Riggs, D.W. & Due, D. (2013). Mapping the health experiences of Australians who were female assigned at birth but who now identify with a different gender identity. *lambda nordica*, 19, 54-76.

DAMIEN W. RIGGS & CLEMENCE DUE

Mapping the Health Experiences

of Australians Who Were Female Assigned at Birth But Who Now Identify with a Different Gender Identity

PREVIOUS RESEARCH CONCERNING the health care experiences of people who do not identify with the gender identity assigned to them at birth suggests that this population typically report low levels of satisfaction with the health care they receive, and frequently report experiences of discrimination and/or misunderstanding when accessing health services (see, e.g. Harcourt 2006; Grant et al. 2011). To date, however, the specific health care experiences of people who were female assigned at birth (FAAB) but who now identify with a different gender identity have received little attention from researchers, with much of the research on non-normative gender identities and health care primarily focusing upon people who were male assigned at birth and who now identify with a different gender identity (e.g., Johnson 2007; Alleyn and Jones 2008). The health research that does exist in relation to those people who were FAAB has primarily focused on the unique physical health issues faced by this population. Whilst this focus upon the specific physical health needs of those who were FAAB (such as the ongoing risk of cervical cancer, the effects of hormone therapy, and the outcomes of sex affirming surgery, e.g., Burcombe et al. 2003; Turner et al. 2004) is important, there has been little attendant focus on the psychosocial aspects of health, such as satisfaction with health care received. As such, this article attempts to address this gap in the literature by focusing on

lambda nordica **3-4/2013**

the experiences of those people in Australia who were FAAB but who now identify with a different gender identity in relation to their health care experiences and access to support.

Before considering the previous research in this area in greater detail, it is important to address the issue of terminology. In this paper we utilise the language of ”people who were female assigned at birth (FAAB) and who now identify with a different gender identity”. We acknowledge that this is lengthy, and we acknowledge that for some readers it may be a relatively new way of referring to this population of people. Our decision to utilise this term arose from extensive engagement with community members prior to the development of the research reported here. At first, the terms ”trans men” and ”non-gender normative people” were utilised to refer to the community of people we sought to engage with. Over time and through discussions with community members it became apparent that the first of these terms did not capture the full spectrum of experiences that fall within the category of people FAAB but who now identify with a different gender identity.[1] This was for a number of reasons. First, some people who were FAAB now identify simply as men. The term ”trans” thus is not applicable to this population of people. Similarly, some people who were FAAB now identify with more flexible notions of gender, such as genderqueer, and thus the category ”trans” does not adequately encompass the shifting nature of gender identities for some people FAAB. The term ”female assigned at birth” was introduced to us by community members as a more encompassing way of referring to non-normative gender identities amongst those FAAB, and importantly, one that recognises the coercive function of gender assignation (i.e., to be ”assigned” denotes that the categories under question are socially constructed, rather than automatically derived from any given body).

We of course acknowledge that the term ”FAAB” may still remain problematic for some people (primarily as it includes the word ”female” in the description). As we hope will be apparent in this paper, however, we use the term to refer not to specific gender identities *per se* (for this we utilise the gender identities described by our participants), but to signal the problems that arise from gender categories, and the ways in which this marginalises particular groups of people. For similar reasons we retain our use of the term ”non-gender normative” to refer more generally to people who are, by the fact of identifying with a different gender identity to that assigned to them at birth, positioned outside of gender norms (which presume that a person's gender identity will coincide with the assignation of sex). Having noted our own decisions about terminology, we are of course respectful of the range of ways in which people who were FAAB describe their lives, and the ways in which those who engage in research with this population describe their participants. As such, in the literature review presented below we utilise the language of each of the studies we report.

With these points about language in mind, we now move on to provide a review of the existing literature related to people who were FAAB in terms of their health care experiences (including both Australian and international research), before reporting findings from our own survey undertaken with a sample of Australian FAAB. Following Harcourt (2008), we believe that the survey reported here, whilst modest in size, is important for the map it provides of Australian people who were FAAB. Harcourt argues that research concerning the health care experiences and needs of trans communities is still in its infancy, with an ongoing need for small-scale studies that can help identify the needs of specific populations (given that broader generalizations are often problematic in light of the complexities relating to identification outlined above). As such, the study reported below makes an important contribution to mapping out something of the current situation for people FAAB in Australia in terms of health care experiences.

Literature Review

In regards to the health care and support experiences of people FAAB, the recent Australian and New Zealand *TranZnation Report* (Couch et al. 2007) indicates that trans people in general experience high levels of discrimination from multiple sectors (including from health care professionals), reflecting findings of previous research internationally (see, e.g. Lombardi 2001). Importantly, however, only a minority of the participants in the Report identified as trans men (26% of 256 participants), and the analyses provided in the Report in regards to discrimination and issues relating to health care were not gender identity-specific, meaning that few conclusion can be drawn from the Report concerning the specific experiences of people FAAB.

However, what the *TranZnation Report* (Couch et al. 2007) does indicate in relation to experiences with health care professionals in general is that whilst most respondents did have a regular general practitioner (GP) and reported at least some positive experiences with other health care professionals, many also reported hesitation and discomfort in entering the health care system in case they were met with negative reactions or discrimination. Many respondents also reported frustration either at being ”pigeon-holed” by health care professionals in relation to their gender identity, or by a lack of recognition of their gender identity, reflecting findings from a previous Australian Human Rights and Equal Opportunity Commission Report in 2008. Findings from both these reports are replicated by McLean (2011), who found that most of his participants from the Australian city of Melbourne reported experiencing a lack of knowledge amongst health care providers in relation to transgender issues, leading to insensitive questioning as well as a general lack of recognition of gender identity issues. Similar findings are reported in the US context by Clements-Nolle and colleagues (2001) in relation to services around HIV/AIDS education and testing, where insensitivity, lack of understanding, and lack of respect concerning identity on the part of health care professionals were frequently cited as some of the main reasons for trans people under-accessing such services.

In other international research on people FAAB and health services, Lombardi (2007) argues that trans men in particular report feeling ”invisible” in regards to services such as HIV/AIDS prevention programs due to assumptions made about their gender identity and sexual orientation (including that people FAAB only have sex with cisgendered women and are therefore at lower risk for contracting HIV). These findings are echoed in the *Injustice at Every Turn* report (Grant et al. 2011), which examined the experiences of transgender people across a range of areas in the US, including health. The report indicates that 19% of the respondents had been refused care due to their transgender status, 28% were subject to harassment in medical settings, and 50% had to teach their health care providers about transgender care, with trans men reporting higher levels of inadequate care than trans women.

In relation to mental health, previous US research concerning trans people in general has similarly identified that many transgender people report negative experiences when dealing with mental health professionals (Bockting, Knudson and Goldberg 2006), and this is particularly the case when the contact with those professionals is mandated (such as for a diagnosis of Gender Identity Disorder). Further research in this area suggests that psychiatrists frequently act unnecessarily or excessively as ”gatekeepers” in regards to diagnosis of Gender Identity Disorder (i.e., whilst some degree of gatekeeping will continue so long as a diagnosis of GID is required to access surgery, some psychiatrists go beyond simple assessment by regulating what they consider to be an appropriate performance of gender identity). For example, Speer and Parsons’ (2006) UK research suggests that such gatekeeping occurs through the use of hypothetical questioning within interviews by psychiatrists with trans clients, which places such clients in a position whereby they are required to continually monitor their responses to ensure that they appear genuine and authentic. Such acts of gatekeeping and negative experiences in contact with mental health professionals in general are of concern given the fact that research suggests that trans people frequently report high levels of suicidal ideation, together with other mental health concerns including diagnoses of depression and anxiety. In regards to trans men specifically, Clements-Nolle et al. (2001) in their study of 123 San Franciscan trans men found that 55% of the sample reached levels for clinical depression, with 32% having attempted suicide and 20% having been hospitalized for mental health concerns.

On the whole, then, previous research, both from within Australia and internationally, suggests that whilst people who were female assigned at birth but who now identify with a different gender identity continue to experience negative interactions with health care professionals, this population of people are still required to engage with health care professionals. They need to engage with health care professionals either in seeking a diagnosis for gender identity disorder (now ”gender dysphoria”) so as to access hormones or surgery, or for support in other areas of life that may be specific to this population or a product of the population’s marginalisation within the broader community. This combination of the need for services and the potential discrimination enacted by some health care professionals highlights the vexed position that many non-gender normative people find themselves in regards to health care. This is an issue that again arises in the findings presented below, and is one we return to in our conclusion.

Methodology

Participants

Participants were 79 Australian people who responded to a survey (described below) that was framed as targeting ”people female assigned at birth but who now identify with a different gender identity”. In regards to the question ”What is your current gender identity”, 30 participants (38.5%) self-identified as male, 20 (25.6%) self-identified as trans or as trans male, 18 (23.1%) self-identified as genderqueer, and 10 (12.8%) self-identified as FTM. The average length of time since participants had publically identified as their current gender identity was 6.74 years (SD = 6.54). In response to the question ”How would you describe your sexual orientation”, 26 participants (33.3%) self-identified as gay or homosexual, 17 (21.8%) self-identified as heterosexual, 17 (21.8%) self-identified as queer, 9 (11.5%) identified as bisexual, 6 (7.7%) identified as pansexual, and 2 (2.6%) identified as asexual, with one participant not answering the question. The average age of participants was 32.05 years (SD = 10.71).

There was a statistically significant relationship between gender identity and sexual orientation, $\chi^2 (15) = 36.24$, $p < .01$. Within the context of the sample, both those who identified as male and those who identified as trans were significantly more likely to identify as gay or homosexual than were those who identified as either genderqueer or FTM. Those who identified as genderqueer were significantly more likely than any other group to identify as queer in their sexual orientation. Those who identified as FTM were significantly more likely to identify as bisexual than any other group.

In terms of residence, the majority of participants (88.5%) lived in urban areas, with the remaining participants living in rural or regional areas.[2] The majority of participants (71.8%) were living in private rental, with the remainder living in either properties they owned or had a mortgage for (18%), public housing (5.1%), or having no fixed address (2.6%), with two participants not responding to the question.

In terms of income, the majority of the participants were in paid employment (70.5%). Of those in paid employment, the majority (52.7%) were in full time work, with the remainder working casually/on contracts/part time. Of those not in paid employment, the majority (39.1%) were in receipt of a disability support pension, and the remainder in receipt of newstart (30.4%), youth allowance (21.7%), or a form of family support (8.8%). Income was recorded according to the 2011–2012 Australian income taxation brackets in Australian dollars, with nineteen participants (24.4%) reporting that their income was less than $6,000, 23 (29.5%) between $6,001 and $34,000, 28 (35.9%) between $34,0001 and $80,000, and 8 (10.3%) over $80,001. With regard to education, 24 (30.8%) had undertaken a tertiary diploma or trade as their highest level of education, 20 (25.6%) had undertaken an undergraduate degree, 19 (24.4%) had undertaken a postgraduate degree, and 15 (19.2%) had completed year 12.[3]

With regard to relationships, the majority (47.4%) of the participants reported that they were single, with the remainder of the sample reporting that they were either in a monogamous relationship (17.9%), in an open/polyamorous relationship/s (12.8%), or were de facto/engaged/married (20.5%), with 1 participant not answering the question. In terms of the gender identity of their partner for those who were in a relationship/s, 22 (53.7%) of the participants were in a relationship with cisgendered (i.e., people whose gender identity accords with that assigned to them at birth) women, 10 (24.4%) were in relationships with cisgendered men, and 9 (21.9%) were in relationships with other people female assigned at birth but who now identify with another gender identity. A minority of the sample (16.7%) had children. Of those who had children, 6 (46.2%) had given birth to their child/ren, 6 (46.2%) had become a parent by their partner giving birth, and 1 had become a parent through a mode of family formation other than themselves or a partner giving birth.

Materials

SurveyMonkey (www. surveymonkey.com) was used to administer the survey. SurveyMonkey provides tools for researchers to construct, promote, and analyse surveys online. The survey contained questions developed by the authors, beginning with a set of demographic questions reported above. Open-ended questions concerning gender were chosen due to the risk that a ”tick the box” format would bring with it the privileging of certain identities over others (within a framework of heteronormativity and gender normativity, see Goins and Pye 2012 for a discussion of this in relation to health care research).

Next, participants were asked to provide information about the non-surgical health care services they had accessed, and how supported they felt by those services. We were specifically interested in experiences with non-surgical health care professionals who were aware of their clients' non-normative gender identity, given previous research has suggested that discrimination increases when medical professionals are aware of their clients' transgender status (see Grant et al. 2011). Participants were asked, for each non-surgical health care professional they had accessed, whether 1) they felt discriminated against, 2) they felt respected, 3) they felt comfortable, 4) they felt they were provided with adequate information, and 5) they were, overall, satisfied with their experience with each of the non-surgical health care professionals. They responded to each of these questions on five-point rating scales, with the options being 1 = ”Not at all”, 2 = ”Somewhat”, 3 = ”Neutral”, 4 = ”Mostly”, and 5 = ”Definitely”. Participants were also given the opportunity to provide open-ended comments about their experiences for each group of professionals.

Participants were also asked about their mental health, including whether they had accessed any counsellors, psychologists or psychiatrists concerning their gender identity, and what their experiences with these professionals was like. One item asked about satisfaction with the support received, utilising the same rating scale as for non-surgical health professionals. Another item asked participants to rate their overall experience on a five-point rating scale, the options being 1 = ”Very negative”, 2 = ”Negative”, 3 = ”Neutral”, 4 = ”Positive”, and 5 = ”Very positive”. Participants were asked if they had ever been diagnosed with a mental disorder, and how they would rate their mental health, on a scale of 1 = ”Very bad”, 2 = ”Bad”, 3 = ”Neither good nor bad”, 4 = ”Good”, and 5 = ”Very good”. Participants were also able to respond to open-ended questions about their experience with each group of mental health professionals.

Experiences of hospital admission and surgery were also canvassed. Five-point rating scales were again used to assess experiences of surgery and post-surgery support, utilising the same options as for questions about mental health professionals. Participants were also asked whether they felt they were fully informed about surgery options, whether they felt in control of decisions about surgery, and were they aware of possible surgery outcomes. Reponses to these questions were provided on the same five-point rating scales as were used for responses regarding non-surgical health care professionals. Participants were also asked about general health issues such as financial costs associated with gender identity-related surgery and overall ratings of physical health utilising the same scale as the rating of overall mental health.

Finally, participants were asked to complete a modified version of the Sense of Community Index (Chavis, Lee and Acosta 2008) for both a community specific to their gender identity (if they were a member of one) and the broader community, in order to ascertain whether there was any relationship between sense of community and health outcomes. The Sense of Community Index for the general community was an 11 item scale, with responses reported on a five-point rating scale with the options being 1 = ”Not at all”, 2 = ”Sometimes”, 3 = ”Neither yes or no”, 4 = ”Often” and 5 = ”Definitely”. The Sense of Community Index for a community specific to gender identity was a 13 item scale, utilising the same ratings as for the general community.

Procedure

Participants were recruited via a flyer circulated through the first author’s existing networks, with further participants being recruited through snowball sampling. The flyer contained a link to the survey in SurveyMonkey, together with information about the project. Participants then had the opportunity to access the survey through the link. Upon accessing the survey, participants were initially provided with more information about the survey consistent with the information provided on an information sheet and consent form. This screen also outlined that ethics approval had been granted for the research by the first author’s university. On this screen, participants were given the opportunity to either provide their consent, or decline to continue with the survey.

Analytic Approach

Data from SurveyMonkey were entered into the IBM SPSS Statistics Programme (Version 19), a programme that assists researchers in analysing quantitative data. Descriptive statistics were generated in the form of percentages, means (the averaged response to a question across all participants who provided a response, reported in the analysis below as M), and standard deviations (which indicate how much variability there is within a sample from the average reported for each question, with a low standard deviation representing low variation and a higher standard deviation representing higher variation), reported in the analysis below as SD. Inferential statistics were generated comparing each gender identity category to responses on rating scales, but significant differences between groups were seldom identified. Similarly, inferential statistics were generated to compare other likely relationships between variables, though again significant differences were seldom identified. The instances where significant differences were identified are reported in the analysis below.

Results

Accessing Non-Surgical Health Care

In this section we summarise findings from each of the specific areas of non-surgical health care that participants had engaged with in terms of gender-related issues. We also include some of the open-ended responses made by participants about one of the groups of professionals (the only group whom comments were made about, despite open-ended questions being available in relation to all non-surgical health care professionals).

Generally in terms of physical health the sample reported a moderate to good level of physical health (M=3.75, SD=0.94). Participants were also asked about the length of time since their last pap smear, with the range of years amongst participants being from 1 year since last pap smear up to 7 years (M=4.37, SD=2.41).

General Practitioners

The majority (75%) of participants had accessed a general practitioner at some point in regards to their gender identity. In general, the sample reported a high level of respect from general practitioners (M=4.34, SD=1.14), but that nonetheless there was some degree of discrimination from general practitioners (M=1.65, SD=1.18). The sample in general was on the positive side of neutral in its assessment of general practitioners in terms of the degree of comfort they engendered (M=3.72, SD=1.50), the level of information they provided (M=3.53, SD=1.55), and the overall satisfaction felt in regards to general practitioners' responses to issues related to the participants gender identity (M=3.78, SD=1.49). Comments from participants who responded to an open-ended question about general practitioners include: ”My GP has always been respectful and eager to learn, but has little knowledge even after the three years I have been talking to him”, ”Even though my current GP is very supportive it took me many tries with multiple GPs before I could get a GP that didn't require strict gatekeeping documentation and could provide the medical care I needed as soon as possible”, and ”It's not something the doctors I've seen have had experience with, and it seems to make them uncomfortable”.

Pharmacists

Almost half of the participants (41%) had accessed a pharmacist at some point in relation to their gender identity. Of those who had accessed a pharmacist, it was generally reported that pharmacists were respectful in regards to gender identity issues (M=4.07, SD=1.22), though there was also some degree of discrimination experienced (M=1.64, SD=1.16). Those participants who had accessed a pharmacist were in general neutral in regards to their assessment of the comfort engendered (M=3.14, SD= 1.59), where on the positive side of neutral about the overall service provided by pharmacists (M=3.61, SD=1.67), though they were somewhat less positive about pharmacists in terms of the information they provided related to gender identity (M=2.86, SD=1.53).

Sexual Health Clinics

One sixth of the participants (13%) had accessed a sexual health clinic at some point in regards to their gender identity. Of those participants who had accessed a sexual health clinic, in general they were on the positive side of neutral about the degree of respect they felt they received from staff at sexual health clinics (M=3.79, SD=1.58). Similarly in terms of information provided by staff in relation to gender identity (M=3.29, SD=1.72), their overall experience with sexual health clinics (M=3.21, SD=1.88), and the degree of comfort they felt in visiting sexual health clinics about their gender identity (M=3.50, SD=1.83) was on the positive side of neutral. Those who had accessed a sexual health clinic reported experiencing some discrimination from staff (M=2.00, SD=1.60).

Gynaecologists

One sixth (15%) of participants had accessed a gynaecologist at some point in regards to their gender identity. Responses to questions about gynaecologists showed a similar pattern to those reported for staff in sexual health clinics, with those who had accessed a gynaecologist being in general on the positive side of neutral about the level of respect shown to them by gynaecologists (M=3.79, SD=1.58). The same was true in regards to the comfort engendered by gynaecologists (M=3.50, SD=1.83), the information provided to them in terms of gender identity (M=3.29, SD=1.73), and their overall experience with gynaecologists in terms of gender identity (M=3.21, SD=1.88). Participants who had accessed a gynaecologist in general reported experiencing some discrimination in terms of their gender identity (M=2.00, SD=1.604).

Accessing Mental Health Professionals

Overall, participants reported that their mental health in general was slightly above neutral (M=3.55, SD=1.12). Almost half of the sample had been diagnosed with a mental disorder (46.2%). Of those who had been diagnosed with a mental disorder, only a minority (34.6%) had been prescribed medication. This is likely due to the fact that the majority of those who reported receiving a diagnosis had received a diagnosis of gender identity disorder, with the remaining participants who had a diagnosed disorder being diagnosed as having depression, anxiety, bulimia, bipolar, post traumatic stress disorder, Asperger syndrome or borderline personality disorder.

In terms of which specific groups of individuals within the sample were accessing each of the groups of mental health professionals, no significant differences were found for counsellors or psychologists. In regards to psychiatrists, however, those participants who identified as trans men or as male were significantly more likely to access a psychiatrist than were those who identified as genderqueer or FTM, χ^2 (3) = 12.53, $p < .01$.

Counsellors

Over half of the sample (51%) had accessed a counsellor in regards to their gender identity, for issues including help and guidance, to talk about gender identity-related issues, for diagnosis of gender identity disorder, and for gender-related relationship issues. Those who had accessed a counsellor suggested that in general their experience of the counsellor was negative (M=2.05, SD=1.06), but nonetheless that they rated the support they received as on the positive side of neutral (M=3.86, M=1.21). Reasons for this overall less than positive appraisal of counsellors included: ”Even though my counsellor was very supportive and helpful with the mechanical stuff I was seeing her about, it is still sometimes a bit frustrating when you are educating a professional about a huge aspect of what makes you tick”, and ”I had a bit of an issue with a counsellor refusing to accept that I am a gay man – not sure if this was because I am trans or my partner is or both. The same counsellor tried to get me to talk about my body using female terms which I don’t identify with”.

Psychologists

Almost half of the sample (48%) had seen a psychologist at some point in regards to their gender identity. Reasons for this included distress related to genitalia, assessment for gender identity disorder, depression related to the difficulties of transitioning, and as a compulsory precursor to accessing surgery. Those who had accessed a psychologist suggested that in general their experience was negative (M=2.22, SD=1.14), though their assessment of the support they received from the psychologist was on the positive side of neutral (M=3.56, SD=1.43). Reasons given for what made accessing a psychologist negative included: ”I felt I needed to portray a trans* story rather than my genderqueer one to access the hormones I was asking for”, ”One of my psychologists wasn’t helpful and treated me like I didn’t know what was best for myself”, and ”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 effects to the effectiveness of treatments”.

Psychiatrists

Almost two thirds of the sample (65%) had accessed a psychiatrist in relation to their gender identity, for reasons restricted solely to approval for surgery or to access hormones via diagnosis of gender identity disorder. Those who had accessed a psychiatrist reported being on the positive side of neutral about the support they received (M=3.86, SD=1.43), and somewhat more neutral about their experience with the psychiatrist in general (M=3.25, SD=1.25). This neutral response to psychiatrists was evident in comments made, such as: ”I saw him once for 40 minutes and he gave me the letter I needed”, ”My first psychiatrist I saw for 40 minutes and he let me have T”, ”Felt like a redundant exercise – just something I did to tick boxes”, and ”I didn’t see them to work through issues, I saw them to be assessed and given permission to medically transition”.

Accessing Gender Identity-Related Surgery

One third (32%) of the sample had accessed surgery in relation to their gender identity, and two thirds (52%) had plans to undertake surgery in relation to their gender identity at some point (these two categories were not mutually exclusive). Of those participants who had accessed surgery in relation to their gender identity, 30 had mastectomies, 9 had hysterectomies, and 2 had surgeries aimed at creating a phallus and/or testes (either through phalloplasty or metoidioplasty and/or scrotoplasty). Those who had undertaken surgery reported spending on average between $5,000 and $10,000 on their surgery.

In terms of experiences of surgery, there seemed to be a gap for participants between engagement with surgeons, and their experience within the hospital itself. In regards to the former, for those participants who had undertaken surgery, they mostly felt that they had received adequate information from their surgeon prior to their surgery (M=4.34, SD=1.26), mostly felt in control of the decisions they made in regards to surgery (M=4.28, SD=1.32) and mostly felt provided with adequate information by their surgeon post-surgery (M=4.31, SD=1.25). In terms of experiences within hospitals, however, participants who had surgery in general indicated that they had negative experiences both in regards to the surgery itself (M=1.66, SD=1.09), and within the hospital post-surgery (M=1.84, SD=1.16). This finding of a negative perception of hospitals might be explained by comments made in response to open-ended questions, such as: ”Hospital staff are extremely rude and the men’s toilets/showers often are not very private when in shared male wards, which can be a concern about safety with regards atypical anatomy”, and ”When I had my chest done a nurse kept calling me she”.

Of those participants who intended to undertake surgery in the future in relation to their gender identity, 31 intended to have mastectomies, 13 intended to have hysterectomies, and 14 intended to have surgeries aimed at creating a phallus and/or testes (either phalloplasty or metoidioplasty and/or scrotoplasty).

In terms of the relationship between surgery and other variables, a statistically significant relationship was found between whether or not a participant had undertaken gender identity-related surgery, and their self-reported level of mental health. Those who had undertaken surgery reported slightly higher levels of positive mental health (M=3.84, SD=1.08) than did those who had not undertaken surgery (M=3.31, SD=1.12), and this difference was statistically significant, F=4.074, $p < .05$.

Sense of Community

In terms of sense of community, 40 (51.3%) of the participants reported identifying as part of a community specific to their gender identity. Participants described these communities either in terms of general categories (i.e., queer community, trans community), or in terms of specific groups (i.e., ftmaustralia). Those who identified as part of a specific community reported a well-developed and strong sense of community (M=45.60, SD=11.12, possible range 13–65). By contrast, participants reported a much lower sense of community in terms of the broader community (M=27.60, SD=9.35, possible range 11–55).

Conclusion

The findings presented here provide a useful snapshot of the Australian context as it pertains to people FAAB in terms of their experiences of health care. In what remains of the paper we discuss some of the specific findings in terms of what they indicate might be necessary on the part of health care professionals in order to ensure better service to this population of people.

The open-ended data suggest that one of the overarching concerns of participants in this study was the necessity of having to educate health care professionals in order to ensure adequate service. As has been argued elsewhere in terms of non-heterosexual people's access to services (e.g., Riggs 2011), this type of injunction upon marginal group members to educate professionals displays something of a wilful lack of knowledge amongst professionals. In other words, if competent practice requires knowledge about a range of user populations, then it is the task of the professional to ensure that their knowledge is adequate, not the task of the consumer to educate the professional. Whilst there now exists a range of guidelines advocating for best practice with non-gender normative people, professional organisations need to find ways to ensure the uptake of such guidelines, as well as their implementation in practice.[4] This might require, for example, the development of policies that make it clear to professionals that adherence to practice standards for working with non-gender normative people are mandatory, not a choice. Part of this, we would argue, is the necessity of ensuring that the specific needs of people FAAB are addressed so as to guarantee appropriate information is provided, (i.e., in regards to the need for pap smears for many people FAAB, the risks of hormone therapy and its possible side effects, and counselling prior to surgery in terms of future reproductive desires), as well as to ensure that appropriate terminology is used by professionals.

In terms of experiences with mental health professionals, we would argue that the differences in experiences reflect something of lay knowledge about each group of professionals. Whilst generic categories, such as ”shrink,” ”psych” or ”counsellor,” are variously used by the general public, these categories belie significant differences between the professions, and this has particular consequences for non-gender normative people. Specifically, and in terms of a diagnosis of gender identity disorder and prescription of hormones, it is important that community members are made aware of who can diagnose and prescribe. This may help to circumvent some of the frustrations and disappointments that some participants experienced in attempting to access a diagnosis or hormones through counsellors or psychologists (the former of which in many cases can do neither, the latter of which can only diagnose). Relatedly, it would seem important that psychiatrists are encouraged to do more than just diagnose and prescribe. This may require the development of an adequate referral system so that psychiatrists can connect clients with counsellors or psychologists who can work with clients in terms of gender identity. It may also indicate the need for multidisciplinary teams that collaborate to support non-gender normative clients. Finally, it may be useful for professional organisations and community organisations to collaborate to develop information for community members about where to seek the most appropriate referrals, dependent upon each individual's needs.

One very interesting finding from our survey was the relationship between mental health and surgery. This, we believe, needs clarification. We do not think that this finding indicates that surgery equates to mental wellbeing *per se.* Rather, we believe that, in a sample primarily constituted by people wanting to undertake surgery in relation to their gender identity, and for those who were able to undertake such surgery, it is likely that the success of this would lead to positive mental health outcomes. Of course the opposite of this is also true: our findings indicate that a large number of the sample wish for, or intend to undertake, surgery, but when this is combined with factors that may prevent many of these people accessing surgery (specifically issues of diagnosis, finances and perceived discrimination), then a *lack* of access to surgery may justifiably be linked to poorer mental health. Outside of these two categories there will of course be people for whom surgery holds no interest and for whom the opportunity to undertake surgery will likely have little relationship to their mental health. Indeed, for some the injunction to undertake surgery may be experienced as yet another form of marginalisation resulting from the dominance of the medical model, especially in regards to the recognition of rights for non-gender normative people. Our point here, then, is that surgery should be readily available with minimal gatekeeping for those who want it (as is the case, for example, with prophylactic mastectomies), but it should not be treated as the only mode of citizenship or valid identity for people FAAB.

In terms of experiences of surgery, it is also of note that whilst participants who had undertaken surgery were in general mostly satisfied with their surgeons, they were less satisfied with their general hospital care. This would suggest that whilst some surgeons may at present be more informed about the needs of people FAAB than might have been the case in the past, this does not necessarily extend to other professionals involved in hospital care. As was suggested above, then, what is required are targeted interventions aimed at ensuring that all health care professionals are aware of, and able to meet, the support needs of people FAAB in regards to surgery and hospital care.

Finally, it is interesting to note that whilst a majority of the participants identified with a community group specific to their gender identity, and whilst this was a strong and positive identification, this was not related to more positive levels of mental health *per se.* Similarly, it is interesting that the lower sense of community amongst participants in terms of the broader community was not related to adverse mental health outcomes. Previous research with gay men, for example, has suggested that increased sense of community with both marginal and dominant communities results in a decrease in negative mental health outcomes (e.g., McLaren, Jude and McLachlan 2008). Future research could usefully investigate in closer detail whether or not there is such an association amongst non-gender normative communities, and how it can be utilised to better meet the needs of this population.

In terms of limitations, despite the survey being fairly exhaustive in terms of its battery of questions, it could be argued that the response choices for questions that utilised rating scales did not adequately capture participants' experiences. Future research may benefit from the use of a seven-point scale, or a scale where a neutral middle point is not included. It is also of note that whilst participants' reports of their gender identity were treated as self-evident, it would have been useful to have included an open-ended question asking participants what the category they nominated meant for them. This would have provided further insight as to the homogeneity or heterogeneity of respondents within each category (and might have helped explain why few statistically significant differences were identified).

To conclude, whilst the findings reported in this paper represent a relatively small sample, the sample contained in the *TranZnation Report* (Couch et al. 2007) would suggest that the present sample is broadly indicative of the numbers and experiences of Australian people female assigned at birth but who now identify with a different gender identity (i.e., the Report included 67 people FAAB). Whilst the sample reported here had some positive things to say about the health care professionals they have engaged with, the findings also indicate many areas for improvement. Importantly, and whilst in this paper we have sought to disaggregate where possible the differing experiences of the wide range of people who fall within the umbrella category of FAAB, we did not find statistically significant differences in terms of experiences (other than access to psychiatrists). Whilst we would not suggest this means that disaggregation is not necessary in future research, we would suggest that, in general, people FAAB experience a range of similarities in terms of interactions with health care providers, all of which indicate the need for further training and upskilling amongst those who work with this population.

Acknowledgments

We begin by acknowledging the sovereignty of the Kaurna people, the First Nations people upon whose land we live in Adelaide, South Australia. Thanks are due to the *Zoe Belle Gender Centre* and *A Gender Agenda* for supporting this research. Specific thanks are due to Ash Pike, Jennie Yates, and Peter Hyndal for their support. The research was supported by a Faculty Research Grant.

DAMIEN W. RIGGS is a senior lecturer in social work at Flinders University. His research and teaching encompass gender/sexuality studies, parenting studies, and critical race and whiteness studies, and he is the author of over 100 publications in these areas, including *Lesbian, Gay, Bisexual, Trans and Queer Psychology: An Introduction* (Cambridge University Press, 2010, with Victoria Clarke, Sonja Ellis and Elizabeth Peel).

CLEMENCE DUE is a researcher in the School of Psychology at the University of Adelaide. Her research focuses on parenting studies, re-

fugee studies, and child mental health and she has published widely in these areas. She is author of *Representations of Indigenous Australians in the Mainstream News Media* (Post Pressed, 2011, with Damien Riggs).

REFERENCES

Alleyn, Chrissey, and Rebecca L. Jones. 2008. "Queerying Care: Dissident Trans Identities in Health and Social Care Settings". In *LGBT Issues: Looking Beyond Categories*, edited by Rebecca L. Jones and Richard Ward, 56–68. Edinburgh: Dunedin Academic Press.

Bockting, Walter, Gail Knudson, and Joshua Mira Goldberg. 2006. "Counselling and Mental Health Care for Transgender Adults and Loved Ones". *International Journal of Transgenderism* 9.3–4:35–82.

Burcombe, Russell, Andreas Makris, Michael Pittam, and Nicholas Finer. 2003. "Breast Cancer after Bilateral Subcutaneous Mastectomy in a Female-to-Male Transsexual". *The Breast* 12.4:290–3.

Centre of Excellence for Transgender Health. 2011. "Primary Care Protocol for Transgender Patient Care". http://transhealth.ucsf.edu/trans?page=protocol-00-00 (accessed 2010-08-20).

Chavis, David, Kien Lee, and Joie Acosta. 2008. "The Sense of Community (SCI) Revised: The Reliability and Validity of the SCI-2". Paper presented at the 2nd *International Community Psychology Conference*, Lisbon, Portugal.

Clements-Nolle, Kristen, Rani Marx, Robert Guzman, and Mitchell Katz. 2001. "HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgender Persons: Implications for Public Health Intervention". *American Journal of Public Health* 91.6:915–21.

Couch, Murray, Marian Pitts, Hunter Mulcare, Samantha Croy, Anne Mitchell, and Sunil Patel. 2007. *TranZnation: A Report on the Health and Wellbeing of Transgender People in Australia and New Zealand*. Melbourne: Australian Research Centre in Sex Health and Society.

Goins, Elizabeth, and Danee Pye. 2012. "Check the Box that Best Describes You: Reflexively Managing Theory and Praxis in LGBTQ Health Communication Research". *Health Communication* 2012.2:1–11.

Grant, Jaime, Lisa Mottet, Justin Tanis, Jack Harrison, Jody Herman, and Mara Keisling. 2011. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force.

Harcourt, Jay. 2006. "Current Issues in Lesbian, Gay, Bisexual and Transgender

(LGBT) Health". *Journal of Homosexuality* 51.1:1–11.

Human Rights and Equal Opportunity Commission. 2008. "Sex and Gender Diversity: Report of Initial Consultation". http://www.humanrights.gov.au/sex-and-gender-diversity-report-initial-consultation-2008 (accessed 2013-05-15).

IBM Corp. Released 2010. IBM SPSS Statistics for Windows, Version 19.0. Armonk, NY: IBM Corp.

Johnson, Katherine. 2007. "Transsexualism: Diagnostic Dilemmas, Transgender Politics and the Future of Transgender Care". In *Out in Psychology: Lesbian, Gay, Bisexual, Trans and Queer Perspectives*, edited by Victoria Clarke and Elizabeth Peel, 445–64. Chichester, West Sussex, England: John Wiley.

Lombardi, Emilia. 2001. "Enhancing Transgender Health Care". *American Journal of Public Health* 91.6:869–72.

–. 2007. "Public Health and Trans People: Barriers to Care and Strategies to Improve Treatment". In *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations*, edited by Ilan Meyer and Mary Northridge, 638–52. New York: Springer.

McLaren, Suzanne, Belinda Jude, and Angus McLachlan. 2008. "Sense of Belonging to the General and Gay Communities as Predictors of Depression amongst Australian Gay Men". *International Journal of Men's Health* 7.1:90–9.

McLean, Andrew. 2011. "A 'Gender Centre' for Melbourne? Assessing the Need for a Transgender Specific Service Provider". *Gay and Lesbian Issues and Psychology Review* 7.1:33–42.

Riggs, Damien Wayne. 2011. "Australian Lesbian and Gay Foster Carers Negotiating the Child Protection System: Strengths and Challenges". *Sexuality Research and Social Policy* 8.3:215–26.

Speer, Susan, and Ceri Parsons. 2006. "Gatekeeping Gender: Some Features of the Use of Hypothetical Questions in the Psychiatric Assessment of Transsexual Patients". *Discourse and Society* 17:785–812.

Turner, Adrian, Tai Chen, Tom Barber, Alan Malabanan, Michael Holick, and Vin Tangpricha. 2004. "Testosterone Increases Bone Mineral Density in Female-to-Male Transsexuals: A Case Series of 15 Subjects". *Clinical Endocrinology* 61.5:560–6.

WPATH. 2001. *The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders*. 6th Version. Minneapolis: WPATH.

NOTES

1. Throughout the paper we will utilise this acronym "FAAB", to refer to people who were assigned female at birth but who now identify with a different gender identity. For brevity, we will most often simply use the acronym alone without following it with the clarifier "but who now identify with a different gender identity".

2. The term ”regional areas” refers to large towns or groups of townships located outside of major cities.
3. Year 12 is the highest level of secondary school education that Australian students complete before going on to employment or tertiary study.
4. For examples of such guidelines, see Bockting, Knudson and Goldberg (2006) for protocols for working with trans people in relation to mental health care, and the Centre of Excellence for Transgender Health's *Primary Care Protocol for Transgender Patient Care* (2011), and the World Professional Association for Transgender Health's *Standards of Care* (WPATH 2001) for more general guidelines for health professionals.

SAMMANFATTNING

Fast det numera bedrivs en allt mer omfattande forskning kring transpersoner i Australien, har den hittills främst varit inriktad på erfarenheter av diskriminering i det omgivande samhället och undersökningspersonerna har främst varit transkvinnor. Den forskning som presenteras i denna artikel söker balansera dessa begränsningar genom att undersöka vilka erfarenheter personer som tillskrevs kvinnligt kön vid födseln (*female assigned at birth*, FAAB) men som numera identifierar sig med någon annan genusidentitet, har av möten med hälso- och sjukvårdspersonal. Studien granskar i synnerhet personernas interaktioner med vårdgivare, de unika hälsobehoven hos gruppen, samt känslan av gemenskap och tillhörighet som dessa människor upplever, både inom den egna gemenskapen och i det omgivande samhället. Resultaten pekar på att de som var FAAB fortsätter att kämpa för erkännande från vårdgivare och att hälsobehoven hos denna grupp människor inte är lätta att inordna i existerande hälsovårdsmodeller eller -populationer. Rekommendationer presenteras också för att gruppens hälsobehov bättre skall kunna tillfredsställas.

Keywords: gender identity, health care provision, discrimination, Australia, best practice