surgery. It is notable that at the federal level the Australian government now allows for change of sex on official documents without requiring surgery. This is a change that may, eventually, minimise some of the differences in terms of mental health as reported in this document. There are, however, two notable factors that potentially mitigate the effects of this legislative change.

One of these factors is that

changes to birth certificates occur at state/territory level rather than federally, so whilst individuals may change their passport, Centrelink, or Medicare information under the new legislation without surgery, changes to birth certificates currently still require surgery. This discrepancy must be addressed to favour legal change at all levels without surgery, given the negative effects identified in the present report of not being able to have surgery if desired.

The second factor relates to public and professional awareness and attitudes. Whilst at the federal level surgery may no longer be required, individual professionals may still encourage surgery as the best option. Whether or not surgery is the best option for all people (and particularly with regards to age and health and their impact on surgery outcomes) requires careful consideration, one that treats choosing not to undertake surgery as a legitimate option (which can only be the case if surgery is not required to change any legal document).

Recommendations

Of course in discussing surgery we must discuss who authorises surgery. At present in Australian surgery must be authorised via assessment, an issue that brings with it gatekeeping, as many of our participants noted. It is notable, however, that whilst individuals must seek authorisation from mental health professionals in support of sex-affirming surgery, Medicare does not necessarily cover such surgery in all instances.

This discrepancy is contradictory, given that on the one hand a diagnosis of disorder is required (even if in its current iteration this is framed as ‘dysphoria’), but then the ‘treatment’ of that disorder (for those who desire it) is not necessarily covered. Whilst there is indication that recent changes to Medicare will ensure greater access to Medicare coverage of sex-affirming surgeries, it remains unclear as to what the criteria might be for this (i.e., a diagnosis of ‘gender dysphoria’), and again this is still regulated by whether or not healthcare professionals deem such surgery necessary and are willing to operate.

Of course this brings us to the issue of diagnosis. Whilst it is beyond the scope of this report to comment empirically on the effects of labeling any individual’s experience as ‘disordered’ or ‘dysphoric’, the analogy often used to prophylactic mastectomies is relevant. A person can have such a mastectomy, funded by Medicare, and without a diagnosis of pathology, if they are at potential risk. The same logic could be applied to people whose gender identity differs from that expected of their natal assigned sex. This diverse population of people is at risk of negative outcomes if healthcare responses are not adequate, and for some people this involves hormone therapy and/or surgery.

Of course these points about recognition and access relate circuitously to the relationship we found between sense of community and mental health. Whilst there are many factors that shape cisgenderism, a primary factor is the belief that sex is immutable, and that having a penis makes one male and having a vagina

make one female. At present, the requirement of a diagnosis of dysphoria to access surgery or hormones reinforces the pathologising view of the populations of people involved in our surveys.

Our suggestion here, however, is not that access to hormones or surgery should occur at the click of a finger. This does not occur with other forms of surgery or medication. There will always be an important role for properly trained and supportive professionals in working with people to weigh up the options available to them and to make informed decisions.

Ensuring that people have access to support for weighing up options will also involve that community members are aware of which professionals are best suited to this role, and the differing services that each mental and physical health professional can offer (for example, some of the challenges that some participants experienced in accessing counselors or psychologists were a product of the expectation that such professionals

Recommendations

could prescribe hormones). Information dissemination would thus appear necessary at a community level about the most appropriate referrals for a range of support needs in regards to informed decisions.

And it is this word ‘informed’ that we believe captures the way forward. Much like is represented by the changes to federal laws that allow people to alter their recorded sex on federal documents without surgery (but through consultation with a supportive professional), people whose gender identity differs from that expected of their natively assigned sex must be acknowledged as having the right and capacity to

make informed decisions about their own lives.

As such, we advocate both for the provision of government funded surgery and therapy options for people seeking such forms of support in living their gender identity as they see fit. We acknowledge that this can best be facilitated through engagement with mental or physical health professionals, but this is not because such engagement is automatically the best locus within which people should have to frame their gender experiences.

Rather, it is because a cisgenderist society makes this so. In other words, needing support to live as one’s affirmed gender or to

live outside gender binaries is a product of a cisgenderist society. That such a society should offer support to people whose gender identity differs from that expected of their natively assigned sex is about redress for the effects of cisgenderism. That such redress may involve physical or mental interventions aimed at countering the distress caused by living in a cisgenderist society should be determined by the individual, and not as a blanket presumption that all people experience such distress. As this report has shown, distress in the face of cisgenderist norms is differential, but what is relatively uniform is the imposition of cisgender norms.