Self-made women: The (re) construction of self following male to female gender reassignment surgery

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Declaration of Originality

I hereby declare that this thesis is an original piece of work, created solely by the author.

The contents of this thesis have not been submitted for any award other than the Doctorate in Clinical Psychology.

Katie Bohane, April 2010.

Title: Self-made women: The (re) construction of self following male to female gender reassignment surgery

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Abstract

Aims and Method: Surgical intervention as a treatment for Gender Identity Disorder is a procedure increasingly well examined from a medical perspective, yet relatively poorly in terms of psychological outcomes. Further to a systematic review of the literature evidencing post-operative outcomes from a psychological perspective, a qualitative study was designed with a view to exploring this comparatively rare and under-examined phenomenon. Interpretative Phenomenological Analysis was selected as the method of data analysis, for the purpose of capturing the relative novelty of the subject matter and due to its emphasis on process and meaning. Eight participants who had completed male to female surgery were recruited and interviewed by the researcher.

Results: Emergent themes in the interview data were clustered into five super-ordinate themes, where participants had communicated the following issues of significance to them: the importance of contextualising surgery; the social dimension of the procedure; the need to distinguish between gender and sex; the notion of having made a difficult but necessary choice; and the sense of living between genders post-operatively.

Conclusions: The findings of the current study suggest that from a psychological perspective, surgical gender reassignment has complex implications for both the patient and those around them, such that it is perceived as both life-changing yet ultimately limited as an intervention. Further research is needed to build on these findings, for example through examining the experiences of partners and family members whose are themselves integral to the experience of constructing gender in this way.

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Word Count

	Excluding References	Including References
Thesis Abstract	245	245
Literature Review	5,448	6,330
Research Report	11,440	12,186
Critical Appraisal	2,334	2,334
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CONTENTS

Thesis Abstract 3

Acknowledgements 4

Word Count 5

List of Tables 8

List of Figures 9

Part One: Literature Review **10**

Abstract 11

1. *Introduction*
   - 1.1 Background 12
   - 1.2 Defining GID: current issues and controversies 13
   - 1.3 Contested discourses: A note on the language of problems of gender 15
   - 1.4 Issues of treatment: A surgical solution? 16
   - 1.5 Criticisms of surgical interventions for GID and alternative approaches to treatment 17
   - 1.6 Examining the evidence 19
   - 1.7 Previous reviews 19
   - 1.8 Aims of the current review 22
2. *Method*
   - 2.1 Search strategy and terms 22
   - 2.2 Inclusion/exclusion 24
3. *Results*
   - 3.1 Participant characteristics 25
   - 3.2 Methodological features 26
   - 3.3 Summary of findings 28
4. *Discussion and conclusions* 31

Part Two: Research Report **39**

1. *Introduction*
   - 1.1 Surgery for gender identity disorder 40
   - 1.2 GID in context: a continuum of cross-gender experiences 41
   - 1.3 Surgical pathways 41
   - 1.4 Creating gender: Surgical limitations 42
   - 1.5 The evidence: Bodies versus minds 42
   - 1.6 Psychological outcomes 43
   - 1.7 The current study: Exploring life after surgery 43

2. *Method*
2.1 Background to the Author's Research Interests 44
2.2 Overall design of the study 44
2.3 Ethical approval 45
2.4 Epistemology and choice of method 45
2.5 Procedure 47
2.6 The sample 49
2.7 Data analysis 51
3. *Results and Analysis*
3.1 Overview of main themes and sub-ordinate themes 54
3.2 Exploration and evidencing of themes 56
4. *Discussion*
4.1 The results in relation to literature and theory 79
4.2 Methodological issues 82
4.3 Clinical Implications 84
4.4 Conclusions 86

Part Three: Critical Appraisal 93

1. Choosing the project 94
2. Hopes and fears 94
3. Lessons in patience and pragmatism 95
4. Collaboration with services 96
5. Interviewing: restraint of the inner clinician 96
6. Tentative interpretations 97
7. Writing up: continuing the interpretative process 98
8. Balancing the professional and the personal 98
9. On learning from participants 99
10. Endings 101

Appendices

Appendix A: Summary of studies included in the literature review 103

Appendix B: Guidelines to authors for journal targeted for literature review 107

Appendix C: Participant information sheet 108

Appendix D: Interview schedule 113

Appendix E: Ethics correspondence 115

Appendix F: Overview of the research process 122

Appendix G: Example of a coded transcript (extract) 123

Addenda Addendum: A separately bound volume of interview transcripts

List of Tables

PART ONE:

Table 1: Search terms used for systematic review of literature

PART TWO:

Table 1: Participant demographic information

List of Figures

PART TWO:

Figure 1: Representation of super- and sub-ordinate themes

PART ONE:

Literature Review

Self-made women: The (re) construction of self following male to female gender reassignment surgery

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Literature Review

ABSTRACT

Purpose: To provide a distillation of research into surgical gender reassignment as a treatment for Gender Identity Disorder (GID), with specific reference to recent studies evidencing outcome from a psychological perspective.

Method: A systematic search of electronic databases was conducted, followed by a hand search through studies by Abstract. Studies with a primarily medical/surgical focus were discarded, as were those of a discursive nature. Qualitative methodologies precluded inclusion in the current review, for the purpose of meaningful synthesis.

Results: After elimination of inappropriate, irrelevant and inaccessible papers, a pool of ten studies remained for inclusion in the review. Methodological features of these studies were explored, including the apparent shift from using 'objective' to 'subjective' criteria as measures of post-operative outcome.

Modest findings across studies were examined, such as statistically non-significant trends for improvements in family and social relationships after surgery. Potential problems were highlighted, for example, the possibility of distress relating to sexual functioning after the intervention, and a negative impact on partnered relationships.

Limitations across studies were evidenced, including small sample sizes, low response rates, poorly matched controls, and the potential bias of clinicians doubling as researchers using their own patients as participants.

Conclusions: The findings of the current review underlined a continuing need for empirically robust investigation into surgical gender reassignment as a treatment for GID, especially from a psychological perspective. The use of qualitative methodologies was suggested as one way in which existing knowledge in the field might be advanced, such that specific hypotheses might be generated as the basis for future quantitative enquiry.

Key words: Gender Identity Disorder (GID), surgical gender reassignment

Target journal: Sexual and Relationship Therapy: International Perspectives on Theory, Research and Practice.

Psychological Perspectives on Gender, Gender Identity Disorder and Surgical Gender Reassignment.

1. INTRODUCTION

1.1 Background

Gender identity has been described as such a powerful and defining part of an individual's self-concept, that for most adults it is virtually impossible to change (Lips, 2008). Furthermore, the male-female distinction to which it conventionally refers is argued to permeate human experience, shaping our interactions and the social structures organizing our lives (Ridgeway, 2009). Yet increasingly there is recognition that such a distinction may not fully capture the range of ways in which gender identity is experienced, as Butler (2007) suggests:

> 'gender is not a fact, the various acts of gender create the idea of gender.... (it is) an identity tenuously constituted in time' (p.190-191).

For some this might be reflected in a rejection of conventional notions of masculinity or femininity, or through sexual expression which does not conform to heterosexual norms. Yet despite an increasing awareness of such diversity, theorists such as Butler argue that stigma persists for those who 'fail to do their gender right' (Butler, 2007. p.190).

There is evidence to suggest that the subjective perception of failing to conform to a conventional gender identity can have a significant impact on psychological wellbeing. For example, studies have indicated a significant relationship between gender role nonconformity in childhood and increased risk of suicide in lesbian, gay

and bisexual populations (Ploderl & Fartacek, 2009). Similar results have been found in heterosexual populations, such as a reported link between gender nonconformity and elevated levels of anxiety, particularly in men (Lippa, 2008).

For some people distress is located in a perceived incongruence between gender identity and the experience of being bodily male or female, conceived in psychiatric nosology as gender dysphoria, or Gender Identity Disorder (GID) where dysphoric feelings are persistent and pervasive. Often this is associated with the desire to physically alter the body to match the lived experience of gender identity. Surgical intervention for this purpose has been available in the NHS for over seventy years, yet remains controversial. As Manners (2009) points out, GID is the only psychiatric diagnosis where surgery is commonly advocated as the treatment of choice, highlighting parallels drawn by lobbyists with the inclusion of homosexuality as a psychiatric disorder until 1974. Others such as Meyerowitz (2006) indicate that surgery has been conceptualised as an 'active form of self-expression' (Meyerowitz, p.367), drawing from humanist psychology and notions of self-actualisation.

1.2 Defining GID: current issues and controversies

GID as it is currently conceptualised entered the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1994, replacing the diagnostic category of Transsexualism which was first introduced in 1980. It is described as a relatively rare disorder; prevalence is indicated as 1 in every 12,900 males and 1 in 33,800 females (Lawrence, 2008), although these figures capture only those presenting for treatment and are likely to be under-representative of prevalence as whole. According to current DSM criteria, a diagnosis of GID requires persistent cross-gender identification, and

discomfort with one's sex as anatomically defined. Diagnosis also specifies that there must be evidence of significant distress or impairment of social functioning for the affected individual. Physical abnormalities or atypical features as in intersex conditions would exclude the possibility of a diagnosis (APA, 1994). Experiences of GID across the lifespan are differentiated, such that GID in Children (GIDC) is labelled as a separate diagnosis. The key difference between diagnoses appears to be one of prognosis, in that clinical features observed in children are said to commonly diminish by puberty, often reconciled by choice of sexual identity (Bartlett et al, 2000).

The validity of GID and its diagnostic criteria are fervently contested in the scientific literature. For example, Bower (2009) questions the ecological validity of the criterion relating to distress and impairment of social functioning, suggesting that many of those who fit the profile from an intrapsychic perspective are still able to 'live reasonably well-adjusted existences in society' (Bower, p.2). The distinction between GID and its counterpart in children is also challenged. Asserting that cross gender identification 'almost invariably starts prior to puberty' (Bower, p.2), Bower questions whether difficulties that arise later in life are genuinely reflective of the psychopathology to which GID is intended to refer.

Others advocate more radical diagnostic reform, involving deconstruction of the notion of a disordered gender identity. From this perspective, diagnostic criteria such as impairment of social functioning might be conceptualised differently, perhaps as reflective of the inflexibility of social norms rather than problems located within the individual per se. Thus changes have been suggested such as Kelley's (2005) notion of GID reconceptualised as 'gender dissonance', emphasizing chronic distress rather than social nonconformity as a key criterion. Yet such changes would likely still not go far

enough for some, in their continued deference to the notion of difficulties as a disorder characterised by distinct psychopathological features. At the same time is suggested that there is at least a practical function to the inclusion of problems of gender identity in psychiatric nosology, and that without it there would be risks in treatment being sought and obtained without psychiatric scrutiny (Levine & Soloman, 2009).

1.3 Contested discourses: A note on the language of problems of gender.

Emerging concepts such as 'gender dissonance' are characteristic of the diversity of terms used to describe problems of gender identity in the literature. Just as the replacement of 'Transsexualism' with 'Gender Identity Disorder' in psychiatric terminology could be argued to have been influenced by a shift in socio-political discourses on gender, the language used by those affected by the issue is dynamic and evolving. Thus what psychiatry refers to as GID might alternatively be referred to as 'gender-variance' or increasingly, 'transgenderism' (see Ekins & King, 2006). Lev (2007) describes how the latter was first used as a term as early as the 1960s, referring to men who chose cross-dressing as a lifestyle without the desire to anatomically change sex, subsequently evolving as an umbrella term which seeks to foster a sense of social identity for those who do not conform to gender norms. Lev goes on to suggest that the term has gained status as:

> 'a self-descriptor of a radical, proud, activist transgender community that currently demands social justice and the right to self-definition and actualisation' (Lev, 2007. p. 152).

1.4 Issues of treatment: a surgical solution?

Considering the debate around definitions of GID and evolving discourses on gender identity, it is unsurprising that approaches to treatment are equally controversial. Currently the criteria for treatment used by UK gender identity clinics are informed by guidelines produced by The Harry Benjamin International Gender Dysphoria Association's (HBIGDA) Standards of Care (HBIGDA, 2001). These are described as 'flexible directions' for the treatment of GID, although recommendations are more prescriptive on certain issues, such as treatment of GID occurring in children as opposed to difficulties which emerge later in the lifespan. For the former group, a range of psychosocial and in some cases reversible physical interventions are recommended, with the specification that irreversible surgical interventions should not be carried out (HBIGDA, 2001). On the other hand, guidelines for adults with GID specify that psychological intervention 'is not an absolute requirement' and that 'many adults with Gender Identity Disorder find comfortable, effective ways of living' without it (HBIGDA, 2001. p.11). Thus such psychological intervention is indicated to be at the discretion of psychiatric professionals, for example if it is felt that the individual requires intervention to cope with the stress of transition. In contrast, medical interventions including hormone therapy are considered an integral component of treatment for GID, together with an extended period of 'real life experience', usually one to two years, in the desired gender role. Ultimately in many cases, surgery is indicated as the treatment of choice to achieve physical sex reassignment, which is conceptualised as: 'not experimental, investigational, elective, cosmetic, or optional in any meaningful sense. It constitutes very effective and appropriate treatment' (HBIGDA, 2001. p. 18).

Furthermore, HBIGDA guidelines go on to suggest that:

> 'in order to understand how surgery can alleviate the psychological discomfort of patients diagnosed with Gender Identity Disorders, professionals need to listen to these patients discuss their life histories and dilemmas' (HBIGDA, 2001. p.19).

Certainly the NHS has embraced surgical interventions for GID, with most recent estimates indicating that over one hundred surgeries occur each year (HES, 2006) at significant financial cost, with further procedures occurring in the private sector. Post-operatively, patients are required to attend for long-term follow-up with their surgeon and an endocrinologist to monitor the physical outcomes of surgery. Psychological follow-up is not considered mandatory, although guidelines indicate its usefulness in some cases to support adjustment in the post-transition period (Jain & Bradbeer, 2007).

1.5 Criticisms of surgical interventions for GID and alternative approaches to treatment

Just as there are those who criticise diagnostic labelling of problems of gender identity, there is fervent debate as to the function and appropriateness of their amelioration through surgical intervention. Although much of this protestation is located in sociological and political debate, there are perspectives within the psychological literature which argue for alternative methods of treatment based on individual formulation. Historically this has tended to come from the psychoanalytic literature which is critical of reductionist conceptualisations of gender and the body,

asking the question, ‘how can surgical intervention into biological material alter the accretion of socio-cultural matter, the experiences that make up our lives as men and women?’ (Prosser, 1998. p. 63).

More recently other psychological models have addressed the issue, including person-centred approaches which argue that there is a loss of personhood in viewing and addressing problems of gender identity through a medical lens (Livingstone, 2008). From this perspective, preferred treatment emphasizes the importance of ‘proactive affirmation’, acknowledging that clients are likely to have encountered significant social stigma and perhaps isolation as a result of their experiences (Livingstone, 2008). Although this approach is not necessarily diametrically opposed to the role of surgery in the alleviation of distress, there is certainly an emphasis on the possibility of enabling individuals to ‘comfortably transcend the binary framework’ (Livingstone, 2008, p. 141), without the need for physical interventions.

At the same time, single case accounts from those who have themselves experienced problems of gender identity caution against vilification of the medical model, warning of false hope in the utility of talking therapies as a resolution for this type of difficulty. Based on a personal reflection of engaging in psychoanalytic treatment for gender dysphoria, an anonymous male- to -female psychiatrist (2004) recalls a sense of ‘futility and hopelessness’ (2004, p.22) in her experiences of psychological treatment, and feelings of having disappointed both herself and her therapist in failing to reconcile her gender identity through talking treatment. In her own words, she suggests that a more helpful approach would have been support in helping her to, ‘come to the recognition that my efforts to overcome my ‘difference’ through the

psychoanalytic process were futile' (2004, p.23). Although such cases are undoubtedly complex and not in themselves evidence of the usefulness of a particular type of intervention over any other, they are certainly useful in highlighting the importance of listening to the views of those affected by the problem and their opinions on preferred treatment.

1.6 Examining the evidence

Clearly there is a case for examining the evidence on what works for individuals affected by problems of gender identity, not least because of the potentially profound impact of such difficulties on mental health and wellbeing. For example, studies have highlighted the 'crippling effects of guilt' frequently experienced by those affected (Schaefer & Wheeler, 2004), fears about discrimination and isolation and their relationship to symptoms of psychological distress (Sanchez & Vilain, 2009), substance misuse (Lombardi, 2001), and elevated levels of attempted suicide which some studies have estimated as high as twenty per cent or more of those with problems of gender identity (Gainor, 2000).

1.7 Previous Reviews

Attempts to review the evidence for surgical interventions for GID began to emerge several decades after procedures were first used therapeutically. Abramowitz (1986) highlighted the 'still primitive methodological state' of literature in the area (Abramowitz, 1986. p. 183), referring to difficulties specific to the client group relating to the infeasibility of random assignment, waiting-list controls or psychotherapy

comparison cases. Furthermore, serious omissions in the existing research were indicated, including absence of inclusion/exclusion criteria, drop-out rates and, alarmingly, instances where data had not been included for subjects who had committed suicide because they were unavailable for follow-up (Abramowitz, p.184). Given this chaotic approach, Abramowitz was able to refer only tentatively to trends in the research, which were characterised by mixed results. On the one hand, reference was made to defining studies such as Meyer and Reter's (1979) paper later to be referred to as the Hopkins Report, which anecdotally was said to have precipitated the closing of the Hopkins Gender Identity Clinic from which outcome data had been sourced. The findings of the Hopkins Report indicated that sex reassignment surgery did not appear to result in significant psychosocial improvement for those affected, and indeed appeared to have impacted negatively in a number of cases (Abramowitz, 1986). On the other hand, Abramowitz referred to a substantive finding of an improvement rate of approximately two-thirds evident in the existing research, which included improvements in sexual health, relationship satisfaction and reduced psychiatric symptomatology.

A review by Pfafflin (1992) referred to thirty years of follow-up literature together with a sample of patients from the author's clinic, with a focus on whether patients regretted their surgery as one of the most poignant outcome criteria. It was indicated that less than one per cent of female-to-male individuals regretted the intervention, with the figure rising to around 1-1.5% for male-to-female patients (Pfafflin, 1992, p.73). Three main factors associated with regret were suggested based on the data: psychological difficulties additional to problems of gender identity; absence of sufficient real life experience in the desired gender role prior to surgery; and

physical difficulties related to surgical outcome. Based on these findings, Pfafflin's (1992) review indicated the importance of adherence to HBIGDA's Standards of Care in treating GID, which it was intimated were not universally respected by professionals working in the field. Unfortunately the review failed to interpret why this might be the case, or to question the evidence on which HBIGDA's guidelines are based. Furthermore, the opportunity was arguably missed to examine the specific nature of regrets, their potential impact on psychological wellbeing, and indeed the psychological complexities of regretting a procedure which presumably was desired and anticipated for so long.

In a further review, Cohen-Kettenis and Gooren (1999) reiterated previously cited criticisms of the existing literature, including difficulties of small sample size, the potential for samples overlapping between studies to distort results, and overreliance on 'objective criteria' as an outcome measure as opposed to patients' subjective reports of the effectiveness of surgery in treating their difficulties (Cohen-Kettenis & Gooren, p. 327). Acknowledging these flaws, they tentatively referred to trends in the literature on factors associated with 'poor postoperative functioning', although this concept was not explicitly defined. Factors identified included: surgery being sought later in life; 'a non-cooperative attitude towards clinicians'; 'inadequate social functioning'; and 'suicidality' (Cohen-Kettenis & Gooren, p.327). Unfortunately the review did not appear to examine the possibility that surgical interventions might have triggered such difficulties, instead conceptualising them as pre-existing factors contraindicating the role of surgery. Nonetheless their conclusions included the assertion that surgical interventions were not evidenced as a panacea for GID, but that they had the potential

to ‘substantially alleviate the suffering’ of those affected (Cohen-Kettenis & Gooren, p.315).

1.8 Aims of the current review

Whilst surgical interventions are a frequently used treatment for GID in adulthood as recommended by HBIGDA’s standards of care, it is evident that such treatment is highly controversial and contested in the literature, with previous reviews highlighting a number of ways in which the existing evidence of effectiveness is limited. The aim of the present review was to systematically appraise the literature examining the effectiveness of surgical interventions for GID conducted subsequent to previous reviews, focusing on evidence of effectiveness from a psychological perspective.

2 Method

2.1 Search Strategy and Terms

Through consultation with clinicians and reading key textbooks in the area of gender and sexual health, a list of search terms (see Table 1) was generated and used to perform an initial search of EBSCO (Psych Info & PsyArticles), Scopus and Web of Science. Links to related articles generated by this search were also followed. Finally, articles were cross-referenced to identify names of key authors which were then used as search terms. Due to limitations on time and resources, the search was restricted to papers published in the English language. Papers predating the most recent review

(Cohen-Kettenis & Gooren, 1999) were excluded both to avoid repetition, and in acknowledgment of the cited litany of flaws in the literature evident prior to this time.

Table 1: Search terms used for systematic review of literature

Search Terms	**Databases**	**Years**
Gender Identity Disorder **OR** GID **&** Sex reassignment surgery **OR** SRS	EBSCO (PsychInfo and PsyArticles) , Scopus and Web of Science	1999-present
Gender Identity Disorder **OR** GID **&** surgery **OR** surgical treatment	EBSCO (PsychInfo and PsyArticles) , Scopus and Web of Science	1999-present
Gender Identity Disorder, surgery **&** psychological functioning **OR** psychosocial functioning	EBSCO (PsychInfo and PsyArticles), Scopus and Web of Science	1999-present
Gender Identity Disorder, surgery **&** mental health **OR** wellbeing	EBSCO (PsychInfo and PsyArticles), Scopus and Web of Science	1999-present

Gender Identity Disorder, surgery **&** psychological functioning, psychosocial functioning	Google Scholar	N/A
Gender Identity Disorder, surgery **&** mental health, wellbeing	Google Scholar	N/A

2.2 Inclusion/Exclusion Criteria

Studies examining psychosocial outcomes following surgical sex reassignment for adults of both sexes diagnosed with GID were included. Outcomes covering the broad range of psychosocial experiences were included, covering mental health, wellbeing, sexual health and subjective satisfaction with the experience of having chosen to pursue surgery. It was anticipated that as randomised controlled trials tend to be clinically impractical and indeed unethical for the target group, most studies would employ a repeated measures or retrospective design.

Exclusion criteria employed in the current review were any studies involving children (age 16 and under), consistent with psychiatric distinctions between GID and GID occurring in childhood. Studies involving individuals with specific medical difficulties related to their anatomical sex, for example intersex conditions, were also excluded to avoid confounding variables. Purely discursive accounts were excluded, as were studies with a primarily medical or surgical focus. Due to practical constraints

and for the purpose of clarity, a small number of single case reports and studies using qualitative methodology were also excluded from the review.

3 Results

An initial search yielded in excess of five hundred papers which were sifted via Abstract for their relevance, to eliminate inappropriate studies and repetitions. Over three quarters of these (n= approx 400) were discarded because of a focus on surgical outcomes per se, rather than the effectiveness of surgery for the treatment of the psychosocial difficulties in GID. Further papers (n= 86) were designed to inform fellow clinicians of best practice for the treatment of gender difficulties, often based on received wisdoms from work in the field rather than up to date empirical findings. Similarly there were numerous papers (n= 31) discursively examining surgery in the treatment of GID as a new practice in many countries, with little empirical research emanating from countries other than the UK or a handful of clinics abroad, notably the Netherlands. After elimination of such papers, a pool of twelve studies remained, of which ten (two studies were pending publication and unavailable at the time) were accessible for inclusion in the review. A summary of the main features of these ten studies has been included as an Appendix (see Appendix A).

3.1 Participant Characteristics

Most studies combined results for male- to- female and female- to- male patients, although some focused exclusively on male-to-female surgery (e.g. Udeze et al, 2008; Weyers et al, 2008). The combined design invites the possibility that any

differences in outcome for biological males in comparison to females might have been missed, although such studies tended to justify their decision based on significantly lower numbers of the female-to-male group, and therefore the likelihood of inconclusive results (e.g. Kuhn et al, 2009). This is consistent with evidence of a lower incidence of biological females seeking gender reassignment surgery, although by focusing on biological males, there is the danger that the needs of the former group remain less well understood.

In the majority of studies, most participants appeared to be in the middle age range and upwards, although this was difficult to accurately compare due to variable methods of reporting age across studies, whilst one study (Smith et al, 2002) examined post-operative outcomes for an adolescent cohort. This trend is perhaps reflective of the lengthy process facing those with gender difficulties who seek to address them via a surgical route, or indeed of the complexities and evolution of such difficulties across an individual's lifespan.

3.2 Methodological features

Outcome criteria: A shift from the 'objective' to the 'subjective. '

It was evident from the reviewed sample that more recent studies of outcome following gender reassignment have begun to assert that data evidencing the subjective realities of patients are apposite for meaningful evaluation of the intervention. As Kuhn et al (2009) suggested, ' an evaluation of sexual reassignment surgery can be made only on the basis of subjective data because (surgery) is intended to solve a problem that cannot be determined objectively' (2009, p. 1687).

Thus contemporary research indicates something of a shift away from evidence of outcome based on criteria such as objectively measured psychological or social functioning (e.g. Smith et al, 2002; De Cuypere et al, 2005), favouring patient led accounts of factors such as degree of satisfaction or quality of life after the intervention (e.g. Kuhn et al, 2009).

Comparison groups; challenges in finding control data

Many of the studies in the sample purported to use subjects as their own controls, by comparing pre- and post-operative data (e.g. Udeze et al, 2008). Others used only data gathered retrospectively (e.g. Weyers et al, 2008), thus increasing the possibility of bias. Few studies used control groups, with most referring to the impracticability of this from a clinical perspective. Where control subjects were identified, difficulties included a lack of transparency as to the sourcing and characteristics of controls (e.g. De Cuypere et al, 2006), and confounding variables such as controls who had undergone surgical procedures for physical health reasons (e.g. Kuhn et al, 2009). None of the studies used waiting list controls which would arguably have facilitated more meaningful comparison.

'Putting their past behind them': common problems of low response rates and attrition

As De Cuypere et al (2006) reflected following their study, significant numbers of those who have completed their surgery 'obviously wanted to put their past behind them' (2006, p.132), hypothesizing a correlation between longer follow-up periods and lower rates of response. Across all studies there was a trend for low rates of response and participant attrition, consistent with findings from the earlier reviews. It was

evident that a number of studies had attempted to capture greater number of participants by using a shorter follow up period (e.g. Udeze et al, 2008), yet tended to conclude that this may have compromised sensitivity to the detection of change. As implied by previous reviews, such difficulties are a significant obstacle to evaluation of outcome after surgery, not least since it may be those who have experienced the least favourable outcomes, such as poor mental health for example, who fail to be included in the final analysis.

3.3 Summary of Findings

Outcome according to 'objective' criteria: Aspects of psychosocial functioning and sexual health.

Five of the reviewed studies aimed to evaluate post-operative psychological functioning using validated assessment tools, for example the Symptom Check-List 90R (SCL 90-R) (e.g. Udeze et al, 2008; De Cuypere et al, 2006). The utility of such tools seemed to be their brevity, and convenience where clinics administered questionnaires as part of routine procedure. Conversely, there is the possibility that questionnaires with limited response options fail to capture the full range of experiences, and could be subject to socially desirable responding, especially where researchers also have clinical relationships with their participants (e.g. Udeze et al, 2008). The findings of such studies were modest. Udeze et al (2008) hypothesized that scores on the SCL 90-R would indicate significant improvements in psychological functioning after surgery, yet their results indicated no such change. Interesting trends in the data were however explored, such as a tendency for improved sexual functioning and decreased levels of anxiety. However, a trend for increased levels of anger and

hostility post-operatively was also identified, which it was hypothesized might be reflective of unrealistic expectations of the surgery, or difficulties involved in adjusting to life in the new gender role. De Cuypere et al's (2006) comparison of scores on the SCL 90-R between post-operative participants and a 'normal' population control group also indicated an absence of statistically significant differences, although statistically non-significant trends for positive post-operative outcomes in the domain of family and social relationships were reported.

Sexual health after surgery was a further criterion by which outcome was measured (e.g. Weyers et al, 2008; De Cuypere et al, 2005; Lawrence, 2005). In some cases there were clear problems with how this was conceptualised. For example, one study examined retrospectively the number of sexual partners and frequency of sexual activity before and after surgery, together with prevalence of stable partnered relationships in comparison to survey statistics from the general population (Lawrence, 2005). Whilst the findings indicated interesting trends, for example that post-operative participants were less sexually active than controls, and less likely to be in a stable partnered relationship, there was a failure to examine why such trends might be the case, and indeed whether participants themselves deemed them reflective of the utility or otherwise of their surgery. Other studies highlighted significant findings in terms of distress associated with problems of sexual functioning post-operatively, which appeared related to functional outcome following surgery (e.g. Weyers et al, 2008).

Outcome according to 'subjective' criteria: Satisfaction, regret, quality of life.

Subjective accounts of degree of satisfaction and quality of life after surgery were explored in several studies (e.g. Kuhn et al, 2009; Lawrence, 2003). Such studies

also attempted to assess incidence of regret with regards to the decision to undergo surgery, as potentially the most profound litmus test for the intervention. Assessment of these factors varied across studies, and in some cases there were shortcomings in the validity and reliability of tools, for example where questionnaires included items composed by investigators specifically for the study (e.g. Lawrence, 2003). Equally the use of Likert scales, although informative, arguably limited the depth of responses in some cases. Results of these studies appeared to show that a significant majority of participants were satisfied with the results of their surgery, and that their quality of life was improved as a result. For example, as reported by Lawrence (2003), 97% of subjects indicated that surgery had resulted in a better quality of life than they had previously experienced, with no participants indicating that they consistently regretted the intervention. For six percent of this sample, there were occasional feelings of regret, yet this was not elaborated in terms of the context or impact of such feelings. Other studies attempted a more quantifiable approach to assessing quality of life after surgery, for example Kuhn et al (2009) who used the King's Health Questionnaire (Kelleher et al, 1997), which was described as a validated tool for this purpose. They found that compared to a control group, 'physical and personal limitations' were significantly elevated in post-operative participants, and general life satisfaction was significantly lower than controls. At the same time, the patient group reported significantly lower 'role limitations', which was interpreted as a positive consequence of the intervention. Results from this particular study may have been more meaningful had these outcome criteria been more explicitly defined, and specific to the patient group. Indeed, their rationale for using the King's Health Questionnaire is problematic, in that the original conception of this tool was based on quality of life for patients who had been treated for urinary incontinence.

Certainly the theory that subjective accounts of outcome are most appropriate for a subjectively experienced problem is convincing, yet there were several ways in which studies adopting this approach were flawed. On a practical level there were difficulties with control comparisons (e.g. Kuhn et al, 2009), not least since gender patients will arguably have been subject to social pressures and stigma impacting on their quality of life to a greater extent than controls. Psychologically there are also difficulties in measuring outcome based on incidence of satisfaction or regret. For example, in many cases, investigators were in the dual role of researcher and clinician, which might have influenced expressions of satisfaction. At a personal level, it could also be argued that participants might defend against openly regretting their decision to undergo surgery, be it consciously or at an unconscious level. Furthermore, even though numbers expressing regret may have been small, the clinical impact of these cases is likely to be significant, informed by evidence of self-harm and rates of attempted suicide for this client group.

4 Discussion and Conclusions

The aim of the current review was to provide a distillation of contemporary research into psychological outcomes following gender reassignment surgery as a treatment for Gender Identity Disorder (GID). Following a systematic search of key databases, in excess of five hundred papers were sifted by Abstract, and reduced to a pool of ten studies which were relevant and appropriate for inclusion in the review. One of the most startling findings of the review was the relative paucity of empirical research into psychosocial post-operative outcomes in comparison to the wealth of medically-orientated literature, considering that psychosocial difficulties are central to the

conceptualisation of GID. Furthermore, findings were compromised by a range of methodological difficulties, presenting a confusing picture of the utility of the intervention. Most commonly, these difficulties included small sample sizes as a result of low response rates and attrition, poorly matched controls, and potential biases such as clinical involvement of researchers with their participants. Unfortunately such factors were not always explored as potential biases, and there seemed a tendency for any findings of positive outcome to be attributed to the surgery, without rigorous attempts to consider confounding variables. Apparent moves towards using subjective measures of outcome such as patient satisfaction were undoubtedly of value, yet potentially confounded by the way in which views on satisfaction were sought, and the extent to which it might be difficult for individuals to express regret for such a life changing decision. Indeed, accounts from the small minority who were reported to have any regrets were absent, and it was perhaps those cases that required more extensive investigation, not least because their impact was likely to be significant from a clinical perspective.

Overall, the contemporary picture was reminiscent of earlier reviews, highlighting the continued paucity of empirically robust research in the area of treatment outcomes for GID. On the other hand there was evidence of progress, for example in an increased awareness of the importance of patients' opinions on efficacy. Yet from a clinical perspective, the current review presented a frustratingly mixed picture of evidence on the efficacy of surgical intervention for GID. Certainly there was the suggestion that a majority of patients were satisfied with their decision to undergo this type of treatment and did not tend to regret it. The possibility was also tentatively suggested that social relationships might be positively affected as a result of the intervention, and pre-operative difficulties in social role ameliorated to some extent.

Yet the findings referred only to trends, and not statistically significant results, and therefore could not be considered indicative of firm evidence of improvement. Equally, one was left to wonder what might be the outcome were there studies comparing outcomes after surgery with those after alternative types of intervention, for example psychotherapy.

Trends which indicated potential difficulties following surgery are certainly worthy of further investigation, not least so that services are able to fully prepare patients for the possible impact of the intervention. The potential for post-operative distress relating to sexual functioning was highlighted, as were trends in the impact of surgery on partnered relationships. The suggestion that elevated levels of anger and hostility may result also seemed an important area of concern, inviting further research into factors which might precipitate or protect against such experiences. Certainly, the current review has highlighted a general need for more psychologically-orientated research into GID, and the extent to which surgical intervention offers the most appropriate intervention. One way of achieving this might be to begin with research which uses a qualitative methodology, with a view to generating a number of hypotheses to form the basis of further quantitative enquiry.

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NB: Asterisks denote studies which comprised the review of literature

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PART TWO:

Research Report

1. INTRODUCTION

1.1 Surgery for Gender Identity Disorder

Gender reassignment surgery is a procedure currently funded by the NHS as treatment for Gender Identity Disorder (GID), where patients have persistently experienced incongruity between their biological sex and their sense of gendered identity. GID entered the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1994, replacing the category of Transsexualism which DSM first included in 1980. Upwards of one hundred surgeries for GID are performed yearly by NHS providers, subsequent to lengthy input from a team of professionals assessing patients' appropriateness for the intervention. Indeed before surgery can take place, services require patients to commit to living full time in their preferred gender role, and subsequently commence hormonal treatments to prepare their body for physical transition. Prosser (1998) describes this as

> "entering into a lengthy, formalized, and normally substantive transition: a correlated set of corporeal, psychic and social changes" (Prosser, p.4).

That the process is so prescriptive has led to some suggesting it reflects the ideological power of medicine over the individual, dictating conventions for how gender should appropriately be expressed (see Hausman, 1995). Others argue that patients have themselves constructed and shaped the route through transition, citing cases of individuals

who have pursued a changed anatomy even before concepts of disordered gender identity were formalised and surgery offered as a treatment (Prosser, 1998).

1.2 GID in context: A continuum of cross-gender experiences

Those who are seen for assessment and treatment of their gender difficulties reflect only a small proportion of a broader population of individuals who identify with or engage in cross-gender behaviour. Increasingly this population is associated with the label Transgenderism, which has evolved as a term used by both professionals and the transgender community itself as a means to developing a social and political identity (Ekins & King, 2006). Transgender does not imply any specific sexual orientation, and indeed some transgendered individuals may consider conventional labels of sexual orientation inadequate reflections of their experiences (Feinberg, 1997). As the term evolves so does the range of experiences to which it refers, which might be conceptualised as a continuum, from occasional cross-dressers, to those who ultimately see surgical gender reassignment as their goal.

1.3 Surgical pathways

Clinical experience indicates that surgery for GID tends to occur later in the lifespan, often in middle age and beyond (Ekins & King, 2006), reflecting the complexity of both the nature of gender difficulties, and typical trajectories through treatment. Male to female surgery is more common than female to male, with an estimated ratio of around 4:1 (Jain & Bradbeer, 2007). It has been suggested that the female to male group tend to experience better psychosocial outcomes following surgery (Carroll, 1999), although this has not been rigorously examined in the literature. Speculatively it is thought that biological women who become men often find it easier to be accepted by others in their changed gender role, perhaps because of a more easily achievable aesthetic. Equally it

could be argued that surgically created women are in the same way as biological females faced with greater societal pressures and disadvantages compared to men, and indeed are less equipped to cope with them having previously only experienced life from the male perspective.

1.4 Creating gender: Surgical limitations

Despite advances in surgical technique, gender reassignment remains limited in the extent to which the full range of experiences of a biological male or female can be reconstructed. For example, female to male patients will not be able to produce sperm and impregnate a female, just as male to female patients will not menstruate or be able to bear a child. It is suggested that the ability to have orgasms should in most cases be preserved, although this cannot be guaranteed, just as the possibility of complications and the need for further corrective surgery cannot be ruled out. Surgical interventions are in most cases considered irreversible, highlighting the importance of thorough assessment and evidence of readiness for the procedure.

1.5 The evidence: Bodies versus minds

Reviews of the evidence of effectiveness for surgical gender reassignment in treating GID (e.g. Pfafflin, 1992, Cohen-Kettenis & Gooren, 1999) indicate a paucity of robust research, particularly into psychological outcomes. Typically studies have focused on evaluating outcomes from a medical perspective, and indeed an initial literature search of databases EBSCO, Scopus and Web of Science generated over five hundred papers where the majority (over three quarters) referred to evidence of the effectiveness of surgical technique. Arguably this reflects the assumption that refining the technical aspects of surgery, with a focus on achieving the most functional and authentic physical outcome, is synonymous with improving outcomes for people affected by GID. Yet such an

approach fails to evaluate how patients' lives are changed after the intervention, and how they perceive the procedure to have addressed their difficulties as a whole.

1.6 Psychological outcomes

Across the small number of studies where psychological outcomes after surgery for GID have been investigated, there has been a shift away from clinician-rated and other objective measures of outcome, towards a focus on patient-centred accounts of quality of life after the intervention. For example, studies have investigated instances of satisfaction and regret (e.g. Olsson & Moller, 2006), concluding that outright regret is rare and that most patients are satisfied that their lives have improved as a result of surgery. However such studies are plagued by a litany of methodological flaws, not least including the potential bias resulting from a handful of clinics using their own patients as participants, where clinicians with whom patients are likely to have had years of prior contact double as researchers. Equally there are problems at a conceptual level, for example: through framing outcomes in terms of satisfaction and outright regret, there is little scope for exploration of the grey areas in between which might realistically characterise patients' lives post-operatively. Could it be that the choice to pursue surgery is more complex than finding a 'cure', and that each patient has a unique lived experience of surgery and way of understanding its function and meaning?

1.7 The current study: Exploring life after surgery

In the context of so little existing psychological research into gender reassignment, the aim of the current study was to explore the reality of life after this type of surgery, investigating what it is to be a woman whose identity has been constructed in this way. Freeing patients from needing to artificially categorise and quantify their experiences, the aim was to examine something of the meaning of surgery as experienced by the individual,

in the context of reflecting on life from a post-operative perspective. The intention was that such an investigation would not only be of benefit to specialist services for the treatment of gender difficulties, but also to inform formulation of other types of difficulty where gender is a contextual factor.

2. METHOD

2.1 Background to the Author's Research Interests

Choosing to undertake the current study related to both the author's long-standing interest in gender issues from a personal and professional perspective, and her experience of having worked in a setting where surgical gender reassignment was available as an intervention. This existing link with a service enabled both refinement of the research question, and easier access to the relevant clients and professionals than might otherwise have been available.

2.2 Overall Design of the Study

The essence of the present inquiry was to understand something of the lived experience of those who have been through a process which is poorly understood in the scientific literature and in generic healthcare services. For this reason, it was decided in the first instance that the study should employ a qualitative methodology, consistent also with evidence indicating the likelihood of difficulties in attracting sufficient numbers of participants to meet the requirements of a robust quantitative inquiry. Indeed, it was anticipated that the rich data generated by a qualitative methodology

might subsequently be used in future research to define the parameters of a quantitative investigation.

2.3 Ethical Approval

A proposal for the research was considered by the South Yorkshire Research Ethics Committee, and a favourable ethical opinion for the study was given in July 2009. Research Governance approval was obtained from the sponsor (Leicestershire Partnership Trust) and the research site (Sheffield Health and Social Care Trust).

2.4 Epistemology and Choice of Method

Researcher's position

The author's training as a clinical psychologist led her to seek a method where notions of human understanding and sense-making were a central component. Ideally such a methodology would not only capture this process from the perspective of study participants, but also the parallel process of the researcher's own attempts to understand and engage with the material.

From the perspective of seeking to understand people's experiences and the way they are made sense of, notions of impartiality and objectivity were considered unachievable, and contrary to the pursuit of attempting to understand the diversity and idiosyncrasies of lived experience. Therefore there would be no single 'truth' to be asserted or false claims to be identified, but rather an exploration of the uniqueness of experience as it is understood and recounted by those who have lived it.

On a personal level, the author was aware of her position as a female researcher, attempting to understand the experiences of individuals who had undergone a lengthy process of transition into womanhood. She wondered how experiences of these

'created' female identities might be described, and how their exploration might impact on both the participants' and the researcher's reflections on their identities.

Selection of a methodology

Based both on the author's epistemological position and the nature of the research question, a number of methodologies were considered for their appropriateness. Crucially it was felt important that the methodology should be able to capture the relative novelty of the subject matter, and be sensitive to notions of transition and process. It was felt that these concepts were expressed succinctly in the existentialist notion that human beings are in a constant process of 'becoming', with the self as an unfurling project rather than finished product (Smith et al, 2009). A methodology which was reflective of such processes also seemed well suited to the task of exploring issues of identity inherent to the current research question.

Established methods such as Grounded Theory (e.g. see Glaser & Strauss, 1967) and Discursive approaches (e.g. see Burkitt, 1999) were considered in terms of their sensitivity to the aforementioned issues. Grounded Theory offered the potential for a systematic approach, with the possibility of generating a theoretical -level account of the phenomenon in question. However, this approach seemed to be missing a focus on idiography, which is arguably so important when examining a relatively rare phenomenon. On the basis of the existing research, it was also felt that sufficient data might not be available to fulfil the requirements of this approach. Discursive approaches were similarly dismissed on the basis that the appropriate form and amount of data might not be available, and as their emphasis on the construction and function of texts was felt to be inconsistent with the research question.

Interpretative Phenomenological Analysis

The approach which stood out as appropriate to both the author's epistemological position and the focus of the research question, was Interpretative Phenomenological Analysis (IPA) (see Smith et al, 2009). With its emphasis on process and meaning from the perspective of the individual, IPA seemed a good fit to explore, rather than explain, a relatively unexamined phenomenon. Anticipating a relatively low sample size, the approach also invited the possibility of detailed examination of small numbers of cases, with scope to highlight meaningful similarities and differences between individual experiences. For these reasons, it was decided that the research question would be addressed using IPA as the methodology of choice.

2.5 Procedure

Recruitment

The researcher made use of existing links with an NHS national service for gender dysphoria, where the lead clinician was invited to offer people who had completed surgery to change gender from male to female the opportunity to participate. Potential recruits were approached either in person or in writing, and informed that they should contact the researcher for further information on the study. Once an Information Sheet (see Appendix C) had been provided via staff at the service, consenting individuals were invited by the researcher to attend an interview to discuss their experiences. Due to a sufficient number of people having responded to this initial invitation, it was not necessary to further promote the study.

Potential participants were made aware that although they personally may not directly benefit from taking part in the study, it was anticipated that their participation

would benefit those experiencing similar difficulties in the future. The Information Sheet also detailed the practicalities of participation, including that interviews would generally be conducted on clinic premises, for an approximate duration of one hour. The option of interviews taking place in clients' homes was also available, providing the researcher was able to confirm with clinic staff that this would not involve significant risk to either the client or researcher.

Key Ethical Procedures and Safeguards

Potential participants were made aware in the Information Sheet that being interviewed about their experiences might in some cases be distressing, and that this would be managed sensitively and respectfully by the researcher. Indeed, it was made explicit that they would be free to withdraw their consent to participate at any time, and that this would not in any way affect any services being provided to them by the clinic.

The Information Sheet also detailed the procedure to be followed in the event of difficulties such as distress resulting from participation, or disclosures of risk to self and/or others. Namely, recruits were informed that although their GP would not routinely be informed of their participation in the study, they may be contacted were issues of safety to arise. Similarly, the researcher was equipped with details of agencies available for participants to contact should they require support following their interview.

Development of the interview schedule

Smith et al (2009) suggest that an interview schedule should be designed to:

> ‘facilitate a comfortable interaction with the participant which will, in turn, enable them to provide a detailed account of the experience under investigation’ (p. 59).

With this in mind, a schedule was designed (see Appendix D) which allowed participants the freedom to describe their experiences in their own words, avoiding closed or leading questions from the interviewer. Questions were formulated to avoid assumptions or implied interpretations of participants’ experiences, and were flexibly sequenced so as to follow the lead of the participant’s narrative. However, the schedule was loosely structured so that participants would be invited to describe their experiences more generally at the start of the interview, and then at a deeper, more analytical level should they wish to do so as the interaction progressed.

In practice the researcher found that participants were very responsive to the invitation to describe their experiences, and interviews tended to flow with few prompts from the interviewer. In some cases this meant that not all questions in the schedule were put to the participant, consistent with Smith et al’s notion of the ‘active listener’ whose role is to follow the concerns of the participant, rather than adhere to a rigid agenda.

2.6 The Sample

The sample consisted of eight people who had completed their surgery to change their gender from male to female. All had completed their surgery at least six months prior to interview, for the purpose of allowing time for physical recovery and adaptation to their new circumstances.

Those whose surgery was to change from a female to male identity were excluded from the sample consistent with the aim of homogeneity, and for the practical reason of their experiences being a less common phenomenon than those of individuals wishing to change from male to female. People with atypical physical features relating to their gender identity were also excluded, as in the case of intersex conditions.

Basic demographic information relating to the sample is illustrated in Table 1 below. Case by case details are not presented so as to protect participants' anonymity.

Table 1: Participant demographic information

Demographic Categories (based on self-report)	Number of participants
Age: 40 or under	0
41-50	1
51-60	3
61-70	3
71-80	1
Ethnicity: White British	8
Other	0
Marital status: Married	1
Living with a partner	3
Single, never married	0
Single, divorced	4
Other	0
No. of children: None	1
1	0
2	6
3	1
Time since surgery: 6 m'ths - 1yr	3
1-2 yrs	3
2-5 yrs	1
5+ yrs	1

2.7 Data analysis

Transcription

Consistent with the IPA methodology, interviews were transcribed as a verbatim record of the data, including a semantic record of the interaction. Therefore notes were made of notable non-verbal utterances such as sighs or laughter, pauses and hesitations. Ideally the full set of data would have been transcribed by the researcher for the purpose of familiarity and immersion in the material, however due to time constraints the decision was made for half of the interviews to be professionally transcribed. Interviews were randomly allocated to be either transcribed by the researcher or professionally, and were subsequently checked for consistency by the researcher upon their completion.

The interpretative process

The first step of analysis was for the researcher to become fully immersed in a process of reading and re-reading each transcript, listening also to the original recordings to get a feel for each participant's unique 'voice'. Further to Smith and Osborn's (2003) suggested approach to analysis, the aim was to enter participants' psychological worlds, rather than to measure or prioritise any particular element of their story. At this stage the researcher noted any 'instinct' reactions to the data, including feelings and recollections of each interview.

The next stage involved a process of initial noting on the text, staying close to participants' explicit meanings. As indicated by Smith et al (2009), this minimises the risk of making superficial and biased interpretations, based on what might be expected of the data as opposed to meanings intended by the participant. However, alongside this

process, more interpretative notes were made as the first stage of developing a meaningful account of what was said. Smith et al (2009) refer to this as a process of moving from a 'face value' reading of the text, to a more conceptual account of the data.

Exploratory commenting on the text was then brought together to identify emergent themes in the data. It is suggested that this stage can be anxiety provoking for the researcher, as the analysis shifts to another level of abstraction from the original text (Smith et al, 2009). However, the aim is for emergent themes to reflect an understanding of what was said by each participant, and the meanings they conveyed about their experiences.

In the later stages of analysis, themes were clustered into super-ordinate categories, making links and connections between issues evident in the data. The researcher viewed this as a dynamic process, whereby her reflections on the material continued to enrich and evolve the resultant interpretations. At all times the aim was to be aware of not only *what* was said by participants, but also *how* and *why* they spoke about the issues raised. In this way, the researcher was able to meaningfully interpret the phenomenology of participants' experiences.

Quality Measures

Yardley (2000) has proposed four broad principles by which qualitative research can be assessed in terms of quality. These principles are suggested to be useful for researchers using an IPA approach, because they avoid simplistic or prescriptive procedures which would arguably fail to reflect subtleties in the interpretative process (Smith et al, 2009). The researcher attempted to adhere to Yardley's principles as follows:

Sensitivity to context: the analysis was conducted with mindfulness for existing literature and research in the area, the researcher's own approach to the material, and the context in which participants delivered accounts of their experiences.

Commitment and rigour: the researcher was committed to the analysis, in that ethically she believed the data should be examined with care and due attention paid to the meanings inferred by those who had taken part. Supervision was sought at each stage, in order to support and enrich this process.

Transparency and coherence: the researcher has attempted to carefully describe each stage of the study, in terms of rationale for what occurred and how it was executed. As suggested by Smith et al (2009), the aim has been to imagine being 'in the shoes of the reader', coherently describing why, what, and how things were done.

Impact and importance: in the context of so little existing research in the area, the study was considered to be of great practical utility, making a valuable contribution to a developing area of knowledge.

3. Results and Analysis

This section contains a narrative account of the findings, comprising a detailed analytic interpretation of the data, illustrated through extracts from each transcript. Participants are identifiable by a pseudonym, and extracts are referenced using the line number of the relevant transcript. The account is organized by the super-ordinate themes which emerged from the data, highlighting patterns across cases and their relationship to instances of idiosyncratic experience.

3.1 Overview of Main Themes and Sub-ordinate Themes

Figure 1 illustrates how the five main themes evident in the data each related to a number of sub-ordinate issues:

Figure 1: Representation of super- and sub-ordinate themes

3.2 Exploration and Evidencing of Themes

Theme (i): Surgery in context

During the interview process the researcher at times felt frustrated by participants' deviations from the questions put to them. For example, prompts to discuss post-operative experiences were often met with descriptions of the initial transition into a female identity, some even going back as far as their feelings in childhood. In trying to make sense of her frustration, the researcher wondered whether her feelings might mirror those of participants: were they irritated by being asked to compartmentalise their experiences, or by being defined solely by having had surgery?

In allowing participants to tell their stories on their own terms, the emergent accounts contextualised surgery amongst other milestones, with surgery often seen as the final step in a long process of change. For others, changes were still in progress in the post-operative phase, such that they were continuing to learn and develop in their changed identity. Accounts also evidenced a desire to describe life outside the realms of gender, where subjects such as work, travel and hobbies were discussed. The researcher at times sensed defiance, as if participants were saying; "there's more to me than gender".

Full time women

Participants uniformly attached significance to the time when they first began living 'full time' in the female role prior to surgery, through daily dressing as a woman and taking female hormones. Sometimes a specific date was named, as though the change represented the birth of their new identity. Some accounts of transition were

passionately expressed, worded with emphasis of clarity and resolve, as exemplified by Dianne's description of her transition:

> "I want to be who I want to be...and on (date) which was a Thursday...I said from this day on, I'm going to be" (Dianne, 15-18).

Other participants sought to highlight the social impact of their transition, as in Fiona's description of her decision to publically announce that she intended to live as a female:

> "It got to the stage when I thought well, I've either got to forget it which wasn't an option, or I'd got to stop living like a man, and I went round all the neighbours and told them" (Fiona, 315-317).

The researcher reflected that parallels could be drawn between these accounts of transition and the experience of 'coming out' in the context of sexual identity. Certainly, participants seemed to share a sense of their transition signifying the start of living life differently, perhaps more authentically for them.

A journey through gender

Participants contextualised their surgery together with their experiences of transition as a journey, often with the operation viewed as the journey's destination, or as Carly put it:

> "the final bit...a bit like the icing on the cake" (Carly, 72-74).

Participants seemed split however in terms of where the journey might end, with some cautioning against focusing on surgery as an end point in the process. Pam refers to this as:

> "an unhealthy attitude. Because what then? Someone has had the surgery...where do they then put their focus?" (Pam, 55-57).

Cheryl develops this idea, suggesting that:

> "I actually believe the true transition starts after your surgery...I think I discovered more about myself as a woman...to live my feelings" (Cheryl, 12-14).

The researcher's training as a clinical psychologist led to her to feel more comfortable with these seemingly more realistic accounts of the process, and sceptical of the notion that participants' journeys had ended in the operating theatre. Yet some were adamant that this had been their experience, which was interpreted as suggestive of how significant and important to them the surgical intervention had been. As Nicola comments:

> "I came out of there feeling you know, that it resolved all the things that had been building up over the years...it's made me more complete" (Nicola, 34-39).

Certainly these differences in the course of participants' journeys seemed reflective of the differing impact of surgery in their lives, and the extent to which the operation was perceived to have solved their difficulties.

More to me than gender

The notion of life as things other than gender emerged in part from the researcher's observation that the data periodically evidenced participants seeking to discuss issues not relating to their surgery, or indeed their gender identity. For the novice researcher, this was anxiety provoking; why did participants not always answer questions directly? In reflecting on her feelings, she began to understand that

participants' diversions and tangents in the conversation had functioned to locate them as people not defined solely by their surgery or gender. The researcher found this reminiscent of patients in health settings, for example where survivors of cancer might defend against being known primarily for their illness, and rather as people with lives outside the medical label.

Exchanges in the dialogue exemplifying this phenomenon were scattered throughout the data, experienced by the researcher as a process of push and pull between conflicting agendas. Perhaps this was a familiar pattern in participants' lives, where the agenda to get on with life as women was met by a variety of obstacles, not least the lengthy process of seeking surgical intervention.

Sometimes participants digressed to find out more about the researcher, as if seeking to detract from their own stories, and also perhaps out of curiosity about the researcher's own identity. For example Carly asked:

> "are you an actual student...like a student as well as your work?...You're at the university and all that? (Carly, 3-11).

Although mundane at a surface level, such enquiries were interpreted in terms of participants attempting to gauge something of their audience, herself a woman, at the same time as steering the dialogue away from a constant focus on gender.

Theme (ii): Social surgeries

The data repeatedly evidenced that social acceptance, or lack thereof, had impacted on participants' quality of life post-operatively. That the issue was so frequently evident in their accounts was interpreted as indicating the depth of its

emotional impact, and how profoundly the acceptance of others had been sought. Particular value was attached to being accepted as part of female society, which participants had experienced to varying degrees. Indeed, the researcher wondered whether the interview process itself was a representation of this phenomenon, in that participants had the experience of having their stories heard and understood by a member of the female community.

Certainly, there was ample suggestion that surgery had brought about profound social change for many, although not always positively. Several participants were parents, and had grappled with how to redefine themselves in the parental role, often in the context of conflict and distress. Many had been married as men, and faced either renegotiation of their marital circumstances with their partner, or in some cases separation as a result of their changed gender identity.

Finally, the data evidenced that participants had encountered myths and the prejudice of others in relation to their surgery, which they had sought to dispel, emphasizing normality as opposed to deviancy.

Being accepted

Participants offered accounts of times when they had felt particularly well supported by others, often emphasising a sense of gratitude , and the feeling that support was an indication that people had accepted them. Betty explained how her experience of being accepted by others had changed since her surgery:

> "I think to people prior to the operation, I was still in their minds no matter how accepting they were, was still a man in a dress. After surgery I think people have

> seen me as a woman...I think it helped them to appreciate it and I felt more accepted" (Betty, 28-32).

In a number of cases participants reported having feared intolerance, yet experienced a reality of acceptance. This was interpreted in terms of relief that their lived experiences tended not to be as traumatic as they might have imagined, and that private fears may well have been far more distressing than their real world experience. Fiona's account exemplifies this point:

> "They'd accepted me and it's a really redneck area as well. You wouldn't have thought they'd accept you but they do. They have accepted me you know so that's good" (Fiona, 487-489).

Although not clarified by the participant, Fiona's use of the word 'redneck' made the researcher think about groups of men, and whether she might have been referring to surprise that men might accept her as freely as women. This could be further interpreted in relation to fears that men might react more negatively because of their own anxieties about gender, for example if they were to encounter a post-operative woman in the context of sexual intimacy. Such a situation might provoke feelings of their own sexuality being questioned, which could be experienced as threatening in a way that would not apply to relationships with women.

Other accounts made explicit the frustrations of achieving acceptance, seeming to communicate disappointment that surgery had not guaranteed recognition of the woman participants saw themselves to be. For example Kate commented of her work colleagues:

> "It took a long time for some of them to accept me, it really has...it's still an ongoing process really" (Kate, 394-396).

Most participants had at some point experienced people who had refused to support or accept their decision to change their gender, which was sometimes recalled with sadness, but more often with a sense that instances of rejection were themselves something to be accepted. However the researcher wondered about the extent to which this had been possible, and how much pain still remained as a result of such rejection. For example, Pam's shrugging of her shoulders belies her assertion of having accepted the situation, revealing perhaps a reality of exasperation that the acceptance of others had not always been achieved:

> "I've got to the point of sort of almost shrugging my shoulders and saying well, I'm sorry that's how it is...but I can't change it" (Pam, 323-326).

It was evident that particular value had been attached to being accepted into communities of other women, as made explicit in another comment from Pam:

> "the result for me was to be integrated into female society and accepted as such" (Pam, 24-25)

For Cheryl this was expressed through being accepted in the gay community, as she explains in response to a prompt for her to elaborate on her experience of entering the gay scene after surgery:

> "Oh it was great...you know and I just felt at home. I thought this is, this really is me..." (Cheryl, 274).

There was a sense in these accounts that somehow before surgery, participants had existed on the margins of society, with their goal being to gain membership into the

mainstream, finding a place to feel at home. The researcher was struck by accounts such as Cheryl's where this home was located in the gay community, which itself exemplifies a culture which has moved from the margins to the mainstream in recent history. This led to curiosity about whether acceptance into female society would be as important, were there to be cultural shifts in the acceptability of different types of gender expression, i.e., if society were more accepting of men wishing to assume certain characteristics more commonly associated with women.

Changes in roles and relationships

In all cases surgery had elicited changes in the participants' roles and relationships, which at times were characterised by painful experiences of conflict and loss. Within families for example, those who had fathered children prior to surgery described their experiences of redefining their role in relation to their children. In part this seemed to be linked to use of language, as Cheryl's account indicates:

> "I am what they call that other parent. They never call me, well occasionally I still get dad...and they said well looking like you do, we find it very hard to send you a Fathers' Day card" (Cheryl, 173-180).

Equally partner relationships were faced with dilemmas of role definition, as in cases where married couples had stayed together through gender reassignment. Participants reported frustration with the system of being required to divorce and reaffirm vows via a civil ceremony, in some cases rejecting the assumption of a gay identity. This was interpreted as reflective of an impossible situation, whether relationships were in a sense caught between the past and present reality of their

circumstances. This is exemplified by the following comment by Diane, where her reference to what she and her partner are not, without indicating what they may be, highlights the impossibility and ambiguity of the situation:

> "The paperwork it says you have to have a civil ceremony...which infers the wrong thing then because a civil ceremony is for gay couples to marry...we are not that" (Diane, 274-277).

Often participants reported how the reality of their new role with their partner had fallen short of their hopes and expectations. For example, Kate suggests that:

> "I'd like to say it's like two sisters but it actually isn't, it isn't like that really...we're just each other's best friends, we always have been" (Kate, 220-224).

Furthermore, conflict and loss in relationships had been commonplace. Often this was evident where family members had struggled to adjust to the new identity. The researcher noted that participants often seemed evasive about questions relating such experiences, describing them only very briefly or cryptically. This was interpreted as reflective of the need to put difficult experiences behind them post-operatively, compartmentalising and trying to forget what had been painful about the emergence of their new identity. The following comment made by Carly exemplified this phenomenon, highlighting the feelings of rejection resulting from such a situation:

> "the family, I can keep it short and sweet...they never approved of a daughter...so we never got on" (Carly, 349-353).

Dispelling myths and prejudice

A further social dimension to the experience of surgery was evident in participants' accounts of encountering other people's prejudices, and the myths propagated by lack of understanding. In some cases people's prejudices were experienced as only minor difficulties, as Diane indicates in her account of being spoken about in the street:

> "they say, that's that person I was telling you about, or somebody told me she used to be a man...and you know...it's just a little upsetting" (Diane, 837-844).

On the other hand, there were accounts which implied a more profound impact of prejudice, such as in Pam's account of the attitudes of hospital staff caring for her post-operatively:

> "I had an Indian nurse on nights who either couldn't understand me or didn't want to understand, but would not give me any help only a matter of days after surgery...and it was clear she was Muslim because she was wearing the bhurka and I thought well probably she's another one who basically doesn't think we should be being done" (Pam, 553-562).

This was interpreted as particularly poignant, representing a betrayal of care at a time when the participant had been physically and emotionally vulnerable. Pam's description is also interesting because at the same time as illustrating her experience of perceived prejudice, it intimates her own assumptions about a minority group, therefore highlighting how different prejudices might be perpetuated.

Participants spoke of encountering common myths about gender reassignment, for example through referencing the language of sensationalist media to indicate how their surgery might be seen by others. For example Betty described the notion of:

> "Shock horror sex change. People think of people who are transsexual as being morally perverse and of course that's completely wrong" (Betty, 137-138).

Often described with passion, the researcher wondered whether such accounts spoke of past experiences of feeling judged and misunderstood; of being tarnished by a label of perversity and seen as morally deficient. This was further interpreted to suggest that participants might have been motivated to participate in research for this very reason, so as to re-educate the wider population and dispel myths about their experiences.

Theme (iii): Gender vs. sex

Participants spoke about the function of their surgery as affirming gender from the perspective of who they saw themselves to be, as opposed to being about sex. Indeed, whether partnered or single, the majority of participants reported a reduction or often complete loss of sexual activity post-surgically. All of those in existing relationships were partnered with women, with whom sexually intimacy was described to have ceased through mutual agreement. However the researcher was struck by how much a partner's own identity would be changed after surgery were a sexual relationship to continue, and wondered at the accounts they might give of the decision not to be sexually active after their partner's surgery. For single participants, accounts implied fears of initiating intimacy with a new partner in the context of their changed anatomy, which was interpreted in relation to fears about not completely fitting in, or possibly even being ridiculed and rejected.

The researcher reflected that her interpretations could only be tentatively made in relation to sex, in that questions about the issue had not been included in the

interview schedule, and because she realised with hindsight how much more the subject might have been elaborated on. This was viewed as reflective of her own sensibilities, perhaps relating to fear of details that she might not wish to know, and further interpreted in terms of how people in a wider setting might resist thoroughly attending to the issue. For participants, this might be thought of as representing their lived experience of a dilemma; the need to talk about sex, but no one asking or wanting to know.

Affirming gender

The surgical procedure was described in terms of bringing the body into alignment with an internal gendered self, affirming the female by which participants had long felt themselves to be characterised. Nicola's account of a discussion with her doctor post-operatively exemplifies this point:

> "And so I said I feel as though I've been like this all my life...it just feels so perfectly normal I, I can't think back to how it was before" (Nicola, 13-15).

Another participant indicates poignancy in the physical indicators of womanhood resulting from the combination of hormones and surgery, describing her experiences of pseudo-menstrual sensations. She recalls with apparent pride a health professionals' comment that:

> "if I didn't know your past I would just look at records of a healthy post-menopausal woman" (Cheryl, 107-108)

which she described as:

> "a feeling...like a wave lifted off my shoulders, it's just about being (Cheryl)...just being me at last" (Cheryl, 110-113).

Although the process was not so straightforward or indeed successful for all participants, they did share this sense of surgery bringing their gender as physically defined into line with its internal representation.

Loss of sex

Conversely, participants were clear that their surgery had not been about sex, although they frequently described how sexual experience had changed for them since surgery. This was often with a sense that other people might want to avoid the issue, as the researcher acknowledged she herself had done. As Nicola's comments:

> "I wondered whether you were going to touch on that, but you've steered clear of it...I think even my psychotherapists have stayed away from that one" (Nicola, 862-866).

Perhaps because of this perceived avoidance of the issue from others, some participants were tentative in their descriptions of what had been lost. This is evident in Carly's account of her sexual functioning post-operatively, in the context of having split from her former wife:

> "What's most important for me is relations. I'd like to have relations but I've never. I've met one or two individuals...nothing's every happened to a continuance" (Carly, 234-236).

Others were more explicit about what had been lost, for example Kate who spoke of not having felt confident enough to use her new anatomy sexually, and consequently the absence of sexual enjoyment in her life:

> "it's a bit sad really because...I still feel unfulfilled...it's like having the whole pie but not quite" (Kate, 702-704).

Theme (iv): No pain, no gain

Necessity of the choice

Participants were unequivocal about the necessity of their decision to have surgery, even those for whom the procedure was feared, or even viewed ambivalently. Kate's comments are an interesting example of this, because in her case there had been doubts about the extent to which surgery could address her difficulties. She explained that:

> "I realised that if I didn't go through with it now I would probably be back there in a year or two years time...and it kind of erm reconciled it...that it was an inevitability that it had to be done" (Kate, 92-97).

going on to say that:

> "it's closer than ever...to my picture of myself in my head...it's not quite harmony but it's close" (Kate, 143-146).

For others the function of the procedure was clearer cut:

> "for me it was just a necessity if you like, a way just to make things regular as it were" (Pam, 42-43).

The researcher interpreted these accounts in relation to the theme of surgery in context, reflecting that although surgery might only have been one part of the journey to becoming a woman, its significance was certainly weighted as a crucial, if not inevitable component of the process. Certainly there was something implicit in participants' accounts about what life would have been like without the surgery, as

though they would have continued to feel 'irregular', and physically discordant with their sense of self.

Aftermath of surgery

Although participants were resolute that their surgery had been necessary and that they would make the same decisions again, it was acknowledged that the intervention had not been undertaken lightly, and the prospect of a painful physical recovery had often been feared. The severity of post-operative pain varied across participants, concomitant with degree of distress. Fiona described her experience:

> "I'd not slept really and it was eight o'clock at night before I could get myself something to eat and then it was just cereal cos I couldn't stand up. I was in agony. Absolute agony and I thought, once or twice I nearly rang 999 cos I couldn't move without pain" (Fiona, 39-42).

The challenge of coping with complications was further highlighted by Betty's account of a post-operative physical problem:

> "The whole point of surgery was to make me better and on a very real level it has done, but on another level it's given me a problem that I didn't have before" (Betty, 465-467).

Returning to Fiona's account, we discover how post-operative physical pain had caused her to be reminded of the physical reality of her procedure, described metaphorically with her body as meat:

> "I get a picture of somebody cutting raw meat in my mind...like somebody chopping raw chicken or something or raw beef...sometimes it just infiltrates into the brain without thinking and it makes me shudder" (Fiona, 122-126).

The researcher recalled her own physical reaction to these words as they were spoken, evoking the sense that something horrendous had been inflicted on the body. Although Fiona had of course not witnessed the procedure, she was left with a very real physical pain which conjured fantasies of the surgeon's knife cutting into flesh. In this instance the imagery of meat was interpreted as functioning to psychologically distance the person from the reality of what was done to their body, although its unexpected infiltration into consciousness is suggestive of traumatic experience, and a reality that has not yet been sufficiently processed. This could be understood in relation to trauma that might potentially result from any type of major surgery, although in this case the particular nature of any trauma might be interpreted in relation to the psychological impact of lost manhood. Literally, these women had experienced having had the male part of themselves cut from their bodies, and however much this had been their desire, it is unsurprising that some might have been traumatised by the experience.

In addition to the experience of post-operative pain, participants also drew attention to perceived flaws in the provision of care after their surgery. Problems included limited access to experts in the field, limited choice as to the timing and specific nature of surgical intervention, and lack of a consistent named individual with whom to discuss any concerns. Instances of such criticisms tended to be brief and tentatively described, although post-operative physical health care was most explicitly appraised, as exemplified by Betty:

> "Aftercare of the patient...it's virtually non-existent if you don't live in (location)...and also getting easier access back in, you know when things go wrong" (Betty, 714-716).

Nicola echoed this opinion, referring to post-operative care as:

> "very much a postcode lottery as to where you live" (Nicola, 471).

In response to a prompt to comment on how this compared to psychological support post-operatively, one participant described this as

> "very resource constrained" (Pam, 613).

The language used in these descriptions was interpreted as potentially moderated by participants' awareness of the researcher's role in the NHS, inviting the possibility that spontaneously occurring accounts might have evidenced more passionate criticisms. However, it occurred to the researcher that in spite of perceived flaws, participants might defend against speaking at greater length about the challenges faced in service provision for two reasons. Firstly, many had extensive histories of contact with services, and might not have wished to appear ungrateful for the care received. Secondly, they might have felt uncomfortable acknowledging any negatives related to undergoing a procedure that was sought after for so long.

Participants had made use of different personal resources to cope with difficult experiences in the aftermath of surgery, although one which stood out in the data was the use of humour. Although not explicitly referenced by participants, humour was certainly a feature of their dialogue. Fiona's description of a conversation with a child after her surgery is illustrative of this point:

> "He says hello...did you used to be a man?...I said well yes I did. And he (laughs) and he asked his dad in the car that he'd seen me, last time he'd seen me as a man I was bald. How had I grown my hair? Did they plant seeds in my hair?" (Fiona, 622-626).

She goes on to explain:

> "I try and make it lightweight...I have some fun about it...I'm not in it for the laughs, but I can have a laugh about it as much as anybody" (Fiona, 630-633).

Another participant's humour has a more sardonic feel, interpreted as reflective of the personal strength evident in many participants' accounts in the face of adversity:

> "It's like I've been an actor in a long running comedy...and now I'm retired to be myself" (Cheryl, 303-307).

Theme (v): Caught in the middle

Whilst surgery had on the one hand affirmed participants' identities as women, on the other there was a sense of their male past lingering to leave them caught between two genders. Physical reminders of the old identity were often experienced as distressing, particularly those which were beyond people's control, such as height and stature. Comparisons were made with biological females, who were sometimes envied, for example in their capacity to bear children, and at these times the researcher keenly felt the impact of her own identity as a woman. Ultimately participants identified that their surgery had been limited to altering the external representation of their identity, which for some left them feeling incomplete; neither male nor female. On the other hand, surgery had facilitated a move closer to the female ideal, more aligned with the

person they saw themselves to be. Contradictions in accounts between the merits and limitations of surgery were interpreted as suggestive of how the intervention had been reconciled in participants' minds; for them the key issue was the necessity of the operation, therefore forcing its limitations to be rationalised and accepted as part of the experience.

Remnants of masculinity

Participants described with frustration how surgery had been unable to completely erase their former masculinity, for example due to continued growth of facial hair. In the following comment Fiona highlights her experience of needing to maintain the female aesthetic, poignantly set in contrast to the gender label she begins by ascribing to herself:

> "as a biological male, I've got routines I've got to go through in the morning when I get up and when I go to bed at night...I've got a wig you know, I'm bald...I've got to still shave my face...I don't like having to shave my face and it's not what people can see, it's what I can feel" (Fiona, 205-211).

Most distressing were those reminders which were beyond participants' control, as Kate suggests:

> "the three things for me are my height, my voice, and body hair...body hair I can do something about...the other two I can't...that's hard...I mean really everything is just a reinforcer that you're actually not female" (Kate, 419-429)

In Kate's comment there was a real sense of perceived injustice; she had done everything she could do to align herself more as a female, yet her efforts were belied by remnants of the unwanted identity. This was interpreted as a feeling of powerlessness about what could not be controlled, where surgery had at least offered the opportunity for some degree of influence, albeit limited.

Authenticity and comparison with natal females

Further to being reminded of their male past, participants continued to have concerns about their authenticity as women post-operatively, often making comparisons with biological females. The most emotive of these comparisons was in relation to childbearing, highlighting that surgery falls short of facilitating the choice of motherhood, as Nicola implies:

> "we've not had children...it's one of those things that we might have been blessed with I suppose" (Nicola, 457-459).

Cheryl's account is more explicit:

> "I feel that I should have been female from birth...I think I've been robbed of childbirth" (Cheryl, 346-348).

These experiences were interpreted not only as a limitation of the surgery, but as a loss, in that essentially their decision to have the operation had involved committing to a life without the choice to create new life. In reflecting on her own circumstances, the researcher was struck by how profound such as decision would be, and wondered at the potential pain involved in such a life-changing move.

Comparisons with biological women also came across from the interaction between participants and the female researcher, as Kate's comment exemplifies:

"For me to actually say that I was female would be being derogatory to you" (Kate, 453).

The researcher recalled with discomfort her reaction to this comment, as though she had been assigned an elevated status simply as a result of the accident of her birth. She was struck by whether the comment spoke of the inherent impact of feeling somehow inauthentic on a person's self-esteem, and whether it predisposed a greater likelihood of comparing oneself negatively with others.

Feeling different, feeling incomplete

For most participants, surgery had almost, but not quite, created a woman, and often there was a sense that they had been left feeling different and incomplete. This was explicit in participants' accounts to varying degrees, but also reflected more subtly in participants' interactions with the researcher. For example, the researcher recalls with some shame that there were instances where she felt confused about how to relate to the women, particularly when they recalled the more stereotypically male experiences of their past, as Fiona discussed:

> "I was born male. Very much so...I was a lad's lad and a man's man...I was the one that got stuck in physically..." (Fiona, 279-284).

At these times the researcher found herself imagining what kind of man they had been, and where this identity was now located. She was struck by whether other people might react similarly, in seeing these women both in terms of their current identity, but also the man they had previously been. Perhaps, ultimately, surgery could not erase the past,

but at best could fuse the two identities into something more palatably close to how they saw themselves to be. Kate uses a fascinating metaphor in her attempt to encapsulate this phenomenon:

> "if you get a Ferrari and you take the engine magnet chip inside it, but know that it's a Ferrari, and you take it and you put it into a Mini...then that chip still thinks it's a Ferrari...but it performs like Mini" (Kate, 133-139).

The researcher made sense of Kate's analogy as representing the male and female aspects of her identity, and the degree of synthesis between these two realities. It seems from her account she sees some aspects of her identity as impervious to intervention; that despite having become a woman, she still exists in some way as a man. To conclude, she explains:

> "so I think of myself really as a male woman...but as far as anybody else is concerned, I'm just a woman" (Kate, 444-445).

4. DISCUSSION

In the introduction to her polemic 'Gender Trouble', Butler (2007) stated that she sought to

> "undermine efforts to wield a discourse of truth to delegitimize minority gendered practices...this doesn't mean that all minority practices are to be celebrated, but it does mean we ought to think about them before we come to any kinds of conclusions (Butler, p.viii).

The current study aimed to think about such a minority practice, from the perspective of people who have completed surgery to change their gender from male to female. The study was designed to explore their lived experiences, inviting accounts of living with a gender identity that has been constructed in this way. Eight participants were recruited a minimum of six months after their surgery, and were interviewed by the researcher. Interviews were transcribed and analysed using an Interpretative Phenomenological Analysis (IPA) approach, focusing on both the content of the data, and its meaning and intention as presented by participants.

Participants in the study described long and sometimes painful journeys through changing their identity, seeking to emphasize surgery as a necessary but difficult choice. They explained how relationships had been redefined or even lost, although this seemed to have been rationalised by hope of new beginnings. Participants' decisions were not always accepted by others, and in telling their stories, there was a sense of wanting to educate, and be listened to and understood. Ultimately these women sought to portray themselves beyond the confines of the gender patient label; as women getting on with their lives despite the challenges faced. Perhaps surgery had not been the panacea they might have hoped for, and neither had it completely erased the past. Indeed even to label them 'women' failed to fully capture the reality of their experiences, which were described as somewhere between yet encompassing both male and female. Despite this participants wanted to communicate their feelings of determination, that despite the limitations of their surgery, they were committed to life moving forward in their constructed identities.

4.1 The results in relation to literature and theory

Participants wanted to talk about their difficulties and treatment in context, and not just from the perspective of them as individuals, but in terms of the social dimension of what had been experienced. Although they spoke about surgery as self affirming and personally necessary, it was also a social act: a way of fitting in and seeking acceptance. For some this might be used to evidence the continued intolerance of minority behaviours in society, such that a biological male whose internal sense of self is feminine must change his body in order to acceptably express femininity. Some theorists take this further, postulating that to do otherwise would be experienced as a threat to cultural norms:

> "doing gender in a way that does not reflect biological sex is a threat to heterosexuality" (Schilt & Westbrook, 2009).

Yet to view surgery in the case of gender reassignment as solely about fitting in, is to disregard how profoundly its effects were often found in the current study to be quite the reverse. Participants no longer fitted into their roles within marriage or as parents, or indeed into a distinct identity of either male or female. Perhaps again this reflects the inflexibility of societal rules; certainly it suggests that people who take the surgical route never do so lightly, and ultimately need to be aware of how profoundly and pervasively their lives, as well as those of people around them, are likely to change.

The need to understand more about the wider impact of gender reassignment is slowly being addressed through empirical research. For example, a study by White and Ettner (2004) investigated the effect of parental transition on children, finding evidence of behavioural and emotional difficulties as an expression of the child's struggle to adjust, particularly if parental transition occurred during the child's adolescence. With

children in this age group, some families experienced high levels of conflict, impacting on the young person's adaptation and development (White & Ettner, 2004). Erhardt (2007) looked at partnered relationships, specifically the accounts of women who had stood by their partner through their transition from male to female. The challenges faced by such couples were highlighted, including the issue of maintaining physical intimacy, and partners' struggles in adjusting to implications for their own identity, namely that of presumed homosexuality (Erhardt, 2007). Evidently there is increasing awareness in the literature that surgery seldom impacts on the individual in isolation, but rather on whole networks of people from partners and children, to friends and work colleagues. Further research might be useful to fully explore these dynamics, and indeed the wider context of society's conventions and values within which they exist.

From the perspective of their own understanding, participants indicated that surgery was about gender, not sex. At the same time their accounts illustrated the clinical relevance of surgery on sexual functioning, in that for many, enjoyment of sex had been lost following the procedure. This was a new finding in comparison to the existing research, which offers a mixed picture of sexual health after surgery, with some studies indicating post-operative improvement (e.g. Mate-Kole et al, 1990). In contrast, the current findings implied a myriad of potential difficulties, including that the surgically changed anatomy might be unacceptable to a partner, that there might be functional difficulties, or even physical pain associated with sex. Certainly the current findings indicated that people wanted to talk about their sex lives after surgery, and implied that the opportunity to do so had not always been forthcoming. Perhaps in asserting that their surgery had not been about sex, it had therefore been difficult for them to feel able to address how sex had been affected, and what support they might

need in adjusting to sex after surgery. This is an issue for the consideration of both future empirical investigation, and service providers offering post-operative care.

That gender reassignment is likely to be physically painful and potentially traumatic for some was evident in the current findings. A small number of studies have referred to these issues, for example De Cuypere et al (2005) who reported elevated levels of general health problems following male to female surgery, although confounding factors such as age and lifestyle were highlighted. Further research is required to examine the phenomenon of pain after gender reassignment more specifically, drawing upon the psychological dimensions highlighted in the current study, for example that physical pain might be exacerbated by the subjective experience of lost manhood. Furthermore, research in other contexts has demonstrated the interplay between experiences of pain and psychological ill health (e.g. Le Marchand & Raphael, 2008) which could be investigated in the context of gender reassignment. This might also be examined in relation to the psychological health of partners, and the extent to which they are affected by an individual's experience of post-operative pain or trauma.

Finally, the findings of the current study evidenced the inherent danger of viewing surgery to change one's gender as a panacea, suggesting that patients might need to come to terms with disappointments, and the reality of surgery perhaps not fully creating the woman they longed to be. The existing literature touches on patients' experiences of the limitations of gender reassignment, in that studies have shown patients' expectations prior to surgery are not always matched with the post-operative reality (e.g. De Cuypere, 2005). Equally studies have highlighted instances of particular dissatisfaction, for example in the functional results of surgery (Lawrence, 2006). The possibility that women who achieve their female identity in this way might continue to envy biological females is unexplored in the existing research, although the

phenomenon is implied in psychodynamic accounts of gender difficulties (e.g. Lothstein, 1979). Future research would be useful to further explore the meaning of being 'caught in the middle' between genders, investigating how this is accommodated from both the individual's perspective, and within their wider social context.

4.2 Methodological Issues

The sample

The findings of the current study resulted from an Interpretative Phenomenological approach to analysis, which emphasizes processes of sense-making and understanding idiosyncratic experience. Eight transcripts were analysed using this framework, although the same process could equally have been applied to a single case. The researcher wondered whether a smaller sample might have allowed for even deeper levels of analysis, or indeed whether the current data might in future be examined in greater detail using only one or two of the transcripts.

Other changes might have included widening recruitment to include a broader range of people, although this would have been incompatible with the aim of homogeneity as required for IPA, and would have necessitated alterations in the methodology. The researcher was however mindful that her sample was exclusively White British, and specific to a particular time and place. Given the social aspect of surgical intervention evident in the data, it would be interesting to perform a comparable investigation in the future, exploring the potential impact of cultural shifts in how gender is understood. Similarly experiences might be further contextualised by approaching the phenomenon systemically, for example through investigating lived

experiences within intimate relationships or the family in addition to individuals themselves.

The interview process

Semi-structured interviews were designed to elicit participants' accounts of their experiences, offering them the opportunity to elaborate on areas of interest in their own words, and pursue issues of particular pertinence to them. One disadvantage of this approach is that it could be argued to bias the data in favour of the researcher's agenda, and potentially miss important aspects of participants' lived experiences. This risk was evidenced in the finding that participants had wanted to discuss their experiences of sex, yet had not been invited to do so by the researcher, and were forced to decide whether or not to raise the issue themselves. Although on this occasion participants were able to ensure their experiences were heard, it is quite conceivable that for another group of people, such issues would have remained unexamined. Arguably refinement of a researcher's interview technique might guard against such potential bias, through ensuring questions are never leading, and that all lines of enquiry which emerge during an interview are given space to develop. Alternatively, a different approach such as facilitating a focus group or unstructured discussion as the basis for the data set might have addressed the issue, although this potentially would have compromised the sensitivity of findings to the question being investigated. Nonetheless, future studies might explore alternative options of data collection, considering the possibility of naturally occurring data sets, for example diaries, or even material on the internet such as entries made on discussion forums.

Validation of the analysis

Analysis of results was conducted by a lone researcher, inviting the possibility that findings may have been different had the data been examined within a team. Supervision was made use of as a space to generate and develop ideas based on the data, yet due to time constraints was conducted largely via e-mail and in writing. Validity of the findings might have been improved through increasing the amount of face-to-face supervision, where potential themes would arguably have been discussed more organically. Equally the researcher wondered how the analysis would have been affected had she been male as opposed to female, anticipating that a changed dynamic would likely have impacted on participants' portrayal of their experiences, and indeed how they were received by the researcher.

4.3 Clinical Implications

The main utility of the current findings will be to inform practice for those providing services for people with gender difficulties, be it in specialist clinics or professionals such as GPs who will encounter such types of presentation in their practice. Clinical psychologists, particularly those working in a sexual health context, may use these findings to inform their awareness of the issues facing the client group, or indeed other clients for whom issues relating to gender are a component of their presentation.

From a psychological perspective, there are a number of ways in which services might be improved to best support patients through the journeys they described. Individual differences were evident in trajectories through treatment, where at the one extreme surgery was seen an end point of the process, whilst for others it was only the beginning. This implies the importance of clinicians supporting patients to clarify what

they expect from the procedure, and to be emotionally prepared for the possibility that the hard work might begin after leaving the operating theatre. Although experienced clinicians are undoubtedly already practising in this way, it could be that at times consideration of these factors is overshadowed by a focus on the medical aspects of care.

That surgeries were social as well as individual acts, with a clear impact on patients' social worlds, suggests the importance of structuring services so that significant people in an individual's life can be included in the treatment process, should the client consider this useful. This might take the form of greater provision of information for families and partners, or even the invitation for them to have direct involvement with services, perhaps with the option of family or couples therapy where appropriate. Again this might be at the stage of preparing for the impact of surgery, or even as a resource to help families and partners cope in the aftermath of the procedure.

Patients appeared to want to feel more able to speak freely about their sexual health after surgery, and certainly the difficulties they reported they had encountered implied the need for the availability of support in managing problems related to sex. In some cases this might mean work with couples, supporting them to adjust to their changed physical relationship, perhaps facilitating them to grieve for what had been lost. For those looking to forge new intimacies, there might be help to gain confidence in the context of a new anatomy, and perhaps some form of peer support focused on issues relating to making new relationships after surgery.

Pain and potential trauma were issues pertinent to patients' experiences post-operatively, implying the importance of developing the nature and availability of aftercare, both physical and psychological. There was a sense that some patients felt

abandoned when their surgery was complete, in contrast to the lengthy input from services in preparation for the procedure. Improvements patients themselves suggested included better access to specialist support after surgery, greater empowerment through choice in their care options, and consistent involvement of a named clinician to see them through the process. Psychologically there might also be improvements in supporting patients with management of pain, and promoting greater awareness of the possibility of trauma following surgical intervention.

Finally, services would benefit from greater awareness of how the surgical re-construction of gender impacts on identity, and of the possibility that patients might ultimately perceive themselves as neither clearly male nor female after surgery. Support might involve facilitating acceptance of this conundrum, and perhaps the provision of space to work through any specific concerns, such as envy of biological women. Indeed the latter might even be addressed through biological and transgender women coming together in mutual support, possibility in the form of peer groups where experiences and reflections could safely be exchanged.

4.4 Conclusions

The current research sought to explore the lived experiences of people who have completed male to female gender reassignment surgery. Eight recruits were interviewed and their transcripts analysed using an IPA approach. The findings evidenced the different meanings and context of surgery in participants' lives, including accounts of what it did not represent, where participants distanced themselves from misconceptions about gender and sex. There was a sense that others might misconstrue the women's choices as reflective of some manner of deviancy, yet ironically participants' lives had

tended to involve reduced sexual activity after surgery, which was keenly felt as a loss to some. Sacrifices had also been made in the context of family and partner relationships, although there was hope for new and different social connections to be forged. Whatever the challenges faced, the women had generally done so stoically and with humour. Their lives were not perfect after surgery, and certainly there were instances where the researcher felt an uncomfortable awareness of her own womanhood in comparison to that of participants. These were women who had also been men, and their accounts implied with sadness that no intervention would be able to alter this fact. Yet ultimately, surgery had offered the reality of a life lived closer to womanhood; a result which on balance had been worth the journey. It is the intention that the findings of the current study will be of interest and importance not only for specialist gender services, but also to inform how gender frames people's lived experiences in a wider context. The current findings could be developed through further research in the area, perhaps from investigating a broader sample, or by contextualising findings through examining the experiences of people indirectly affected by surgery such as partners and family.

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PART THREE:

Critical Appraisal

Critical Appraisal

1. Choosing the project

In the first entry of my research diary, I asked myself: why have I chosen this unusual topic? What does it say about me, and how might the topic be viewed by others? At its conception the project was born out of my previous experience working in sexual health, and in particular links with a clinic which I knew to be active and supportive of research. On further examination I knew my interest ran deeper, in that I was attracted to the unconventionality of the subject matter, and even the possibility that some might find it shocking or provocative. Equally, my interest derived from a personal curiosity about female identity, and I found the prospect of comparing surgically created identities with my own experience of womanhood stimulating. As I progressed through the research process, I was struck by how the reality of participants' lives compared with my initial reactions to the subject. I felt myself move from someone looking in with curiosity on an unfamiliar world, to feeling I had almost spent time in participants' shoes, identifying with their journeys through establishing an identity. From this perspective, their stories no longer seemed shocking or subversive, but merely stories of people trying to live their lives as best they knew how. I wondered at whether some of the common prejudices and misconceptions about this group of people might disappear, if only the wider public had the opportunity to see through the eyes of others as I felt I had done.

2. Hopes and fears

Prior to the current study I had conducted relatively little formal research, and certainly nothing of similar depth or scale. As such I felt out of my depth at times, and

frustrated that the project as I had conceived it might not do justice to the subject matter. On the other hand, I was excited by the prospect of using a qualitative methodology, and considered it a good match both epistemologically and from the perspective of my identity as a clinician. That is to say, I was enthusiastic about the idea of approaching a phenomenon creatively and with imagination. Whether this was always borne out in reality is a matter for debate, and the experience of exercising ideas in a real world setting has certainly given me ample food for thought which will inform any future investigations.

3. Lessons in patience and pragmatism

The road from writing a research proposal to completing the final copy of this project felt long, and littered with obstacles and set-backs which tested my determination to see the study through to the end. It has been an education on learning to be patient, focused, and above all pragmatic, which I now feel are crucial characteristics of a successful researcher. At times when I found these qualities flagging in myself, I also learnt the value of good supervision, and the importance of an open dialogue with your supervisor.

At times when I felt hampered by external constraints and the pressure to meet deadlines, it was easy to forget that at the core of the project were real people, whose experiences I was ethically bound to represent as accurately and respectfully as I could. As such I experienced frustration when participants cancelled their interviews, or from having to exclude those who did not meet eligibility criteria. Again this taught me something of the need for patience in the research process, and to hold in mind that without participants' willingness to freely share their experiences, there would be no material to investigate.

4. Collaboration with services

The experience of working with a busy NHS clinic, relying on them to identify and make initial contact with potential participants, was more positive than I had imagined, and overall the process of recruitment ran smoothly. I felt this was facilitated in particular by the clinic's valuing of research, and strengthened by the researcher having existing links with the service. It demonstrated to me how important it would be to develop such a relationship as the foundation for any investigation, prior to attempting the process of recruitment. On the other hand, I was aware of the potential sensitivity of my resultant findings in this real-world context in a way that might not apply to other student projects, and mindful of being diplomatic at the same time as scientific. For example, I considered how I might handle matters were participants to highlight any perceived failings in their care, in a way which accurately represented findings without being received as unconstructively critical. As a Clinical Psychologist I also grappled with frustrations relating to what I perceived to be the over medicalisation of existing services for people with gender difficulties, which was reminiscent of my work in other settings where tensions exist between professional groups. Navigating these potential difficulties helped develop my negotiation skills, as well as strengthening my professional identity, which will certainly be of value for future research projects and clinical work alike.

5. Interviewing: restraint of the inner clinician

Completion of this project marked the end of several years of training in the core skills of assessing, formulating, and intervening for the purpose of alleviating people's distress. I found it very uncomfortable at times that my role as a researcher required me to put these therapeutic skills to one side, and focus on the task of drawing

out information. Equally I was unaccustomed to the brevity of contact with interviewees, being used to the luxury of developing an understanding of a person over a number of sessions. Thus the pressure to skilfully elicit participants' accounts of their experiences was keenly felt, alongside fears about unduly leading the dialogue according to my own agenda. Surprisingly I felt this experience not only enhanced my potential as a researcher, but also my skills as a clinician, in that I was reminded of the power of actively listening to people's stories, and allowing them to define the parameters of exploration.

As in clinical work, I found that some interviews flowed more successfully than others, just as I felt a greater sense of rapport with some interviewees compared to others. On reflection it may have been useful to look more closely at these dynamics, and to have incorporated this to a greater extent into the data analysis. However again I felt cautious about maintaining the stance of researcher, which may at times have been to the detriment of the interpretative process.

6. Tentative interpretations

My reading into Interpretative Phenomenological Analysis (IPA) as a methodology had left me excited about a creative approach to making sense of my data, however in reality I found myself fearful of deeply engaging with the process, and especially of imposing too much of myself on what participants had said. Equally there were times when I felt so immersed in the minutiae of the dialogue, I found it hard to make sense of the material conceptually. Although this is acknowledged as a common anxiety amongst researchers, I failed to be comforted because I was so aware of the ethical responsibility to do justice to participants' experiences as they had described them. Ultimately however, this may have functioned to maximise the validity of my

results, in so much that I was mindful of keeping the analysis close to the data. Whether this may have been better suited a different methodology, for example a Grounded theory approach, is open to debate, however on reflection I felt that I would have returned to IPA as the most appropriate method for capturing the idiosyncrasies of people whose experiences are so rare and under-investigated.

7. Writing up: Continuing the interpretative process

There were two main learning points which emerged from my experience of writing up the research. Firstly, I reflected that I may have been too hasty in beginning to write, in that having spent many hours poring through raw data, I was anxious about time passing without formal evidence of my analysis. Thus I eagerly began to formulate my ideas in written form, but perhaps prematurely and to the detriment of an exhaustive immersion in the data. However in my eagerness I experienced the second learning point, that the interpretative process continued through the write up stage, as labelling my ideas gave rise to new avenues of curiosity and reflection. Thus although I felt I might have benefited from approaching the analysis more steadily and patiently, I did at least in my eagerness embrace the possibility that the material would develop and evolve.

8. Balancing the professional and the personal

It would be unrealistic to assume that a project of such proportions could be undertaken without impacting on the researcher's private life, and indeed there were times when I felt exasperated by the task of completing the project, and resentful of its prominence in my daily consciousness. Certainly I was constantly aware of the data on some level at all times, occasionally generating an idea whilst performing an unrelated task. In order to manage this I found it very useful to keep a research diary, where I

could deposit thoughts, ideas and reflections and return to them at my leisure. Similarly the process of supervision was useful as a space for experimenting with these ideas, and just as in clinical work, deciphering to what extent issues related to my participants or to what I brought to the data. Hopefully in the final analysis I was able to synthesize and extract meaning from both of these perspectives.

The timing of this project added a further dimension to the analysis, in that as I was writing up my results I became aware that I was pregnant. This made me especially aware of my own identity as a woman, and the extent to which it would change as I approached motherhood. It also deepened my appreciation of some of the difficult decisions faced by people who surgically change gender, from the perspective of relinquishing the option to procreate. I was cautious as to how much this perspective might infiltrate my approach to the data, and was careful not to allow my awareness of the difference between myself and participants to overwhelm the meanings they attached to their womanhood. I was however curious about whether the material might have been changed in some way were participants to have known about my circumstances at the time.

9. On learning from participants

Even without the added dimension of developments in my own life as a woman at the time, the process of hearing participants' stories was a deeply moving experience. I had a sense that these women felt they otherwise were without a voice in society, and was humbled by their willingness to so openly and frankly talk about their lives, perhaps not knowing how their accounts might be received. Indeed, I was left with the impression that participants were truly grateful for the interest in their circumstances,

and had described their experiences with hope that lay people's understanding of gender issues might be improved as well as benefiting service provision.

At times I felt ashamed about my reactions to the women, be it because aspects of their stories shocked, or on occasions when I grappled with making sense of their identity in relation to what I understood of my own. Sex was particularly difficult to talk about, and even to write up in the analysis, as I resisted admitting my own prudishness about the issue. Equally I was reluctant to make explicit the differences between myself and participants, which I felt most keenly when writing about how they found themselves caught between categories of gender. I debated at length about whether this might be perceived as offensive to participants, mindful that they would eventually be an audience to the final analysis. I did not want to position myself as 'better', or 'more complete', and in thinking through these issues I came to realise that my own gender identity was perhaps more complex than I had previously imagined. I may have been born a female and been largely happy with this gender label, but this was not to say I had been impervious to confusion about ways of being a woman over my lifetime. I was reminded of a phrase in the literature about 'doing' gender, and the various ways in which gender might be seen as an act. Had I not myself subscribed to performing such an act, albeit one that was now so automatic and familiar? In this way, I felt that participants had not only realised their goal of educating on issues of their own gender experiences, but had equally taught me something of gender more broadly, which made sense to me as much as I imagined it might to any human being who considers themself to have a gendered identity.

10. Endings

As this project came to an end, I reflected on what I had learnt about gender, about the process of conducting research, and about myself as a researcher and an individual. The overwhelming feeling was one of pride in completing what had felt at times unachievable, together with a sense of privilege at having glimpsed something of participants' lived experiences and facilitated their stories to be told. Certainly I was left with a feeling of wanting to know more, and eager to promote the findings so that further research might address those new lines of enquiry generated by the data. I knew this would not have been the case had the material not moved me in some way, and indeed I felt changed as a result of the process: more aware of my womanhood, more aware of the struggles faced by others, and more confident in my ability to investigate such issues through empirical research again in the future. In fact, it was hard to know when to actually end the project, and to bid a final farewell to Diane, Kate, Nicola, Pam, Carly, Betty, Fiona and Cheryl, feeling that I had done justice to the accounts they gave of their lives.

APPENDICES

Appendix A: Summary of the main features of studies included in the literature review

Study ID, First Author, Year of Publication, Country	Study Type/Design	Participants	Aims	Analysis /Statistics	Conclusions
1. Kuhn, A. 2009 Switzerland	Case-control design. Data gathered retrospectively Visual Analogue Scale (VAS) to assess satisfaction & quality of life. King's Health Questionnaire to assess quality of life.	55 people who had undergone sex reassignment surgery (52 male-to-female, 3 female-to male). Comparison with 20 'controls'. Median age of gender group = 51, median age controls = 49.	To evaluate quality of life and satisfaction after sex reassignment in comparison to 'healthy controls'.	Analysis of differences between group means (*t*-tests), comparing gender patients with controls.	Scores on VAS (satisfaction & quality of life) significantly lower in the gender patient group compared to controls (but no validated data for pre-surgery). 'Physical and personal limitations' (King's Health Q) significantly more evident in post-surgery group compared to controls.
2. Johansson,A. 2009 Sweden	Repeated measures before and after surgery, longitudinal. Clinical interview used as assessment tool and Global Assessment of Functioning (GAF scores)	32 patients who had completed their surgery. Comparison with 5 subjects in the process of surgery & 5 who had discontinued surgery. Mean age = 43 yrs.	To evaluate outcomes of surgery in terms of symptoms of dysphoria, patient satisfaction, social functioning, work, relationships and sexuality.	Descriptive statistics, comparison of pre- and post operative scores.	Clinician's findings of 60% of patients showing improvement in global functioning, 95% from patients' perspective. 95% of patients satisfied with their

					experiences. No evidence of regret, although some discontent with surgical outcomes.
3. Udeze, B. 2008 UK	Repeated measures, using SCL-90R as measure of psychological functioning	40 people within six months of completing male to female surgery Mean age = 47.33 yrs	To assess psychological functioning pre and post surgery	Analysis of differences between the means of pre and post operative SCL-90R scores (*t*-test), inc. total scores & sub-tests.	No significant evidence of changed psychological functioning following surgery.
4. Weyers, S. 2008 Belgium	Retrospective, evaluating post-operative mental health. Comparison with general population (using existing data as reference)	50 people who had undergone male to female surgery ≥ 6 months earlier Mean age = 43.06 yrs	To assess mental health post surgery	Distributions between groups compared	Overall perception of good mental health post-operatively, no significant differences with general pop, except: some evidence of specific difficulties in sexual health for post-operative group.
5. Lobato, M. 2006 Brazil	Retrospective	19 people who had undergone male to female (18) and female to male (1) surgery. Mean age = 31.21 yrs.	To examine the impact of surgery on sexual health, partnerships and r'ships with family members.	Results from a service-developed questionnaire presented descriptively. Statistical significanc	Trends of positive effect of surgery on sexual functioning, partnerships and family relationships, although not uniformly.

				e calculated using non-parametric McNemar's test .	
6.DeCuypere,G. 2006 Belgium	Retrospective	62 people who had undergone male to female (35) and female to male (27) surgery. Mean age = 41.4 yrs (male to female), 33.3 yrs (female to male)	To assess psychosocial outcomes at least 1 yr post-operatively .	Correlational, multiple regression analysis with prognostic factors	Positive effect of surgery on dysphoric symptomatology, evidence of good social adaptation, absence of expressed regrets. Pre-operative psychological difficulties associated with poorer outcome. Attempted suicides more common following male to female surgeries. Better surgical results associated with better psychological outcomes.
7.DeCuypere,G. 2005 Belgium	Retrospective, 'long-term follow-up'	55 people who had undergone male to female (32) and female to male (23) surgery.	To evaluate general and sexual health outcomes post-operatively .	Analysis of distributions between groups (chi-square), *t*-test statistics	Improvements indicated psychosocially but less so in terms of physical and sexual health.
8. Lawrence, A. 2005 USA	Retrospective	232 people who had undergone male to female surgery.	To evaluate sexual health and relationships outcomes	Chi-square statistic, Stuart-Maxwell test of marginal	Some evidence of shift in sexual behaviour after surgery, e.g. changed

		Mean age = 47 yrs.	post-operatively	homogeneity. Described as 'descriptive & exploratory', so no adjustments made for multiple comparisons	sexual preference, decreased sexual activity, low prevalence of partnered relationships post-operatively.
9.Lawrence, A. 2003 USA	Retrospective	232 people who had undergone male to female surgery, at least 1 yr post-operative	To evaluate outcomes of surgery in terms of satisfaction or regret, identifying factors associated with such outcomes.	Correlational (Spearman rank-order)	Reported high levels of post-operative satisfaction, a small minority of participants expressed 'occasional regrets'. No significant associations between pre-operative participant characteristics and outcomes post-operatively.
10. Smith, Y. 2002 The Netherlands	Repeated measures, Rorschach protocol pre and post-surgery	19 young people who had undergone male to female (6) and female to male (13) surgery. Mean age = 22.5 yrs.	To assess post-operative psychological functioning in people who had sought surgery as young people.	*t*-tests to compare differences between pre- and post-surgery measurements (Rorschach Comprehensive System variables)	Significant decrease in 'distorted perception' and 'idiosyncratic perception'. No evidence for deterioration in psychological functioning.

Appendix B: Guidelines to authors for journal targeted for literature review

Journal: Sexual and Relationship Therapy: International Perspectives on Theory, Research and Practice (Routledge).

General guidelines

- Papers are accepted only in English. American or British English spelling and punctuation is acceptable provided usage is consistent throughout.
- A typical article will not exceed **6,000 words**. Short communications and case reports, will be limited to two journal pages (approximately **1200 words** including tables and references). Papers that greatly exceed these limits will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgments; appendixes (as appropriate); references; table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- The first page should include the title and contain an Abstract of not more than 200 words. The second page should repeat the title as the heading to the start of the main text of the paper. All pages should be numbered.
- Each paper should have up to six keywords.
- Section headings should be concise and numbered sequentially, using a decimal system for subsections.
- All the authors of a paper should include their full names, affiliations, postal addresses, telephone and fax numbers and email addresses on the cover page of the manuscript. One author should be identified as the Corresponding Author.
- Please supply a short biographical note for each author (50 words).
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms should not be used.
- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

Appendix C: Participant Information Sheet

Participant Information Sheet

Study Title:

'**Self-made Women: The (re) Construction of Self following Male to Female Gender Reassignment Surgery'**

We would like you to take part in a research study. Before you decide whether to take part you need to understand why the research is being done, and what it would involve for you. Please take some time to read the following information carefully. You may wish to discuss the study with others to help you make your decision.

Please ask us if there is anything that is not clear, or if you would like further information. Take your time in deciding whether or not you wish to take part.

What is the purpose of the study?

The purpose of this study is to find out more about the lives of people who have surgically changed their gender identity from male to female. The study is being carried out in partial fulfilment of the award of Doctorate in Clinical Psychology.

Why have I been invited?

You have been chosen to take part in this study because you have been through the process of surgical gender reassignment, and we are interested in finding out more about your experiences since this took place. People who have been through a similar experience are also being invited to take part, and it is hoped that we will be able to include at least eight people in the study.

Do I have to take part?

It is entirely up to you to decide whether you wish to take part in the study. We will describe the study and go through this information sheet, which we will then give to

you. We will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without the need to give a reason. This would not affect the standard of care you receive.

What will happen to me if I take part?

The study involves attending the clinic for an interview, which will last for approximately one hour. It might be possible for this to take place in your home, if this is more convenient for you. The interview will involve a researcher asking you some questions about your experiences since having surgery, for example about returning to work, and relationships with partners, friends and family. A guide to the kind of topics you might be asked about is available for you to read through before taking part in the interview.

Your interview will be audio-taped so that what you say can later be written down by the researcher. Both audio-tapes and written material will be coded so as not to reveal your personal details, and securely stored. Once the study has ended these materials will be destroyed. All information will be treated confidentially and not passed on to a third party.

Expenses and payments

In acknowledgement of your valuable contribution to the study, you will receive a £10 gift voucher as a 'thank you' for taking part. In addition, we are able to reimburse any travel expenses reasonably incurred as a result of your participation in the study.

What will I have to do?

There are no further requirements of you other than taking part in your interview with the researcher, and you are of course free to decide whether or not you wish to answer the questions put to you.

What are the possible disadvantages and risks of taking part?

There are unlikely to be any significant disadvantages or risks involved in you participating in this study, other than the possible inconvenience of you taking time

out from your usual activities to participate. There is a small risk that during the interview you may experience discomfort such as embarrassment or distress as a result of the issues raised, however this risk has been minimised by ensuring that you are aware in advance of the types of areas which will be covered. In the event that you do become distressed, the interview will of course be stopped immediately and the researcher will ensure you have access to the appropriate support.

What are the possible benefits of taking part?

Although we cannot promise that the study will help you as an individual, it is hoped that the information we get from this study will help in the development of services for people who have been through experiences similar to yourself.

What if there is a problem?

Any complaint about the way you have been dealt with during the study, or any possible harm you might suffer, will be promptly addressed. If you do have concerns, you should first speak to the researcher by telephoning 0116 223 1639, and they will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details of this are available at the clinic.

In the unlikely event that something does go wrong and you are harmed during the research, and this is due to someone's negligence, then you may have grounds for a legal action for compensation against the sponsor, which is Leicestershire Partnership NHS Trust. However, you may have to pay your own legal costs. The normal NHS complaints mechanisms will still be available to you (if appropriate).

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice, and all information about you will be handled in confidence.

The audio-tape and written materials from your interview will be stored securely and coded so that your personal identity is protected. Once the study is completed this data will be disposed of securely.

What will happen if I decide not to carry on with the study?

If you withdraw from the study but have completed some of your interview, we may use the data collected up to your withdrawal when writing up the results of the study.

Involvement of the General Practitioner (GP) / Family doctor

It will not be necessary to inform your GP/family doctor of your participation in this study, apart from in circumstances where you may have be harmed as a result of taking part, or require follow up support.

What will happen to the results of the research study?

The results of the study will be published as a thesis document, and also submitted for publication in relevant scientific journals. A 'newsletter' will also be provided for participants and patients and the clinic who might be interested in the findings.

Direct quotations from your interview may be included as part of the results of the study, however your personal details will not be used, and we will make sure that you cannot be identified as a result of any quotations.

Who is organising and funding the research?

This research is being sponsored by Leicestershire Partnership NHS Trust.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your safety, wellbeing, rights and dignity. This study had been reviewed and given favourable opinion by South Yorkshire Research Ethics Committee.

Further Information and Contact Details

Any further information about this research project can be obtained from the Chief Investigator of this study, Katie Oakley, whom you can contact on 0116 223 1639. You might also wish to seek advice on whether to participate in the study, which could be from staff at the Porterbrook Clinic on 0114 271 6671, or your local Patient Advisory Liaison Service (PALS) who can be contacted on 0114 271 8768 or via their website at http://www.pals.nhs.uk

Appendix D: Interview Schedule

Interview Topic Guide

Introduction for participants:

"I am interested in understanding the experiences you have had since having surgery to change your gender. I would like to explore what it has been like for you to live with a changed gender identity, and how you have made sense of your experiences".

Topic points for semi-structured interview:

- The experience of having completed their surgery to change gender
- View of self after surgery; the experience of a changed identity
- The experience of physical change from male to female; what are the psychosocial consequences of this change? What does it mean to the individual to have become a woman in this way, and how is this experienced?
- Life after surgery; going back to work, resuming everyday activities?
- Relationships after the surgery; experiences of relating to family, friends, partners?
- Appraisal of experiences; is life after surgery as they had imagined? Are there any key challenges / benefits resulting from their experience of changing gender identity?

Example questions

- "Talk me through your experience of what it was like to have completed your surgery to change gender"

- “What has been your experience of having changed your gender identity in this way?”
- “How did you experience the transition from being physically male to female?”
- “What has been your experience of living as a woman after surgery? How does this compare to your experience of life as a man?”
- “How did you experience resuming everyday activities with your changed gender identity? For example, what was your experience of returning to work?”
- “What has been your experience of family life since the surgery?”
- “What has been your experience of relationships with friends since the surgery?”
- “How have you experienced life with your partner after changing your gender identity?”
- “How do your experiences of life after the surgery compare with your hopes/expectation prior to having been through it?”
- “Describe any challenges you have faced since completing the surgery”
- “Describe what you feel have been any positive consequences of the surgery in your life”

General Prompts

- Can you tell me a bit more about that?
- Would you like to elaborate on that point?
- What was that like for you?
- How did that make you feel?
- Can you give me an example?
- What is the significance of that for you?
- How has that affected you?

Appendix E: Ethics correspondence

LETTER (i)

Full title of study:	**Self-made Women: The (re) Construction of Self following Male to Female Gender Reassignment Surgery'.**
REC reference number:	**09/H1310/22**

The Research Ethics Committee reviewed the above application at the meeting held on the 30 April 2009. Thank you for attending to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

Document	*Version*	*Date*	
Interview Topic Guide	1	25 February 2009	
Participant Consent Form	1	25 February 2009	
Participant Information Sheet	1	25 February 2009	
Protocol	1	25 February 2009	
Investigator CV			
Application		02 March 2009	

Discussion

It was observed that it was mentioned in the submission that home visits might be taking place but it was pointed out there was no mention of this in the Participant Information Sheet (PIS) and it was felt that details should be included in relation to the possibility of a home visit. You explained that ideally you felt it would be preferable to interview participants in clinic but added that should a home visit be involved you were

aware of and would comply with the Trust's Lone Worker Policy. The committee accepted the clarification in relation to the Lone Worker Policy but requested that the necessary information in relation to home visits be included in the PIS.

It was observed there was no peer review comments submitted in relation to the scientific critique of the study. You confirmed that there were some e-mail comments available that you could forward. The committee requested that these comments be submitted.

It was queried what support arrangements were available if any of the participants became distressed. You explained that if anyone became seriously distressed you would contact their GP. If there was a crisis situation you could contact Crisis Intervention. There were also several charitable groups who had links with the clinic that could be contacted if necessary to provide support for participants. The committee accepted this explanation.

It was queried whether participants' GPs were to be informed of their patient's inclusion in the study and you explained that you were not going to routinely inform the GP but if any participant disclosed as a result of the interview that they might harm themselves in any way, then the GP would be informed. The committee accepted this explanation.

It was observed that participants were to be recruited from six-months post-op up to ten years post-op and it was queried whether you had considered that someone who was ten years post-op might have a very different view from someone who was six months post-op. You accepted the committee's point but observed that there would be a relatively small number of participants available to take part in the study and agreed that whilst you felt it was somewhat of a compromise to include such a wide range of participants, it would be preferable to do that, rather than carry out the study with just two or three participants. The committee accepted this clarification.

You were asked to give a brief explanation of the "snowball" sampling method that would be used and explained that there were strong community links via the clinic for people who had undergone gender reassignment. The clinical lead at the clinic would make people aware of the study that was being carried out and ask whether they would like to be given more information, or whether they knew anyone who they thought might like to take part. If so, they would be given your contact details. The committee accepted this explanation.

You were asked to provide more information in relation to the "Newsletter" that was referred to in the application and explained you intended to prepare a Newsletter in order to feed information about the results of the study back to the people who attended the clinic. You felt that clients who accessed the clinic would not necessarily see any journals etc and wanted to provide some information in layman's terms that was accessible for those who were interested on the topic, to see. The committee accepted this explanation.

It was observed there were some minor amendments required to the PIS details of which are listed below.

Provisional opinion

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chair.

Further information or clarification required

- Provide a copy of the email comments in relation to peer review

- Indicate in a written response letter that you should have answered "Yes" to Question A46 on the application form

- Submit amended PIS (Version 2 with a new date) as follows:
  - Insert the study title at the beginning
  - Under the heading "What will happen to me if I take part?" include information in relation to the possibility of the interview taking place in the participant's home.

- Under the heading "Who has reviewed the study amend "Bradford" to "South Yorkshire"
- Under the heading "Further information and contact details" include details for the Patients Advisory Liaison Service (PALs)

The REC has nominated the Co-ordinator Mrs J Brown to be the point of contact should you require further clarification upon receipt of this letter.

When submitting your response to the Committee, please send revised documentation where appropriate **underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.**

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 03 September 2009.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

09/H1310/22	**Please quote this number on all correspondence**

Yours sincerely

Jo Abbott

LETTER (ii)

Study Title:	**Self-made Women: The (re) Construction of Self following Male to Female Gender Reassignment Surgery'.**
REC reference number:	**09/H1310/22**
Protocol number:	**1**

Thank you for your letter of 18 June 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*	
Interview Topic Guide	1	25 February 2009	
Participant Consent Form	1	25 February 2009	
Protocol	1	25 February 2009	
Investigator CV			
Application		02 March 2009	
Letter confirming the answer to Question A46 should have been "yes"		18 June 2009	
Response to Request for Further Information		18 June 2009	
Participant Information Sheet	2	15 June 2009	
Peer Review			

Covering Letter		18 June 2009	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

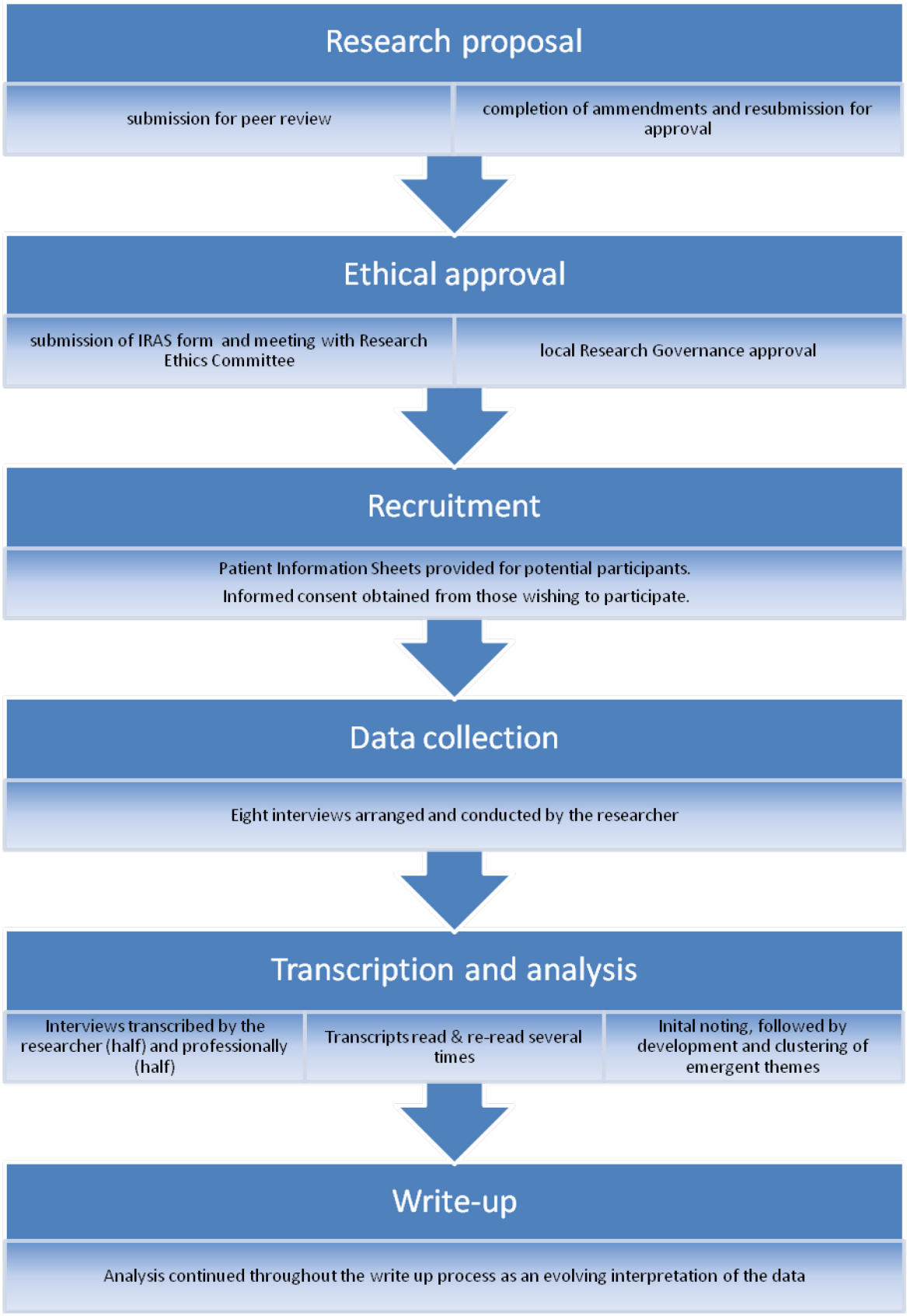
- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H1310/22	**Please quote this number on all correspondence**

Appendix F: Overview of the research process



Appendix G: Example of a coded transcript (extract)

NB: initial noting/exploratory comments in brackets, italicised. Emergent themes in brackets, italicised and underlined.

Participant 4

I: Yeah, I think that's recording...

P: Ok

I: Yes, that's fine. (pause) Ok, so P4 I'm interested erm in understanding the experience you've had since you've your surgery to change your gender.

P: Mm

I: Erm and what it's like to live with a changed identity.

P: Mm

I: Em, so the first thing really just a general question, if you just talk me through perhaps the experiences you've had since you've had your surgery to change your gender.

P: Purely since? *(Participant seems to wonder: why is emphasis post-op? Did a lot happen before this which was significant to her...more significant perhaps?) (Surgery in context?)*

I: Yeah

P: Oh well I suppose life to me wasn't that different; it hadn't been that different in as much as erm I was very late going to surgery due to a number of er mistakes made in the, in the er arrangements. *(Life wasn't that different...describes surgery as 'late', as though there were a 'right' time: when might this have been? Mistakes were made: communicating obstacles*

that were faced?) (Similarities between life pre and post op. A journey involving obstacles and 'right' timing).

I: Mm

P: Erm and I was er, oh I was at least 18 months to 2 years but I've been living as er a female for the best part of a decade. *(Portrays her identity as female without the op: surgery as not the most significant factor?)(Affirming female identity)*

I: Yeah?

P: By the time I finally made; because I took the view, unlike a lot of TSs, I very much took the view that the surgery was, was not, not the pinnacle, the be all and end all, the eventual end result. The result for me was to be integrated into female society and accepted as such. *(Suggesting identity as relative to other people. Surgery not the pinnacle. Sense of significance of being accepted by others, especially other females...reference to biological females, and positioning of self relative to this?)(Surgery in context; not necessarily a 'pinnacle'. Acceptance and comparison within female society)*