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(Trans)Gender Trajectories: Transsexual People Coming to Terms With Their Gender Identities

This chapter is based on the paper Pinto, N., & Moleiro, C. (in press). Gender Trajectories: Transsexual People Coming to Terms With Their Gender Identities. *Professional Psychology: Research & Practice*.

1. Abstract

If you are a professional psychologist, it is quite likely that you have already encountered a transsexual client, or will in the future. How confident are you in your ability to work successfully with this population? Research shows that therapists' knowledge of the specific challenges that transsexual clients have to face through the course of their lives may improve clinical care. The main goal of this study was to explore how transsexual people recognize, acknowledge, and come to terms with their gender identities. In-depth interviews were conducted with a diverse sample of 22 self-identified transsexual individuals (14 male-to-female and 8 female-to-male). The analysis conformed to the principles of grounded theory methodology. Results show the participants moving through five developmental stages: (1) Confusion and increasing sense of gender difference; (2) Finding an explanation and a label: exploring identity; (3) Deciding what to do and when: exploring options; (4) Embracing gender identity: performing a new social identity and undergoing body modifications; and (5) Identity consolidation and invisibility. Findings also highlight various internal and external conditions, action/interaction strategies, and psychosocial consequences that participants had to cope with in each stage. We also acknowledged a series of transition triggers: that is, particular events that facilitated movement from one stage to another. Implications for clinical practice are discussed.

Keywords: transsexual clients, gender trajectory, identity development, grounded theory, clinical competence

2. Introduction

Gender is probably the first feature that we notice when we meet someone new. Gender is omnipresent in our lives and defines most, if not all, social interactions. The dichotomy between women and men is a powerful one, probably one of the most powerful in western societies. Assigning the sex of a newborn, usually from a simple assessment of the genitalia, is often the first procedure after birth. However, later in life, people may realize that their sex does not match their gender identity: that is, the “person’s basic sense of being male, female, or of indeterminate sex” (American Psychological Association [APA], 2009, p.28). So, what happens if the assigned sex at birth does not match someone’s true sense of gender, which is the case with transsexual men and women? How can psychologists help transsexual people manage the incongruence between their sex and their gender identities? Widespread clinical knowledge about the challenges and specific events that transsexual people face throughout their lives may prove crucial for providing effective care to this population (Carroll & Gilroy, 2002; Lev, 2004; Raj, 2002). The main goal of this study is to explore how transsexual people recognize, acknowledge, and come to terms with their gender identities.

Transgender is an umbrella concept that describes different people who transcend society’s traditional gender roles or expressions (Lev, 2004), such as transsexual and intersex individuals, or cross-dressers and drag queens/kings. Within the transgender spectrum, transsexual people are those whose gender identity is the opposite of the assigned sex at birth, and therefore “believe that their physiological bodies do not represent their true sex” (Lev, 2004, p.400). On the contrary, cissexuals are those whose gender identity is congruent with their assigned sex at birth. Despite the traditional medical definitions, nowadays the term transsexual is used regardless of which, if any, medical interventions one has undergone or may desire in the future (APA, 2009). Transsexual women are often referred to as male-to-female (MTF), and transsexual men as female-to-male (FTM). Even when referring specifically to transsexual people, several authors prefer to use the term transgender indiscriminately, likely for political reasons (Serano, 2007). In Portugal, the study’s context, the term transsexual is broadly used, as it is in nearby countries (Platero, 2011). In this study the term transsexual describes “anyone who is currently, or is working toward, living as a member of the sex

other than the one they were assigned at birth, regardless of what procedures they may have had” (Serano, 2007, p.31).

Clinicians, and in particular psychologists, are often asked to help transsexual people who are coping with psychological distress and decreased mental health (APA, 2009). Anxiety, mood disorders, substance abuse, and suicidal behaviors (Budge, Adelson, & Howard, 2013; Maguen & Shipherd, 2010; Nuttbrock et al., 2010) can be related to internal conflicts regarding gender identity (Mizock & Fleming, 2011; Newfield, Hart, Dibble, & Kohler, 2006) and, simultaneously, to social stressors such as discrimination, violence, and stigma (Lombardi, Wilchins, Priesing, & Malouf, 2001). Therefore, clinicians may have a significant impact on the lives of transsexual people through mental health enhancement. This is even truer if we consider the therapist’s role in guarding access to medical treatments, such as hormone therapy and surgery (Coleman et al., 2011). Gatekeeping can be a challenge for both clients and therapists (Bess & Stabb, 2009; Bockting, Robinson, Benner, & Scheltema, 2004). Thus, several authors and studies strongly endorse the need for psychologists to have competence in the effective support of transsexual clients, and, therefore, for accurate training in and knowledge about transsexuals’ specificities (e.g., Carrol & Gilroy, 2002; Hendricks & Testa, 2012; Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008; Raj, 2002).

Research on transsexual people’s lives has focused on various issues and has taken different formats with different purposes in mind. Some studies have focused on particular aspects, such as mental health (e.g., Mizock & Fleming, 2011), family dynamics (e.g., Bethea & McCollum, 2013), the impact of community support (e.g., Lev, 2007), or work experiences (e.g., Budge, Tebbe, & Howard, 2010). At the same time, some studies have addressed transsexuals’ identity growth through the course of life, focusing mainly on the so called “transition” and highlighting a series of developmental stages.

Transgender trajectories: Previous developmental models

Gagné, Tewksbury, and McGaughey (1997) studied the coming-out experiences of “masculine-to-feminine transgenderists” (p.478) and described four main themes of identity formation: early transgender experiences; coming out to oneself; coming out to others; and the resolution of identity. Devor (2004) studied transsexual identity formation and developed a model based on homosexual identity that shows the transsexual person moving through 14 stages, from abiding anxiety to pride. Lev (2004)

presented a model of transgender emergence which describes in detail six developmental stages that transgender people experience while they engage in conscious decisions regarding sex reassignment. The author also describes a series of therapeutic tasks that can guide therapists assisting transgender clients in each stage. More recently, Pollock and Eyre (2012) studied identity development among FTM transgender youth and identified three stages: a growing sense of gender; recognition of transgender identity; and social adjustment.

These models undoubtedly have their merits and may, in fact, be significant in improving competent and effective interventions with transsexual and other transgender people. However, not all of these proposals derive from bottom-up empirical research. Lev's (2004) model is based on clinical experience, and the one proposed by Devor (2004) was built upon a previous model of homosexual identity formation. Furthermore, not all of these studies and proposals address the unique experience of both transsexual men and women. The study developed by Gagné and colleagues (1997) comprised "transsexual, fetish and nonfetishistic cross-dresser, [and] drag queen" (p.483) participants. The model proposed by Lev (2004) refers to the experience of transgendered and transsexual adults, and Pollock and Eyre's study (2012) describes the experiences of FTM individuals. The present study focused on the specificities of transsexual men and women, and is the first of its kind developed in the Portuguese context.

3. Our Study

Context and Aim

We carried out an empirical study within a group of self-identified transsexual women and men. The study was developed and completed in Portugal, a country where research on transsexuality is still very scarce but where significant public attention has been given to transsexuality and transsexual people in recent years due to the approval of a gender identity law (Pinto & Moleiro, 2013).⁹ The main goal of this study is to

⁹ The new legislation allows transsexual people to change their names and legal sex in an administrative process, solely requiring the presentation of a supported clinical diagnosis by a multidisciplinary team of clinicians, including a psychologist. Actually, this means that people can change their names and legal sex without any imposed

explore how transsexual people recognize, acknowledge, and come to terms with their gender identities. Implications for clinical practice will be presented.

Participants

Twenty-two self-identified transsexual people participated in the study: 14 MTF and 8 FTM individuals. The participants' ages ranged between 16 and 55 ($M = 31.81$, $SD = 11.81$). All participants were Portuguese citizens. Most resided at the time in the two major Portuguese cities (or surrounding areas) of Lisbon and Porto, but six lived in or were from smaller towns or rural areas. Nine of the participants were working at the time in areas such as customer service, tourism, health services, data processing, or sex work; seven were unemployed; five were students in areas such as sports, psychology, or fashion; and one was a working student. The vast majority of participants presented themselves as heterosexual (i.e., they were physically and emotionally attracted to people whose gender is contrary to their self-identified gender), with the exception of two MTF participants who indicated that their sexual orientation was homosexual (i.e., they were attracted to women). Thirteen were at the time single, and nine were married or in a relationship. The group was diverse with regard to the state of transition progress: nine participants were, at the time of the study, fully living according their gender identities (and had completed some body modifications or changes in gender expressions); another nine were initiating or going through transition, and either undergoing some kind of body modification or alteration in gender expressions; and the remaining four, although identified themselves as transsexuals, were living socially according to the sex assigned at birth and had not started, during the study, any medical treatment in order to change their bodies.

Procedures: Data Collection and Analysis

Our data *corpus* was composed of in-depth interviews of 22 self-identified transsexual people. Participants were recruited through different channels. A brochure was developed and distributed to a lesbian, gay, bisexual, and transgender (LGBT) community center and also sent to public and private clinical settings where transsexual people may undergo gender oriented treatment. An electronic version of the brochure was sent to several LGBT associations and transgender support/activist groups, and

medical treatment. This law is the “first European law on name change and legal gender recognition that meets the Yogyakarta Principles” (European Commission, 2012, p.72).

thereafter posted in their online channels. As data collection progressed, participants were also recruited through the social networks of past participants. The content of the brochure described the study's aims and procedures, and assured confidentiality. We explicitly mentioned in the brochure that the study was on transsexuality and transsexual people; nevertheless, it was specified that we recognized as a transsexual person anyone whose gender identity is not congruent with the assigned sex at birth, regardless of being in transition or not. All the interviews were conducted in person by the first author – a cissexual young adult male. Interviews took place in different locations, according to the participants' preferences: in a private office at the university, in the houses of the participants, or in public places such as malls or coffee shops. The interviewer explained the nature of the research before the formal interview, and any questions or doubts on the part of participants were answered prior to their signing a written informed consent form. Interviews lasted between 40 and 120 minutes. If necessary or appropriate, the interviewer provided participants with pamphlets from LGBT associations and transgender support groups, and the contact information of public gender health clinics at the end of the interview. All the interviews were audio recorded and transcribed later by the first author or by a research assistant. Any specific information that could lead to an easy recognition of the participant was not transcribed, in order to guarantee confidentiality. This study and all the methods employed were in line with the ethical principles of psychologists (APA, 2010; Ordem dos Psicólogos Portugueses, 2011).

Data collection and analysis followed the canons and procedures of grounded theory (GT) methodology. This research method is intended to develop an integrated set of concepts (i.e., a theory) that provide a detailed description of the social phenomenon under study (Corbin & Strauss, 1990). In GT methodology, data collection and analysis are interrelated processes: analysis must start as soon as the first piece of data is collected, precisely because it is used to direct the next data collection (Corbin & Strauss, 1990). Data collection took place between 2010 and 2012 and happened in three distinct phases: 9 participants were interviewed in the first phase, 6 in the second and 7 in the last one. Analysis followed each of the three data collection periods. Each data collection, but the first, was informed and directed by the previous analysis: while we started with broad interview guidelines, as the process of collecting/analyzing moved forward, more specific research questions emerged and directed subsequent data collection and analysis. The interview protocol was focused on the participants' current

experiences and, at the same time, on their life histories: childhood and adolescence, adulthood, family, significant others, school experiences, professional life, community support and involvement, health care, clinical transition, and legal recognition. The evolution of the analysis obeyed a core principle in GT methodology: constant comparison through processes of open, axial, and selective coding (Strauss & Corbin, 1990). We used the software MAXQDA 10 to assist the analysis. Sampling in GT proceeds on theoretical grounds: as the analysis progressed, we varied the sampling conditions in order to determine what the impact on upcoming analysis would be (e.g., in the second collection phase we intentionally tried to interview more FTM individuals, and in the third and last phase we focused on the testimony of participants who had already concluded, so to speak, their transition processes). The recruitment of participants ended when the analysis process reached saturation. Corbin and Strauss (1990, p.11) endorsed that “an important part of research is testing concepts and their relationships with colleagues who have experience in the same substantive area.” We took advantage of feedback from colleagues on three occasions (respectively at the end of each analysis phase): two times with a small group of researchers working in areas related to diversity and mental health, and one time in a larger seminar with experts in transgender and transsexual experiences. When proved suitable, their comments and suggestions were incorporated in our study.

4. Results

Proceedings from analysis resulted in an integrated and related set of concepts, illustrative of the processes through which the participants recognized, acknowledged, and came to terms with their gender identities. The emergent theoretical model shows the participants moving through five developmental stages: (1) Confusion and increasing sense of gender difference; (2) Finding an explanation and a label: exploring identity; (3) Deciding what to do and when: exploring options; (4) Embracing gender identity: performing a new social identity and undergoing body modifications; and (5) Identity consolidation and invisibility. Each stage reflects a specific form of “gender identity management” the main category that emerged from analysis. Alongside the distinctive phases of these gender trajectories, we identified a set of internal and external intervening conditions, action and interaction strategies, and psychosocial

consequences (see Figure 3.1). In each stage, different conditions, actions, and consequences affected the ways in which each participant managed her or his gender identity. Action/interaction strategies (e.g., the search for clinical help) occurred under specific internal/external conditions (e.g., exposure to information on transsexuality), and were followed by psychosocial consequences (e.g., improved mental health). In their turn, these consequences could also impact conditions and action/interaction strategies.

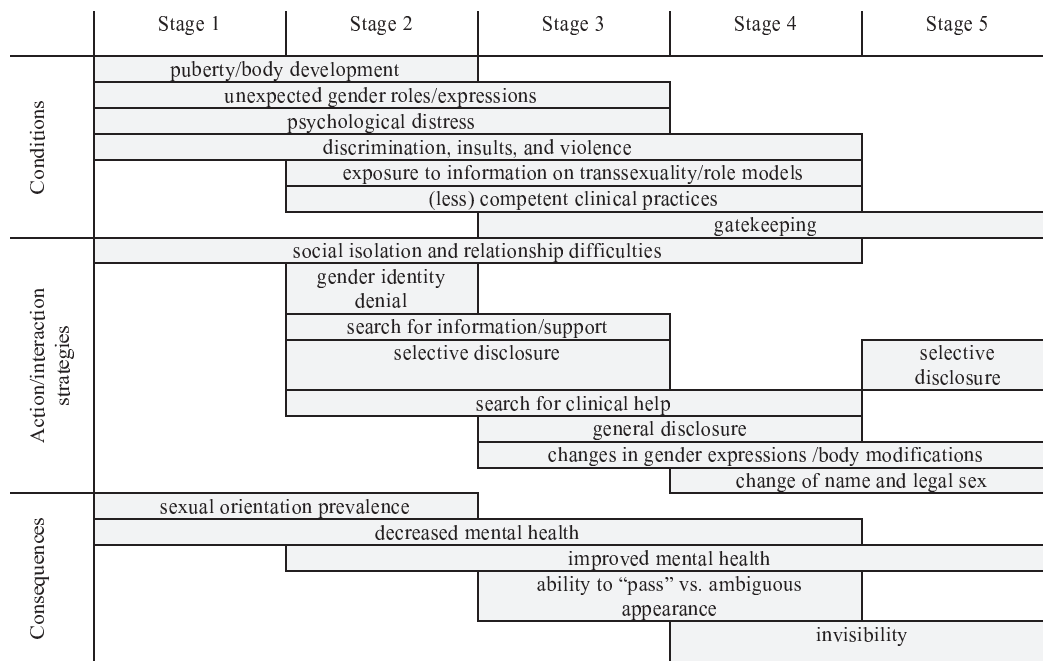


Figure 3.1. Gender trajectories: Conditions, action/interaction strategies, and consequences

We also identified transition triggers, which is to say particular events that facilitated movement from one stage to another. For example, “exposure to information on transsexuality” was found to be a possible trigger from stage 1 to stage 2. These events were not essential to progression through the stages but, when present, facilitated participants’ movement to the subsequent stage. Figure 3.2 shows the main transition triggers. Naturally, participants did not imperatively move through the stages in the same way. Participants crossed the stages at different paces: some remained in the same stage for long periods of time, while others went through a particular stage very quickly.

Nevertheless, the emerged model stresses the commonalities in the participants' processes of developing an authentic self and coming to terms with their gender identities. The next section outlines the model in greater detail. All quotations include a pseudonym chosen for each participant.

Stage 1. Confusion and increasing sense of gender difference	
Transition triggers:	Exposure to information on transsexuality Access to internet or other information sources
Stage 2. Finding an explanation and a label: Exploring identity	
Transition triggers:	Positive transsexual role models Break event (e.g., divorce) Clinical diagnosis Context of acceptance (e.g., personal or clinical relationships)
Stage 3. Deciding what to do and when: Exploring options	
Transition triggers:	Break event (e.g., graduation) Change of context (e.g., job/city) Emotional breaking point
Stage 4. Embracing gender identity: Performing a new social identity and undergoing body modifications	
Transition triggers:	Constant recognition as a woman or man Genital surgery Legal sex change
Stage 5. Identity consolidation and invisibility	

Figure 3.2. Transition triggers: What facilitates movement through the stages?

Stage 1 - Confusion and Increasing Sense of Gender Difference

The first stage is about a growing sense of being different in a way not socially valued, and an increasing awareness that the difference is related to some kind of gender incongruence. This sense of difference is accompanied by a state of confusion and psychological distress: in stage 1 participants could hardly assign a satisfactory meaning to what was going on with them. The words of Andrew (FTM, age 19) concerning his childhood may synthesize the experiences of most participants in this stage: “I was sad, but I didn't know what was happening. I was not quite aware.” When asked about their early phases of life, all participants described in some way a preference for gender expressions and roles socially ascribed to the opposite sex. Some alluded to personal memories or to events that parents or caretakers reported to them of their early childhood. This condition of unexpected gender roles/expressions was not necessarily

experienced as problematic by itself. Some participants lived in a relatively gender-tolerant way until their early teens, if their family dynamics and school environment were complaisant. Maria (MTF, age 19) reported that her preference for girls' toys and female playmates, and her identification with the female characters in TV shows were not a problem until the age of 10 because her parents did not make this an issue, although she later found out that her parents sought advice at the time from a psychologist. Nevertheless, for several participants, their gender expressions/roles were a source of problems in childhood, both in their school environments and families. Stories of bullying, insults, and even violence during childhood and adolescence abound in participants' life stories. Brenda (MTF, age 26) described that it was "normal" to her during childhood to play with dolls, until the day she was beaten by her dad and "began to be afraid."

For all participants, regardless of the degree of the problems they experienced in childhood, events related to body development were a challenge. The onset of puberty created or intensified the confusion about what was happening and the sense of gender incongruence. For most participants, body discomfort and gender incongruence, together with the difficulty of finding a satisfactory definition of their situation, were experienced in a dysphoric state of mind. Decreased mental health and significant psychosocial consequences were often reported, though in very different degrees. For some participants, body discomfort was particularly related to secondary sexual characteristics, such as breasts or facial hair, that explicitly announced them as female or male. However, body dysphoria could also be a serious issue. Paul (FTM, age 22) described the first experience of menstruating: "It was a very strange feeling, and so strong. That could not be happening! It was the realization that everything was wrong." Paul also mentioned that he cut himself in the face at age 16 as a consequence of his body discomfort.

For all participants, exposure to discrimination, both in school and in a family environment, intensified the sense of gender incongruence. Reproof, insults, and sometimes violence clarified that their difference was something unacceptable. Participants reported diverse consequences and coping strategies. Social isolation and difficulties in interpersonal relationships were common in participants' testimonies. Some spent much time at home, each experiencing his or her gender identity "alone, intimately, and not sharing it with anybody" in the words of Catherine (MTF, age 16). Some found partial relief by writing personal diaries, or by secretly performing

idealized gender expressions, namely through purging clothes. Stage 1 extended through adolescence or early adulthood, but rarely to later stages of life. During this phase, some participants had consultations with psychologists and other mental health practitioners (often under pressure from parents, or by referral from a teacher), but very rarely were gender identity or transsexuality issues addressed in therapy.

The vast majority of participants were physically and emotionally attracted to people whose gender is contrary to their self-identified gender. During stage 1, several participants thought of themselves and/or were perceived by others as gay or lesbian: in the absence of other plausible explanations, sexual orientation prevailed over gender identity. Some even came out as lesbian or gay to significant others; however, homosexuality failed to be a satisfactory explanation for their situation, and lesbian or gay was not a comfortable identity. In the words of Amanda (MTF, age 39), “I accepted myself as a homosexual at age 14, and I came out to my friends. I came out as homosexual at that time because, as I liked boys, I thought I was gay.”

Stage 2 - Finding an Explanation and a Label: Exploring Identity

Stage 2 is essentially about finding that there is something called transsexuality and the exploration of that possibility for the self. Transition triggers from stage 1 to stage 2 were usually linked to exposure to some kind of information related to transsexuality. That happened in diverse ways for different participants. Cleo (FTM, age 20) stated that he began to put aside the assumption of being lesbian and to consider the possibility of being transsexual after seeing a series of television reports on transsexuality and the Portuguese gender identity law. Irene (MTF, age 21) described the occasion – when she was 13 years old – in which the school psychologist showed her a book about transsexual people. She referred to that day as the “day I discovered, the day I found the concept and ultimately who I was”.

Seeking information and support was the main action/interaction strategy carried out by the participants in stage 2. Some plunged into internet searches, examining data on transgenderism, transsexuality, and gender identity, or exploring online narratives of other transgender people. Andrew (FTM, age 19) said that he read in an online forum “two life stories such as mine; could have been written by me.” Some contacted LGBT associations or support groups in order to gain information and to encounter people in similar situations. Psychologists and mental health practitioners were also sought out at this stage by some participants. Richard (FTM, age 32) related that when he was 19

years old (and exploring the hypothesis of being a lesbian woman) he called an HIV helpline, then was forwarded to a LGBT support line, which gave him the address of a LGBT community center. Once there, he finally met a transsexual woman and “identified with everything she said.”

For some participants, finding information on transsexuality and on the possibility of transitioning was an occasion of relief and mental health enhancement. They finally encountered a label for their experiences and realized that there were other people in similar situations. For those individuals, stage 2 was crossed very quickly in order to start the process that would allow them to be who they truly felt they were. On the contrary, for other participants the possibility of being transsexual appeared as something daunting. Some remained at this stage for longer periods of time, moving back and forth between engagement and avoidance of the possibility of being transsexual. This could last for days, months, or even years. During this phase, some deliberately tried to act and perform gender roles/expressions consistent with the sex assigned to them at birth. Meryl (MTF, age 51), who currently identifies as a lesbian woman, explained that she had considered being transsexual since she was a teenager, but, with no access to information, she “thought it was a crazy thing that would end.” She got married with a woman and had a child, and only embraced her gender identity five years ago. Information about gender identity is currently much more widespread than it was in the past, and it is much easier to reach other transsexual people (through the internet and LGBT associations or support groups, for instance). Accordingly, younger participants crossed stage 2 in a gentler and faster way than older ones.

Stage 3 - Deciding What to Do and When: Exploring Options

In stage 3 participants had already personally accepted their transsexual situation but were evaluating strategies to manage their gender identity. Transition triggers from stage 2 to stage 3 were usually life events that allowed or endorsed that acceptance: getting to know a transsexual person perceived as a positive role model; having a significant and supportive relationship in which gender identity could be jointly addressed; being in the context of a clinical relationship that promotes acceptance; having a formal clinical diagnosis; or experiencing a break event, such as leaving the family home or a divorce. Accepting transsexuality does not automatically mean having a transsexual identity: most participants stated that they recognized themselves as women or men throughout their trajectories. For the great majority, acceptance of being

transsexual meant accepting a particular experience, not necessarily developing a transsexual identity. Stage 3 is essentially about deciding what to do (and when to do it) within that self-recognition. Lois (MTF, age 25) recognized, at the time of the interview, being a transsexual person, but was still considering options and timing. She stated: “I already know what I am. But, nowadays, I prefer to protect myself.” During the interview she explained that she feared the impact that the transition would have on her mother: “It’s very difficult, especially for parents, and I don’t want my mother to watch such a process. I don’t want to.” She was considering the possibility of going abroad and transitioning in another country.

In stage 3 seeking information was still an important action strategy. However, this time the search was focused not on identity issues but on body modification possibilities, approaches for social transitioning, procuring doctors’ names and contacts, or researching treatment outcomes. An important feature of this phase was selective disclosure: most participants had already come out as transsexual to carefully chosen significant others. Nevertheless, chance or the suspicion of peers or family brought others out. Maria (MTF, age 19) described how her parents found some of her hidden female clothes and read her private diary. The reactions of others to the disclosure of transsexuality was a significant factor incorporated in reflections about what to do and when.

Several participants were aware that therapists and physicians could be an important resource in the process of deciding what to do, so, for some, this was the moment to pursue clinical help. At this stage, some participants had regular contact with other transsexual people. They could have had an internet friend, or have joined a support group or an LGBT association. In any case, interaction and discussions were mainly focused on options, medical treatments, and strategies for successful transitioning. As in stage 2, exposure to positively perceived role models may have been decisive to proceed to the next stages. For some participants, the passage through stage 3 resulted in the delineation of a detailed plan, such as postponing the social transition until a graduation, or matching the adoption of a new social identity with an expected job change.

Some participants went through this third phase very quickly, especially those who spent a longer period of time in the previous stage exploring identity. Others remained in stage 3 for a considerable period of time, again moving between engagement and avoidance, but this time with regard to the possibility of transitioning.

Oliver (FTM, age 22) was in the process of struggling with these issues at the time of the interview: “I have to make a choice between going through a process of transition, and deal with all the professional, social, and familial consequences, or trying to continue living as I have done so far.”

Stage 4 - Embracing Gender Identity: Performing a New Social Identity and Undergoing Body Modifications

The fourth stage of these gender trajectories was mainly about the so-called “transition.” For most participants, the notion of transitioning was not necessarily related to changes or modifications of the self. Instead, it had to do with embracing who they always felt themselves to be. What changed in this stage was the way in which participants presented themselves to others (and consequently the way in which they were perceived) and, for the majority, their bodies changed as well. Transition triggers from stage 3 to stage 4 were life events that allowed or endorsed transition, such as graduation, becoming financially independent, changing jobs or schools, or relocating to another city. Also, some participants described reaching a breaking point in which it was no longer possible to live as in the past.

For those who were not already seeing a therapist, this was the ultimate moment to seek clinical help. However, to find a clinician knowledgeable in gender issues was not necessarily an easy task. Some participants made use of contacts provided by other transsexual individuals, while others resorted to their general practitioner. Andrew (FTM, age 19) went to a hospital emergency room. For some participants, encountering a clinician who was unskilled or unsupportive of their gender identity may have resulted in a halting of progress within the stage and, in some cases, in retrogression. Irene (MTF, age 21) was seen by a psychiatrist who told her that she was not transsexual and that the school psychologist who referred her was “foolish.” For most participants, dealing with less competent clinical practices and undue gatekeeping was a huge barrier in this stage. Some stated that their clinical processes (which included the psychosocial assessment) were accurate and expeditious, but others described long periods of constant assessment that lasted, in some cases, for several years. This undue clinical assessment often had a negative impact on well-being and mental health. The strategy was, for some participants, to express a personal narrative consistent with what they believed the clinicians’ expectations to be.

Some participants reached this phase having already done some body modifications on their own. Vera (MTF, age 33) was taking non prescribed hormones. Lois (MTF, age 25) used laser treatment to remove facial hair when she was still in stage 3. Body interventions that have a significant impact on appearance (and promote the ability to pass successfully as a man or woman) were generally the most desired ones. Hormonal treatment, both in MTF and FTM participants, and mastectomies in FTM individuals, generally resulted in improved mental health. On the other hand, dashed expectations regarding the treatment outcomes, coupled with comparisons with the achievements of others, had a negative impact on psychological well-being.

Stage 4 required a general disclosure. Those who had not yet come out as transsexuals to significant others had to do it in this phase. That represented, for some, a very painful and difficult task, postponed until the last moment. Vera (MTF, age 33) told her mother that she would have genital surgery two days before the intervention. Adapting a new social identity implied being out in all contexts, and often embracing strategies oriented to manage an ambiguous appearance. To be perceived as something in between, neither a man nor a woman, was very threatening to all. Several participants (who were already living full time according to their gender identities, independent of the treatments they had received) changed their names and legal sex in this stage. John (FTM, age 22) was in the early phases of hormonal treatment but already living socially as a man when he managed to change his documentation. He expressed his joy: “I was super happy. Oh my God, I had no words.”

Stage 5 - Identity Consolidation and Invisibility

The boundary between stage 4 and stage 5 is difficult to assign. For some, living full time as a man or a woman (and being constantly perceived as that) marked the entrance into the last stage, despite the fact that they were still doing some body modifications. David (FTM, age 31) was already living full time as a man for several years, and was married and had a child at the moment of the interview, but was still considering adjustments in relation to body interventions. For others, genital surgery was essential to put an end to their gender trajectories. Although most participants desired to have, or had already had, genital surgery, their gender identities were not dependent on that decision. Meryl (MTF, age 51) decided not to have genital surgery. She explained that if gender is something defined by one’s identity, she is “a woman, and had always been a woman.” In stage 5 some participants who had already

transitioned in the past had to face gatekeeping again, in order to undergo the clinical diagnosis required to change their sex legally under the new law.

When asked how they identified themselves, the vast majority of participants answered “woman” or “man.” Transsexuality was rarely addressed as an identity, but as a condition. In the words of Paul (FTM, age 22): “I’m a man. I never say I’m transsexual. Well, only sometimes, to explain to people. But I recognize myself as a man.” Most participants struggled to pass successfully as a man or woman through their trajectories, and for several the invisibility of their transsexual experience was an achievement in stage 5. Despite the fact that few participants were out about their past (especially those who were activists for equality and civil rights), selective disclosure was again a strategy in the last phase: history of transsexuality was only revealed to a carefully chosen few.

5. Discussion

The primary goal of this study was to explore how transsexual people recognize, acknowledge, and come to terms with their gender identities. We interviewed 22 self-identified transsexual people, and reached a theoretical model through GT procedures. The model that emerged shows the participants moving through 5 developmental stages, and implementing action/interaction strategies and coping with a sequence of conditions and consequences at each stage. We also identified a series of transition triggers: that is, particular events that facilitated movement from one stage to the next. No discernable differences were found between FTM and MFT participants in relation to the 5 stages, and the respective action/interaction strategies, conditions, consequences and transition triggers. This model is not intended to be strict and prescriptive. As Cass (1998) outlined, identity development models of sexual and gender minorities are a western phenomenon. Clinicians must recall that “all human identities are impacted by the construction of particular cultural and social perspectives” (Lev, 2004, p.231). There are particular experiences that are unique to each individual, and any theoretical model would hardly capture in detail the complexity of human experience. Nevertheless, in GT the emerging theory becomes somehow predictive or transferable in the sense that if similar conditions occur it is possible that similar consequences arise (Strauss & Corbin,

1990). Thus, results of this study may inform practitioners and compel more competent and effective practices in the treatment of this population.

While most previously published models (Devor, 2004; Gagné et al., 1997; Lev, 2004) addressed the experiences of various people who fall into the transgender spectrum, our study focused on the specific experiences of transsexual men and women. Nevertheless, our results show important and various commonalities with previous studies, such as: the participants' vulnerability to psychological distress increases and mental health declines, especially in the early stages of their paths (Devor, 2004; Gagné et al., 1997; Lev, 2004; Pollock & Eyre, 2012); the exposure to accurate information on transsexuality is of vital importance (Devor, 2004; Lev, 2004), and so, too, are social support, namely the access to transsexuals' support groups and networks (Budge et al., 2013; Lev, 2004, 2007), and family support (Bethea & McCollum, 2013; Lev, 2004); and finally, physical and/or social transition has a crucial impact in the participants' lives (Devor, 2004; Gagné et al., 1997; Lev, 2004; Pollock & Eyre, 2012). In a manner similar to previous models, our results outline a general trajectory organized in developmental stages of people moving from an experience of distress and confusion to a state of (gender) congruence and identity consolidation. However, by stating a series of conditions, action/interaction strategies, and psychosocial consequences, and specifying transition triggers that are unique to each stage, our results may advance a more comprehensive overview of the experiences of transsexual people.

6. Implications and Applications

Our first and overall recommendation regards the need for accurate training in transgender and transsexual matters for clinical psychologists and mental health professionals. Results show that participants, and also their families, had consultations with psychologists and other mental health practitioners throughout their gender trajectories. However, those clinical encounters were, very often, missed opportunities both for clients and clinicians. Frequently, gender identity and transsexuality issues did not emerge in therapy or, when addressed, less competent practices were undertaken. The need for training mental health practitioners in the unique experiences of transgender and transsexual individuals is well documented by several authors (Bess & Stabb, 2009; Carrol & Gilroy, 2002; Hendricks & Testa, 2012; Israel et al., 2008).

We suggest that therapists explore a particular concept within the proposed model: the transition triggers. If adapted to the unique experiences of each individual, these particular events that facilitate movement from one stage to another may be addressed in therapy in order to promote progression. For instance, if a client is presumably in the first stage of confusion and increasing sense of gender difference, therapists should consider the client's exposure to information on transsexuality. In the next stage, related to identity exploration, therapists may consider assisting clients in finding positive role models, or in deepening significant relationships that can evolve into contexts of acceptance. If a transsexual client is already exploring options regarding social and physical transition, break events in life (such as graduation, changing jobs, or even a relationship breakdown) may be addressed in therapy as opportunities for progression in his/her gender trajectory. In the final stages, in which clients are embracing their gender identities, options regarding body modifications and, for instance, legal sex change (if that is a possibility) may be brought into therapy.

Therefore, the knowledge on the transition triggers can help therapists when working with transsexual clients. However, our results also show that each process is unique, even with the communalities identified within the participants' trajectories. Thus, and despite the fact that more advanced stages are associated to stronger psychological, physical and social wellbeing, we recommend that therapists use the transition triggers (the ones identified in this research, and others that can emerge in each individual case) with caution and respect to the unique pace of each client.

As a whole, our results strongly endorse the need for psychologists' advocacy for transsexual clients. More generally, fighting discrimination and stigma in family, school, and work environments, and spreading accurate information through mass media, may be a central role when working with the transsexual population. As Carrol and Gilroy (2002) have pointed out, therapists must "move beyond the goal of transforming the lives of transgendered clients to transforming the cultural context in which they live" (p. 240). Finally, results also align with previous findings (e.g., Bockting et al., 2004) related to how the therapist as gatekeeper may be, in fact, a significant barrier in the access to medical treatments. Some participants described several years of constant assessment and also difficulties in obtaining therapists' endorsement for legal recognition. Based on the study's results, we strongly recommend that therapists exercise the gatekeeper role with responsibility and respect for the transsexual person's autonomy.

7. Limitations

Although we interviewed a diverse sample of transsexual individuals, this sample may not be representative of all transsexual people, even within the Portuguese context. Transsexual people may be a population difficult to reach. The non-random bias of our recruitment strategy may have resulted in a sample of individuals who had generally positive attitudes toward academic research on transgender matters and, therefore, were more willing to participate. Furthermore, and despite the fact that peer consultation was done at different moments during the data analysis, it is important to consider that the main researcher and interviewer was a cissexual man. Even though there are no specific remarks to report, these interviewer statuses may have somehow conditioned the process of data collection.

8. References

- American Psychological Association. (2009). *Report of the task force on gender identity and gender variance*. Retrieved from <http://www.apa.org/pi/lgbt/resources/policy/gender-identity-report.pdf>
- American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct*. Retrieved from <http://apa.org/ethics/code/index.aspx>
- Bess, J. A., & Stabb, S. D. (2009). The experiences of transgendered persons in psychotherapy: Voices and recommendations. *Journal of Mental Health Counseling, 31*(3), 265-282.
- Bethea, M. S., & McCollum, E. E. (2013). The disclosure experiences of male-to-female transgender individuals: A systems theory perspective. *Journal of Couple & Relationship Therapy, 12*, 89-112.
- Bockting, W., Robinson, B., Benner, A., & Scheltema, K. (2004). Patient satisfaction with transgender health services. *Journal of Sex & Marital Therapy, 30*, 277-294.
- Budge, S. L., Adelson, J. L., & Howard, K. A. (2013). Anxiety and depression in transgender individuals: The roles of transition status, loss, social support, and coping. *Journal of Consulting and Clinical Psychology, 81*(3), 545-57. doi:10.1037/a0031774
- Budge, S. L., Tebbe, E. N., & Howard, K. A. (2010). The work experiences of transgender individuals: Negotiating the transition and career decision-making processes. *Journal of Counseling Psychology, 57*(4), 377-393.
- Carrol, L., & Gilroy, P. J. (2002). Transgender issues in counselor preparation. *Counselor Education & Supervision, 41*, 233-242.
- Cass, V. C. (1998). Sexual orientation identity formation: A western phenomenon. In R. J. Cabaj and T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 227-251). Washington, DC: American Psychiatric Press.
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., ... Adler, R. K. (2011). Standards of care for the health of transsexual, transgender,

and gender nonconforming people, 7th version. *International Journal of Transgenderism*, 13, 165–232.

Corbin, J., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, 13, 3-21.

Devor, A. H. (2004). Witnessing and mirroring: A fourteen stage model of transsexual identity formation. *Journal of Gay and Lesbian Psychotherapy*, 8(1/2), 41-67.

European Commission. (2012). *Trans and intersex people. Discrimination on the grounds of sex, gender identity and gender expression*. Retrieved from http://ec.europa.eu/justice/discrimination/files/trans_and_intersex_people_web3_en.pdf

Gagné, P., Tewksbury, R., & McGaughey, D. (1997). Coming out and crossing over: Identity formation and proclamation in a transgender community. *Gender and Society*, 11(4), 478-508.

Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice*, 43(5), 460-467.

Israel, T., Gorcheva, R., Walther, W. A., Sulzner, J. M., & Cohen, J. (2008). Therapists' helpful and unhelpful situations with LGBT clients: An exploratory study. *Professional Psychology: Research and Practice*, 39(3), 361-368. doi:10.1037/0735-7028.39.3.361

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. New York: Haworth Clinical Practice Press.

Lev, A. I. (2007). Transgender communities: Developing identity through connection. In K. Bieschke, R. Perez, & K. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (2nd ed., pp. 147-175). Washington, DC: American Psychological Association

- Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2001). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality*, 42(1), 89-101.
- Maguen, S., & Shipherd, J. (2010). Suicide risk among transgender individuals. *Psychology & Sexuality*, 1(1), 34-43.
- Mizock, L., & Fleming, M. Z. (2011). Transgender and gender variant populations with mental illness: Implications for clinical care. *Professional Psychology: Research and Practice*, 42(2), 208-213. doi:10.1037/a0022522
- Newfield, E., Hart, S., Dibble, S., & Kohler, L. (2006). Female-to-male transgender quality of life. *Quality of Life Research*, 15, 1447-1457.
- Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., & Becker J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research*, 47(1), 12-23.
- Ordem dos Psicólogos Portugueses. (2011). Código deontológico. Regulamento n.º 258/2011. *Diário da República*, 258, 17931-17936.
- Pinto, N., & Moleiro, C. (2013). *Social representations on transsexuality and gender: The public discussion towards an innovative gender identity law*. Communication presented at the 1st International Conference on LGBT Psychology and related fields, Lisbon, Portugal.
- Platero, R. (2011). The narratives of transgender rights mobilization in Spain. *Sexualities*, 14(5), 597-614.
- Pollock, L., & Eyre, S. L. (2012). Growth into manhood: Identity development among female-to-male transgender youth. *Culture, Health & Sexuality*, 14(2), 209-222.
- Raj, R. (2002). Towards a transpositive therapeutic model: Developing clinical sensitivity and cultural competence in the effective support of transsexual and transgendered clients. *The International Journal of Transgenderism*, 6(2). Retrieved from http://www.symposion.com/ijt/ijtvo06no02_04.htm

Serano, J. (2007). *Whipping girl. A transsexual woman on sexism and the scapegoating of femininity*. Berkeley, CA: Seal Press.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage.

