# The Relationship Between Gender Congruence, Social Support and the Mental Health of Transgender and Gender Non-Conforming Individuals in Ireland.

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Submitted in partial fulfilment of the requirements of the Higher Diploma in Psychology at Dublin Business School, School of Arts, Dublin.

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# Declaration

‘I declare that this thesis that I have submitted to Dublin Business School for the award of HDip Psychology is the result of my own investigations, except where otherwise stated, where it is clearly acknowledged by references. Furthermore, this work has not been submitted for any other degree.’

Signed: Sara Holbrook

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Date: 22/03/2019

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## Abstract

This study explores the relationships between gender identity and the mental wellbeing of transgender and gender non-conforming (TGNC) individuals in an Irish context. This correlational study aimed to find significant relationships between gender congruence, gender related wellbeing and life satisfaction, social support, anxiety and depression. Participants were asked through social media to take an online survey. The sample consisted of people currently living in Ireland, who do not identify with their assigned sex. The results found a significant correlation between gender congruence and gender related wellbeing and life satisfaction. High levels of anxiety and depression were reported as well as high levels of social support. This reflects the literature that TGNC individuals experience higher rates of depression and anxiety. It does not reflect the literature that states that social support acts as a protective factor against anxiety and depression. This suggests that peer-specific support may be needed.

# Introduction

Transgender is a term that refers to those whose gender identity or expression differs from their assigned sex at birth (Chen, Granato, Shipherd, Simpson & Lehavot, 2017). Transgender males are people who were assigned female at birth, based on their primary sexual characteristics, but who identify as male. Transgender females are people who were assigned male at birth, based on their primary sexual characteristics, but now identity as female instead (Jones, Bouman, Haycraft & Arcelus, 2018). Some transgender people may also identify between or outside the binary gender spectrum, in that they do not identify as either fully male or female or may identify entirely outside of normative gender binaries (Jones et al., 2018). Gender identity exists irrespective of biological sex and sexual orientation, meaning that a person can exist anywhere on the gender continuum (Weir & Piquette, 2018). People often make heteronormative assumptions about others – inherent in these assumptions are beliefs that biological sex, gender identity, and sexual orientation are congruent (Weir & Piquette, 2018). This means that to come out as transgender is defying these heteronormative assumptions.

Despite the fact that there has been an increase in the visibility of Transgender and Gender Non-Conforming (TGNC) stories on television and in cinema, for instance Caitlyn Jenner, *Transparent*, and *The Danish Girl* (Bouman, de Vries, & T'Sjoen, 2016), there is still little research, education and clinical training specific to transgender health care (Sloan, Berke, & Shipherd, 2017). While studies have been carried out that demonstrate the positive impact of gender affirmation on mental health (Melendez & Pinto, 2007) (Sevelius, 2013), there has been little research carried out in an Irish context. Bouman, de Vries, & T'Sjoen, (2016) argue that the significance of the increase in prevalence of gender dysphoria and gender incongruence should not be underestimated, as it indicates the level of further future

demand for clinical services. This paper takes into account the need for research and services to facilitate the increased prevalence of people identifying as transgender or outside the binary system of gender.

To contextualise the current study, Ireland was the first country to legalise same-sex marriage by popular vote in 2015 (Hilliard, 2015). While sexual preference and gender identity are distinct from each other (Dickey, Hendricks, & Bockting, 2016), this referendum demonstrated a country willing to become more open and accepting of individual difference. In the same year, the Irish Government passed the Gender Recognition Act into law. This act enables transgender people to gain legal recognition of their preferred gender and it also allows for the acquisition of a new birth certificate that reflects this change (Gender Recognition Act, 2015). Despite this activity in terms of lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) rights there has been relatively little research conducted in an Irish context. This study is attempting to engage in this time of change and raise questions and explore ideas surrounding transgender mental health in Ireland and Northern Ireland. Northern Ireland has similar legislation to Ireland in terms of LGBTQ rights. Transgender rights in terms of employment are protected under the Sex Discrimination (Gender Reassignment) Regulations (Northern Ireland) Order 1999 (Breitenbach, 2004).

Along with the increased visibility of TGNC people there is an awareness of the psychological issues that can accompany gender identity issues. TGNC individuals are often more vulnerable to certain psychological issues including depression, low self-esteem and suicidal ideation (Glynn et al, 2016). Budge, Adelson and Howard (2013) argue that TGNC individuals report higher levels of depression and anxiety than the average population. They highlight the fact that within the literature, for TGNC people, the rates of depression range from 48% to 62%, while anxiety and overall distress rates range from 26% to 38% (Budge,

Adelson & Howard, 2013). One study found higher levels of prejudice events were associated with higher levels of self-stigma and expectations of rejection (Timmins, Rimes & Rahman, 2017). These higher levels of self-stigma and expectations of rejection were associated with greater rumination, and such rumination was associated with higher levels of psychological distress (Timmins, Rimes & Rahman, 2017). This vulnerability to mental distress similarly highlights the need for more research into TGNC individuals and their mental health.

While therapy and counselling play an important role in helping to resolve psychological issues, it is also worth noting that there needs to be a focus on educating clinicians in line with best practice for helping with issues that arise as a result of gender identity (Bettergarcia and Israel 2018). Bettergarcia and Israel (2018) explore the way in which TGNC people may have specific experiences with therapists because of their TGNC identity. TGNC people may cover topics such as gender identity, minority stress concerns, or coping with stigma related to their TGNC identity within therapeutic sessions (Bettergarcia & Israel, 2018). Benson's (2013) research highlights the lack of training and education therapists receive regarding gender identity. Benson (2013) interviews TGNC clients and identifies various factors that they found unhelpful or frustrating while seeking therapy. These issues include feeling as if they are wasting money as they must teach therapists about TGNC issues and also encountering clinicians that are unclear on the difference between sexual orientation and gender identity (Benson, 2013). Additionally, there are concerns about being misunderstood and stereotyped because of the lack of education that therapists receive about TGNC issues as well as feeling as if the diverse experiences of TGNC people are ignored (Benson, 2013). This study demonstrates the need for more research on the vast

experiences of TGNC individuals in a variety of contexts so that there is more awareness and education on TGNC issues.

*Discrimination*

Transphobia is a type of discrimination that exists against those who do not adhere to the societal view that biological sex and gender are the same and that males/men are on one end of the binary and females/women are on the other end (Weir & Piquette, 2018). This represents a lack of education and understanding surrounding individuals who do not adhere to the strict binary system of gender. One of the reasons for the high rates of depression and anxiety within the TGNC population occurs as a result of internalised transphobia (Bockting & Coleman, 2007). This results from the internalizing of negative messages based on societal expectations of what is considered to be normative behaviour (Bockting & Coleman, 2007). Sánchez and Vilain's (2009) findings suggest that the internalization of negative feelings regarding a TGNC identity can be detrimental to an individual's wellbeing.

Research show that repeated experiences of discrimination, victimization, and rejection can lead to expectations of similar, future negative experiences which can thus lead to an increase in social anxiety symptoms (Roberts, Schwartz, & Hart, 2011). By not receiving affirmation of their gender identity, individuals might experience embarrassment, shame, or a threat to safety, which may lead to avoidance of or anxiety surrounding social interactions (Butler et al., 2018). This is a representation of internalised discrimination which manifests itself in a fear of rejection and in some cases a fear for their physical well-being which naturally leads to individuals feeling wary of social situations (Butler et al., 2018). Butler et al.'s (2018) research shows that based on previous negative interactions in which their gender identity was not affirmed, fear of future social interactions is generated.

Discrimination can also lead to depression and suicidal ideation. Tebbe and Moradi's (2016) study found that 71.9% of participants reported that they had thought about suicide in the last year. These results demonstrate the need for intervention and prevention efforts in order to reduce depression and suicide risk in TGNC populations (Tebbe and Moradi, 2016). This study also related the high rates of depression with discrimination. The study simultaneously examined experiences of prejudice and discrimination, internalised antitrans attitudes and fear of antitrans stigma in relation to depression (Tebbe and Moradi, 2016). Tebbe and Moradi (2016) highlight the importance of considering these three areas of discrimination when considering risk factors for suicide in TGNC populations. This study also demonstrates the need for education of clinicians in terms of TGNC issues. Clinicians must attempt to reverse the antitrans societal assumptions they have acquired in order to allow clients to explore and resolve internalised transphobia that might be contributing to their distress (Tebbe and Moradi, 2016). It is important to note that while TGNC individuals may suffer the same mental health concerns as others, these concerns can be worsened through discrimination (Butler et al., 2018). Alternatively, though TGNC individuals may present with various mental health concerns in which gender identity may not impact mental health or social problems (Weir & Piquette, 2018).

*Protective Factors*

Pflum, Testa, Balsam, Goldblum, and Bongar (2015) argue that a sense of connection to others can serve as protection against depressive symptoms that result from transphobia. McLemore (2018) argues that there are several protective factors that can alleviate the distress caused by misgendering. The frequency with which participants in McLemore's (2018) study reported being misgendered was associated with depression-related symptoms, stress and perceiving more transgender stigma in their society. The findings also suggested

that transgender people who are misgendered more frequently have weaker social support networks or alternatively social support has the protentional to minimise people's exposure to hostile environments (McLemore, 2018). Internalised transphobia can hinder an individual's ability to connect with others in the TGNC community which can prevent them from benefiting from the protective nature of connection (Sánchez and Vilain, 2009).

*Social support.*

This is where social support plays a significant role, the emotional support received by family and friends can act as a barrier to the mental health issues that may arise as a result of discrimination. The importance of social support is not unique to the TGNC population, it is an integral aspect of human beings, who begin to form attachments from birth (Bowlby, 1969). Research findings clearly state that the more social support an individual receives, the less distress they will experience (Budge, Adelson & Howard, 2013). This, again, highlights the importance of social support, particularly for TGNC individuals who may require more social support as they face the challenge of operating outside societal gender norms. Bockting, Miner, Swinburne Romine, Hamilton and Coleman (2013) highlight the importance of social support, self-acceptance, and integration of minority identity in order to ameliorate minority stress. Integrating into a community of peers can allow for social support and self-acceptance which essentially eliminates the minority aspect thus allowing for a decrease in depression and anxiety (Bockting et al. 2013). This also highlights the importance of peer groups and support services for TGNC individuals.

*Gender affirmation.*

Gender affirmation plays an important role in protective factors for the mental health of TGNC individuals. The framework of gender affirmation is centred on the process by which individuals are affirmed in their gender identity by their everyday social interactions

(Sevelius, 2013). There is a need for outward acceptance of their gender identity and Sevelius (2013) argues that those who have the greatest need for gender affirmation and the lowest access to it are the individuals who are most at risk of negative health outcomes. TGNC affirmative approaches help to counter discrimination by validating and supporting gender identity and are now considered to be the best option for TGNC care (Austin, 2018). TGNC individuals who have higher gender affirmation are likely to have higher gender congruence as their gender identity becomes more aligned (Jones et al., 2018).

In order to receiver gender affirmation the individual will likely have experienced coming out as TGNC in some form. The process of recognising, acknowledging, developing and accepting a TGNC identity is a multistage process that does not take place in a linear fashion (Morgan & Stevens, 2008). These stages can include awareness, seeking information/reaching out to others, disclosure to significant people in their life, exploration with identity and self-labelling, exploration of transitioning including appearance and possible gender affirming body modification, for example hormone therapy or surgeries, and finally a feeling of integration and eventually acceptance (Schimmel-Bristow et al., 2018). Bockting et al. (2013) argue that through the process of coming out, people can overcome negative self-evaluation and learn to cope with the adverse effects of minority stress. They are essentially arguing that coming out can lead to greater gender congruence as the individual's outward appearance begins to align with their preferred gender.

Medical affirmation refers to any medical action taken that will allow the individual's outward appearance to reflect their internal identity (Glynn et al., 2016). Jones et al.'s (2018) study found that TGNC individuals who had not undergone any gender affirming medical interventions reported worse outcomes on the Gender Congruence and Life Satisfaction (GCLS) scale, than both cisgender people and TGNC people who had received hormone

treatment and undergone genital surgery. These findings support previous research that has shown patients to report less distress with their gender, lower levels of body dissatisfaction, better mental well-being, and greater life satisfaction after they had undergone gender affirming surgery (Jones et al., 2018). Medical affirming procedures can also reduce experiences of gender non-affirmation, rejection, discrimination, and victimization by bringing physical characteristics in line with binary gender norms (Butler et al., 2018). Butler et al. (2018) propose that this could lead to a decrease in anxiety as aligning physical characteristics can lessen an individual's negative expectations for social interactions and increase an individual's ability to safely and freely engage socially.

It is possible that the link between medical affirmation and lower rates of depression and anxiety are as a result of the community involvement and support that often surrounds these medical interventions. Butler et al. (2018) highlight that the completion of such a medical intervention may suggest that the individual is already engaged in TGNC support networks or in communities with more support for gender diversity. They suggest that individuals who have gained access to medical treatment have sought advice about where to seek interventions, affordable care options, or physicians who are TGNC friendly and knowledgeable (Butler et al., 2018). Engagement with these communities may both facilitate completion of medical affirmation and relate to lower social anxiety through the social support provided by involvement in a community (Butler et al., 2018). This helps to explain the research that has found that individuals who have received medical affirmation have greater mental well-being, these individuals are likely also receiving social support.

As seen above, medical affirmation often coincides with social affirmation. As Butler et al. (2018) highlights, it could be argued that medical affirmation is essentially a by-product of social affirmation as social support often leads to gender affirming medical procedures.

Social affirmation comes from an agreement of family, friends and colleagues to embrace an individual's gender identity and provide support (Glynn et al., 2016). Legal affirmation is also an important part of the coming out stage. This refers to altering a legal document to display an individual's name and gender (Glynn et al., 2016). If these forms of affirmation are received, they can lead to lower depression rates and higher self-esteem while the absence of gender affirmation is significantly associated with suicidal ideation (Glynn et al., 2016). Medical, social and legal affirmation are all closely linked, and an individual may be receiving one or all forms of affirmation.

*Gender Congruence.*

While there has been a focus in research on the mental health change that occurs in TGNC individuals pre and post gender affirming interventions, Jones et al. (2018) goes further on from gender affirmation and argues that there needs to be more of a focus on the shift from gender incongruence to congruence that can take place. Jones et al. (2018) highlight that one of the most important outcomes that should be measured after gender affirming medical interventions is any change that occurs in relation to the distress and unhappiness a person experiences with their gender identity and body as a result of their gender identity being at odds with their assigned gender (i.e., gender incongruence). Jones et al. (2018) designed a survey with this research question in mind. Their survey allows for a measurement of gender congruence and life satisfaction which can be assessed pre and post gender altering medical treatments. Jones et al. (2018) argue that other measures designed for specific populations such as individuals with eating disorders or measures for the general population are unlikely to be specific enough to be used with the TGNC population for meaningful evaluations and so a measure that looks specifically at gender identity was required. Within the Gender Congruence and Life Satisfaction (GCLS) scale, Jones et al.,

(2018) identify two cluster scales, one for gender congruence, as well as the inclusion of the Gender Related Wellbeing and Life Satisfaction (GRWLS) scale which helps to measure wellbeing and life satisfaction through the specific lens of gender.

The high rates of depression and anxiety discussed above, have been documented in numerous studies and has been attributed to the high rates of discrimination and violence often experienced by TGNC individuals (Glynn et al, 2016). Bockting et al. (2013) argue that TGNC people face systematic oppression and devaluation as a result of the social stigma surrounding their gender nonconformity. While there has been a variety of research projects carried out in terms of social support as a protective factor, gender affirmation and mental health in TGNC there is a lack of research within an Irish context. The aim of this research is to show that there is a relationship between gender congruence and GRWLS and levels of social support alongside the experience of depression and anxiety.

*Aims*

This study was motivated by the lack of research in Ireland and Northern Ireland in terms of gender identity and mental health. The aim of this study was to implement the GCLS scale (Jones et al., 2018) in an Irish context. This scale was combined with depression and anxiety subscales of the Depression, Anxiety and Stress Scale (DASS) (Lovibond & Lovibond, 1993) in order to measure the impact that gender congruence and life satisfaction can have on the depression and anxiety of the individual. The inclusion of the DASS subscales allows for the examination of mental health symptoms. The Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet & Farley, 1988) was included in order to examine the role that support can play on gender congruence, life satisfaction and mental health. This research aimed to implement the GCLS scale but also to incorporate the other aspects to further this research and see how it presented in an Irish

context. Hypothesis 1 states that gender congruence will be positively correlated with GRWLS. Hypothesis 2 states that gender congruence will be negatively correlated with anxiety levels. Hypothesis 3 states that gender congruence will be negatively correlated with depression levels. Hypothesis 4 states that there will be a significant negative correlation between social support and anxiety levels. Hypothesis 5 states that there will be a significant negative correlation between social support and depression levels.

# Method

## *Participants and Recruitment*

The recruitment of participants for this study was a difficult process. The link to the survey was posted on multiple Facebook and Twitter pages as well as on Reddit threads for TGNC and LGBTQ people in Ireland and the UK. The participants were also recruited through snowball sampling in which the link to the survey was posted on TGNC individual's personal Facebook pages. Many support groups have a policy of only posting surveys for research that they are conducting which also limited the number of survey responses. The participants were not required to take part or incentivised in any way.

Table 1 *Demographic Descriptive of Participants*

| Characteristics | n | % |
|---|---|---|
| Sex at birth | | |
| Male | 11 | 42.3 |
| Female | 15 | 57.7 |
| Gender Identity | | |
| Trans Male | 12 | 46.2 |
| Trans Female | 10 | 38.5 |
| Non-Binary | 4 | 15.3 |
| Age Group | | |
| 18-34 | 21 | 80.8 |
| 35-50 | 4 | 15.4 |
| 50-70 | 1 | 3.8 |
| Marital Status | | |
| Married | 1 | 3.8 |
| Divorced | 2 | 7.7 |
| Partner | 5 | 19.2 |
| Single | 18 | 69.2 |

The participants were all individuals who did not identify with the sex they were assigned at birth. They were all over the age of 18 and living in Ireland or Northern Ireland. There were twenty-six individuals in total. The average age was 28.7 while the standard deviation was 11.7. See Table 1 for a description of participants.

*Design*

This study was a correlational design that looked to determine if there is a relationship between gender congruence, gender related wellbeing and life satisfaction (GRWLS), social support, anxiety and depression. The predictor variables are gender congruence and social support and the criterion variables are GRWLS, anxiety and depression. A Pearson's Correlation test was run in order to see if there was a relationship between these variables. Previous research has shown that participants who scored higher in gender congruence and those who perceived themselves to have good social support also had higher levels of GRWLS and lower levels of depression and anxiety. Hypothesis 1 states that gender congruence will be positively correlated with GRWLS. Hypothesis 2 states that gender congruence will be negatively correlated with anxiety levels. Hypothesis 3 states that gender congruence will be negatively correlated with depression levels. Hypothesis 4 states that there will be a significant negative correlation between social support and anxiety levels. Hypothesis 5 states that there will be a significant negative correlation between social support and depression levels.

*Materials*

The survey used in this study was an online survey that contained a cover sheet (see appendix 1) advising participants of the nature of the survey and debriefing sheet (see appendix 2) at the close of the survey that offered information regarding support services for any participants who experienced negative feelings as a result of the survey questions. The

survey contained measures of demographics (see appendix 3), the GCLS scale (Jones et al., 2018) (see appendix 4), the MSPSS (Zimet et al., 1988) (see appendix 5) as well as the anxiety and depression subscales from the DASS (Lovibond & Lovibond, 1993) (see appendix 6).

The GCLS scale (Jones et al., 2018) is a 38-item self report questionnaire that is designed for individuals who do not identify with the sex they were assigned at birth and those who identify outside of the binary gender system. The questionnaire can be used to measure two clusters; gender congruence and GRWLS. It does so by asking participants to answer on a Likert-type scale of 1-5, from *never* to *always*, in relation to the events and emotions of the past six months. The instructions for the questionnaire make it explicit that the experiences are to be related to distress about gender. For example, due to distress about my gender "I have avoided social situations and/or social interactions" and "I have felt like my chest does not match my gender identity". Eleven items are reverse scored. To obtain the subscale and cluster scores the mean is calculated for all the questions pertaining to that subscale or cluster. The higher the participants score indicates a greater gender congruence and gender related wellbeing and life satisfaction (Jones et al., 2018). Norms are provided by Jones et al. (2018) for each cluster score. The GCLS is a valid and reliable measure that can be used in a study with TGNC participants and it is capable of producing high quality data for research purposes (Jones et al., 2018).

The MSPSS (Zimet et al.,1988) is a 12-item questionnaire using a 7-point Likert-type scale from *very strongly disagree* to *very strongly agree*. The participants are asked to read each statement carefully and indicate how they feel about each one. The statements include "My family really tries to help me" and "I can count on my friends when things go wrong". The scale measures the participants perception of support from family, friends and significant

others. The subscales are summed, and the mean is found for each score. An overall picture of support can be found by summing the total score and finding the mean. The mean total scale score ranging from 1 to 2.9 reflects low support; a score of 3 to 5 demonstrates moderate support; a score from 5.1 to 7 could be considered high support. Zimet, Powell, Farley, Werkman and Berkoff (1990) found that the MSPSS is psychometrically sound across various subject groups, making it an appropriate measure for the social support perceived by the TGNC participants in this study.

The DASS 21 (Lovibond & Lovibond, 1993) subscales of depression and anxiety were used to highlight the mental wellbeing of the participants. The stress subscale was not included in order to shorten the length of the survey. Each subscale is a 7-item instrument that measures current symptoms of depression and anxiety. Participants are asked to rate their symptoms from the last week on a 4-point scale from *Did not apply to me at all* to *Applied to me very much or most of the time*. The questions included "I was aware of dryness in my mouth" for measuring anxiety and "I couldn't seem to experience any positive feeling at all" for depression. Participant scores are summed and multiplied by two to match the full 42-item scale. Brown, Chorpita, Korotitsch and Barlow's (1997) study found strong support for the internal consistency of the three DASS subscales in a clinical sample within the various anxiety and mood disorder groups.

*Procedure*

The various questionnaires mentioned above were compiled on Google Forms to create one survey. Once the survey questions were approved by the ethics board, the survey was posted on social media sites directed at LGBTQ individuals or TGNC individuals specifically. In order to post on the pages, it was sometimes necessary to request permission from moderators of the page. The survey was also directly messaged to individuals who are

currently working in the community, asking them to post it on their personal social media pages. The link to the survey advised participants of the reason for the research, how their data would be used and asked them to consent to participate in the research. Eligible participants indicated that they were living in Ireland or Northern Ireland and that their gender identity differed from their sex assigned at birth. Once the data had been collected it was downloaded from Google Forms and saved as an Excel spreadsheet. The data was recoded in order for it to be processed in SPSS 25. The statistical analysis was run using tests in SPSS 25.

*Ethics*

A research proposal was submitted and approved by the ethics board at Dublin Business School in line with the Psychological Society of Ireland Code of Professional Ethics (2011). The proposal outlined the way in which the participants were advised that the surveys are anonymous and that the participants answers will be stored on a password protected computer. This is in order to comply with 1.2.6 in the PSI Code of Ethics (2011) which states that researchers must "[s]tore, handle, transfer and dispose of all records, both written and unwritten in a way that attends to the needs for privacy and security" (p.6). The survey did not ask for any unique identifiers from the participants to allow for anonymity. The participants were also advised that as this research was being conducted as part of postgraduate studies it would be submitted for examination. They were advised that the data collected may be used in academic presentations or publications.

The coversheet advised that participation was voluntary and anonymous. The coversheet also warned that the questions asked in the survey may cause some minor negative feelings and encouraged the participants to contact the support services detailed at the end. The last page of the survey attempted to "debrief research participants in such a way that any

harm caused can be discerned, and act to correct any resultant harm" (PSI, 2011, p.12) The participants were also given the option to end the survey at any time if they felt uncomfortable. The participants were advised that by completing and submitting the survey that they were giving their consent to take part and have their responses used in this research paper. There was also a box that the participants must select in order to demonstrate their participation. This is in line with the PSI Code of Ethics (2011) guidelines on informed consent. If the box is ticked 'no' the survey will go straight to the debrief page at the end. As participation was completely anonymous, the coversheet advised that individual answers could not be withdrawn once they had been submitted as there was no way to identify individual responses.

# Results

The scores for each scale were calculated as directed by the measure instructions. The scores for gender congruence and GRWLS were compared to the norms provided by Jones et al. (2018). The scores for social support were grouped into high, medium and low depending on the mean score. While the anxiety and depression scores were grouped into five considerations from normal to extremely severe. Descriptive statistics of the variables can be found in Table 2.

Table 2 *Descriptive Statistics of Variables*

| | n | Min | Max | Mean | SD |
|---|---|---|---|---|---|
| Gender Congruence | 26 | 1.18 | 4.24 | 2.82 | .85 |
| GRWLS | 26 | 1.62 | 4.38 | 2.98 | .80 |
| Social Support | 26 | 1 | 6.67 | 4.79 | 1.47 |
| Depression | 25 | 2 | 40 | 18 | 10.91 |
| Anxiety | 25 | 2 | 40 | 18 | 10.91 |

Note. GRWLS: Gender related wellbeing and life satisfaction.

Hypothesis 4 and 5 both take into account levels of social support that participants perceive themselves to have. The subscales for the MSPSS were not used as an overall picture of social support was required. Figure 1 shows that the majority of participants (52%) feel that they are receiving high levels of social support from their friends, family and significant others.

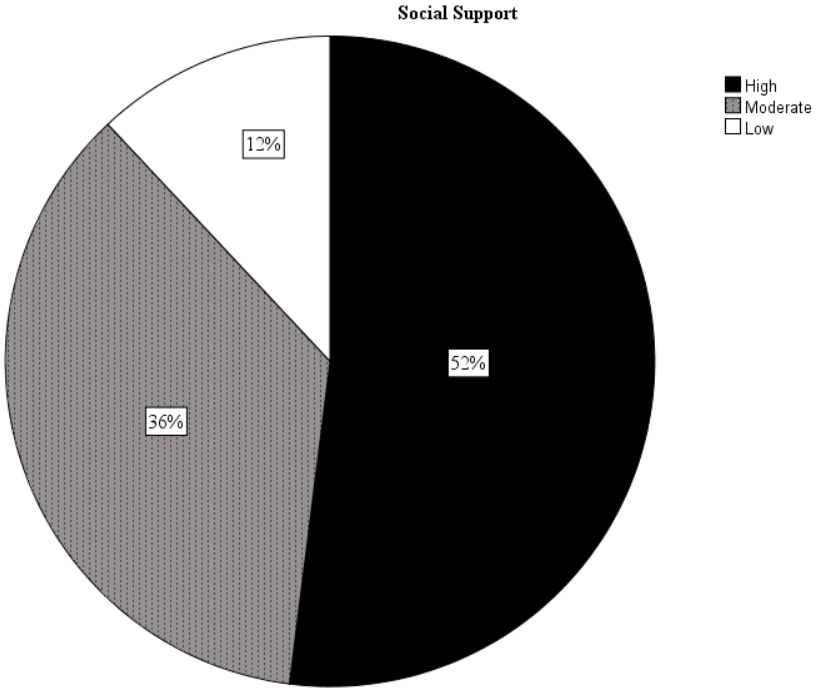


Figure 1 *Perceptions of Social Support*

Hypothesis 2 and 4 are looking at anxiety levels within the sample. Figure 2 demonstrates the breakdown of anxiety levels within the participants. 40% of participants self-reported as experiencing extremely severe anxiety. Alternatively, 16% of participants reported feeling little or no symptoms of anxiety of late.

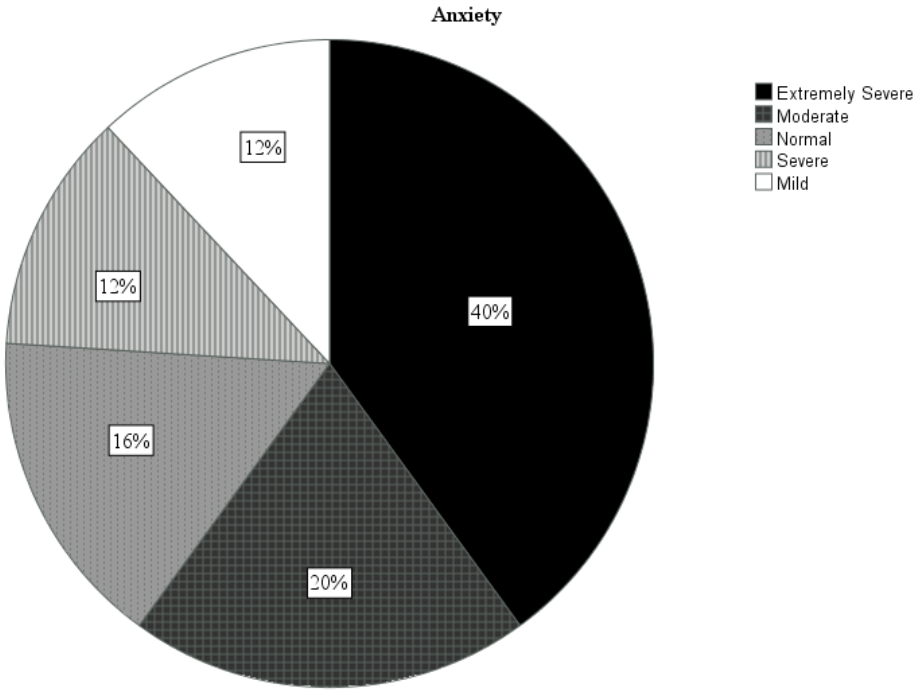

Figure 2 *Self-reported feelings of anxiety*

Hypothesis 3 and 5 focus on depression and its relation to other variables. Figure 3 depicts the breakdown of the depression levels within the group. 36% of participants self-reported that they were currently experiencing extremely severe symptoms of depression while 28% reported feeling normal.

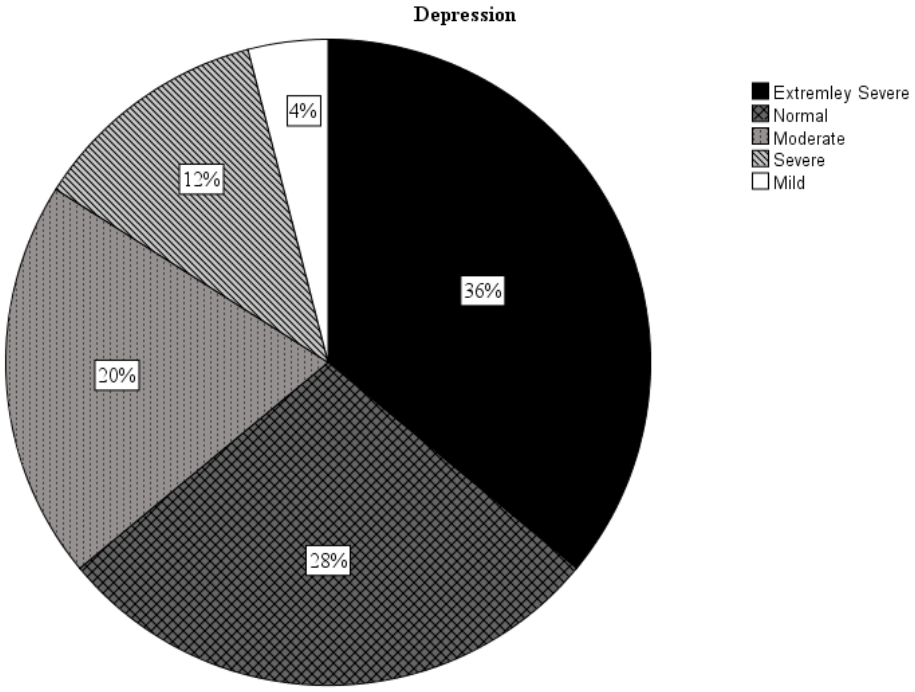


Figure 3 *Self-reported feelings of depression*

Out of the total participants (n=26) 18 (69.2%) of them considered themselves to be "fully out" while 8 (30.8%) were only out to select groups of people. In terms of Hormone Replacement Therapy (HRT) and changing their name and gender indicator, 14 (53.8%) had done both, while 12 (46.2%) had not undergone either. The participants who said yes to Gender Reassignment Surgery (GRS) numbered 4 (15.4%) while those who said no numbered 22 (84.6%). Table 3 shows the level to which the participants have transitioned which gives an indication of their social, medical and legal gender affirmation. Those who are fully out are opening themselves up to the opportunity for social affirmation. The

participants who are receiving HRT or who have undergone GRS demonstrate steps taken towards medical affirmation. The change to their name and the gender indicator on official documents shows legal affirmation.

Table 3 *Gender Affirmation Frequencies*

| Stages of transitioning | **n** | **%** |
|---|---|---|
| Fully Out | | |
| Yes | 18 | 69.2 |
| No | 8 | 30.8 |
| HRT | | |
| Yes | 14 | 53.8 |
| No | 12 | 46.2 |
| Gender/Name Change | | |
| Yes | 14 | 53.8 |
| No | 12 | 46.2 |
| GRS | | |
| Yes | 4 | 15.4 |
| No | 22 | 84.6 |

Note. HRT: Hormone Replacement Therapy; GRS: Gender Reassignment Surgery. .

*Internal Reliability*

The measures used within this study were found to have internal reliability. The Depression, Anxiety and Stress Scale ($\alpha = .93$), The Multidimensional Scale of Perceived Social Support ($\alpha = .95$) and the Gender Congruence and Life Satisfaction scale ($\alpha = .94$) all had good internal reliability.

*Statistical Analysis*

**Hypothesis 1** stated that there would be a significant positive correlation between gender congruence and GRWLS. A Pearson correlation found a positive strong significant association between gender congruence ($M = 2.82$, $SD = .85$) and gender related wellbeing

and life satisfaction (M= 2.98, SD = .80) (r (24) = .64, p< .001). This result accounts for 41% of the variance. The null hypothesis in this case can be rejected.

Jones et al. (2018) provide norms for the mean of each subscales and for the two clusters gender congruence and GRWLS. The mean and standard deviation was calculated in terms of gender congruence and GRWLS for two groups, those who said yes to GRS and those who said no. Table 3 shows the comparison from the norms found in Jones et al.' (2018) study and the current study. The current study found that the mean for gender congruence in the group who had undergone GRS (M = 3.47) was lower than the norm provided by Jones et al.'s (2018) study (M = 3.92). In terms of GRWLS, the yes group (M = 3.64) also had a lower mean than the group (M = 3.86) in Jones et al.'s (2018) study.

Table 4 *Gender Congruence and Gender related Wellbeing and Life Satisfaction*

| | GC M | GC SD | GRWLS M | GRWLS SD |
|---|---|---|---|---|
| Jones et al. (2018) | | | | |
| No GAMI | 2.83 | .84 | 3.18 | .84 |
| CHT and Genital surgery | 3.92 | .61 | 3.86 | .70 |
| Cisgender | 4.48 | .37 | 4.41 | .40 |
| Current Study | | | | |
| No GRS | 2.70 | .86 | 2.86 | .76 |
| Yes GRS | 3.47 | .44 | 3.64 | .78 |

Note. GC: Gender Congruence; GAMI: Gender Affirming Medical Intervention; CHT: Cross-sex Hormone Treatment; GRS: Gender Reassignment Surgery.

**Hypothesis 2** posited that there would be a significant negative correlation between gender congruence and anxiety levels. A Pearson's correlation found that there was no significant

relationship between gender congruence (M = 2.82, SD = .85) and anxiety (M = 18.00, SD = 10.91) (r (24) = -.31, p = .128) therefore the null hypothesis is accepted.

**Hypothesis 3** posited that there would be a significant negative correlation between gender congruence and depression levels. A Pearson's correlation found that there was no significant relationship between gender congruence (M = 2.82, SD = .85) and depression (M = 21.12, SD = 13.08) (r (24) = -.37, p = .69) therefore the null hypothesis is accepted.

**Hypothesis 4** posited that there would be a significant negative correlation between social support and anxiety levels. A Pearson's correlation found that there was no significant relationship between social support (M = 4.79, SD = 1.47) and anxiety (M = 18.00, SD = 10.91) (r (24) = .33, p = .876) therefore the null hypothesis is accepted.

**Hypothesis 5** posited that there would be a significant negative relationship between social support and depression levels. A Pearson's correlation found that there was no significant relationship between social support (M = 4.79, SD = 1.47) and depression (M = 21.12, SD = 13.08) (r (24) = -.09, p = .666) therefore the null hypothesis is accepted.

# Discussion

The hypotheses in this study aimed to try find relationships between gender congruence, GRWLS, social support, anxiety and depression. Hypothesis 1, which stated that there would be a significant positive correlation between gender congruence and GRWLS, was the only hypothesis in which a significant finding was reported. Despite the research in the literature, the other variables did not result in significant findings.

## *Gender Congruence*

The main aim of this study was to conduct research on the mental health of TGNC individuals in an Irish context. All participants were white people living in either Ireland or Northern Ireland. The study aimed to find a relationship between gender congruence and social support and symptoms of mental wellbeing. There was a significant strong positive relationship found between gender congruence and GRWLS. The pairing of these two variables originated from Jones et al.'s (2018) paper in which the GCLS scale was developed. The results from this study demonstrate the findings of Jones et al.'s (2018) research that those who had higher gender congruence had higher levels of gender related wellbeing and life satisfaction. This scale also allows for the tracking of progress of TGNC individuals as they go through the process of transition. Jones et al. (2018) argue that the more medical affirmation that TGNC individual have they more likely they are to have a higher level of gender congruence.

While there was a correlation between gender congruence and GRWLS, the findings in this study were lower on average than the norms provided by Jones et al.'s (2018) study. This demonstrates the fact that although there is a relationship between gender congruence and GRWLS the participants in the current study still had lower average scores for both variables in both the group that indicated yes to GRS and the group that selected no. The fact

that both groups scored below the norm suggests that the Irish context is impacting on these findings. The study by Jones et al. (2018) was conducted in the UK and the norms might not be applicable in an Irish context.

*Gender Affirmation*

As stated earlier, gender affirmation is largely centred around the process by which individuals can be affirmed in terms of their gender through their everyday social interactions (Sevelius, 2013). In this study, 18 (n = 26) of the participants considered themselves to be fully out. In terms of legal affirmation, 14 (53.8%) of the participants had changed their name and their gender marker on legal documents. Medical affirmation was undertaken by 14 (53.8%) participants in terms of HRT and 4 (15.4%) participants had GRS. Even though the process of coming out can help individuals overcome negative self-evaluation (Bockting et al., 2013), the participants in this study experience below the norm in terms of gender congruence and GRWLS. Research shows that TGNC individuals who had experienced no gender affirming medical interventions reported worse outcomes on the GCLS scale which is reflected in this study (Jones et al., 2018). The group who experienced no medical affirmation had a lower mean in terms of gender congruence (M = 2.70) and GRWLS (M = 2.86) than the group who had experienced full medical affirmation in terms of GRS. The group who had undergone GRS had a higher level of gender congruence (M = 3.47) and GRWLS (M = 3.64). The advantage of medical procedures that are gender affirming is that they can help to reduce experiences of gender non-affirmation, rejection, discrimination and victimization by helping to align outward physical characteristics with binary gender norms (Butler et al., 2018).

*Mental Health*

Despite the fact that there was no significant correlation between gender congruence and levels of anxiety and depression, the findings do demonstrate high levels of extremely severe anxiety (40%) and depression (36%). Budge, Adelson and Howard (2013) report that anxiety and overall distress rates within the TGNC community fall between 26% and 38%. The findings in this study show that 40% of participants felt extremely severe anxiety while 12% reported feeling severe anxiety. The rates of depression for TGNC people range from 48% to 62% within the literature (Budge, Adelson & Howard 2013). Within the current study, 36% of participants self-reported having extremely severe depression while 12% reported severe depression. This shows that the depression levels are on the lower end of the range provided by Budge, Adelson and Howard (2013) while anxiety is beyond the range. This demonstrates that the depression and anxiety rates of the participants of the current study are experiencing high levels of anxiety and depression as reflected in the literature.

The survey used in this research failed to ask participants about experiences of transphobia. Bockting and Coleman (2007) argue that internalised transphobia can account for the high rates of depression and anxiety in the TGNC community. Future research should ensure that participants are given the opportunity to document their experiences of transphobia in an attempt to explain high levels of depression and anxiety. This highlights that semi-structured interviews might be a better form of research as they would allow for the discussion of discrimination and its effects.

Research states that the greater social support an individual perceives themselves to have the less likely they are to experience distress. While the majority of participants (52%) felt they had high levels of social support, less than half experienced moderate (36%) or low (12%) social support. The participants were also asked if they were currently seeking support

from any LGBTQ+ services, to which 11 (42.3%) replied yes and 15 (57.7%) replied no. This shows that despite the protective nature of support from family, friends and significant others, over half of participants were not actively seeking support from an LGBTQ+ service. Bockting et al. (2013) highlight the importance of integrating into a community of peers which can help defend against depression and anxiety that may be caused as a result of belonging to a minority group.

Tebbe and Moradi (2016) similarly found that general support from family and significant others was not uniquely related to depression and suicide rates in their TGNC sample. They also suggest that further research is needed to explore the distinctive roles of trans identity-specific support (Tebbe and Moradi, 2016). The fact that these participants indicated that they were not in an LGBTQ+ support group could indicate a reason for their anxiety. Testa, Jimenez and Rankin (2014) examined the risk and resilience of TGNC people during transitioning and they highlighted the importance of being exposed to other TGNC individuals early on in the process of transition. This study found that encountering other members of the TGNC community allowed for lower levels of fear and thoughts of suicide and higher levels of comfort in TGNC individuals (Testa, Jimenez and Rankin, 2014). Similarly, Bockting et al (2013) argue that a community of peers allows for a social environment in which a different identity is not stigmatised. This allows TGNC people to self-evaluate in comparison with like others, rather than with members of the majority culture (Bockting et al., 2013). This demonstrates not only the importance of social support but of specific support from people who are in a similar situation.

*Sample*

The recruitment of participants for this study was a particularly difficult process due to the small number of TGNC people living in Ireland. While the survey was anonymous, the

link to the survey was posted on social media sites that required a personal profile in order to access it. This means that the individuals who took the survey were actively involved in the TGNC community as they had joined these social media pages. The pages were all support groups of various kinds for TGNC individuals as well as LGBTQ pages more generally. The lack of anonymity on these pages means that only individuals who are somewhat "out" in terms of identifying as a different gender are likely to have taken the survey. This could account for the non-significant findings in that their gender identity might not relate to feelings of depression or anxiety.

The difficulty in recruitment lead to a small sample size which could also account for the nonsignificant findings. The referendum in Ireland in 2015 that led to the legalisation of same-sex marriage demonstrated the changing nature of Irish culture. Despite this shift in terms of sexual orientation, it seems that there is still a reluctance on the part of TGNC individuals in Ireland to participate in research. The researcher in this study was not a member of the LGBTQ community which also could have been a reason for the low uptake on the survey. At the same time that the survey for this research was being posted online there was controversy surrounding the inclusion of TV writer, Graham Linehan on an RTE programme on TGNC issues (Falvey, 2019). An online campaign was started to have Linehan removed from the programme as he is neither a medical expert nor a member of the TGNC community and he has expressed transphobic views in the past (Falvey, 2019). This demonstrates that there could have been a justifiable closing off of the community to outsiders as a result of the transphobia encountered at this time. At this stage, the TGNC community in Ireland may be more suited to qualitative research such as semi-structed interviews as the number of willing participants is not enough to yield significant findings in quantitative research.

The majority of the participants in this study were young adults (80.8%) which could be due to the fact that the survey was posted online only. Over the last ten years, young adults have remained the most likely to go online (Ramo & Prochaska, 2012). The fact that the majority of participants were young adults, aged between 18-34 could also help to explain the prevalence of depression and anxiety within the sample group. Harley et al. (2015) conducted research in Ireland in which they found that mood disorders (28.4%) were the most frequent lifetime disorders and anxiety disorders (27.1%) were the second most prevalent disorders among young adults. A study in Northern Ireland similarly found that anxiety disorders (23.5%) were the most frequent within 18-34-year olds with mood disorders (19.3%) having the third highest frequency. This demonstrates that the people who are most likely to answer an online survey are going to be young people while at the same time there is also a high frequency of anxiety and mood disorders within that group.

*Strengths*

This study succeeded in its aim to carry out research in the context of Ireland and Northern Ireland. There was a significant positive correlation found between gender congruence and GRWLS, consistent with past research, which highlights the importance of considering ideas of gender affirmation and gender congruence in relation to the wellbeing of TGNC individuals in Ireland and Northern Ireland. This study also helps to highlight the visibility of TGNC within the population of Ireland and Northern Ireland. The high rates of anxiety and depression discovered within this study demonstrate other research findings that show that TGNC individuals are vulnerable to mental health issues. The fact that the participants of this study reported high levels of social support which did not correlate with anxiety and depression demonstrate that social support from family, friends and significant others might not be enough to protect against discrimination and its effects.

*Limitations*

The small sample size meant that it was not possible to draw significant correlations between most of the variables despite the fact that there is evidence in the literature to suggest a relationship between gender congruence and anxiety and depression, and social support and anxiety and depression levels. The significant correlation that was found between gender congruence and GRWLS was correlational in nature and so no causal relationship can be determined between these two variables. While the literature suggests that higher levels of gender congruence lead to better GRWLS, it could be that the individuals who have a greater sense of gender related wellbeing and life satisfaction are more likely to feel comfortable in their gender identity.

This study had originally planned to do a more extensive comparison in terms of gender and age group and the variables tested. Due to the small sample size this was not possible, however future research that collects a larger sample size should focus on group comparison. The participants that took part in the current study were all white and so there is no variation in terms of race. This means that no conclusions could be drawn regarding the interaction of race and gender identity. This study did not record education or income level. The future inclusion of more racially diverse participants as well the documenting of social class could also allow for more intergroup comparison in a larger sample size.

*Future Research*

The norms that are provided in Jones et al.'s (2018) study for the GCLS scale are for a UK population and so this study on the Irish population had to compare to those norms. A study on the same scale as Jones et al.'s (2018) using the GCLS in Ireland would allow for the establishment of norms within an Irish context. It is also worth noting that grouping of norms is not provided in relation to the GCLS. Future research that defined groups in order to

determine if an individual or sample scores high, medium or low in terms gender congruence and GRWLS would be useful.

As mentioned, qualitative research might be more suitable in an Irish context due to the infancy of research into the mental wellbeing of TGNC people living in Ireland and Northern Ireland. This would also allow for the individual experiences of TGNC people in Ireland to be captured. The themes that emerge from the qualitative research would help in establishing an idea of the variables to be incorporated into future research to help explain the findings of the current study. The introduction of experiences of discrimination could also help to explain some of the findings in this research, for example the high levels of anxiety and depression.

As well as the introduction of experiences of discrimination, stress is a variable not considered in this research project. The current study opted not to include the stress subscale of the DASS as the fear was that participants would be discouraged from filling in the survey if it was too lengthy. However, stress is an important variable that should be included in future research. Stress is concerned with external events or conditions that are taxing to individuals and exceed their capacity to endure, therefore having the potential to induce mental or somatic illness (Meyer, 2003). The concept of social stress extends stress theory by suggesting that conditions in the social environment, not only personal events, are sources of stress that may lead to mental and physical ill effects. Social stress might therefore be expected to have a strong impact in the lives of people belonging to stigmatized social categories, including categories related to socioeconomic status, race/ethnicity, gender, or sexuality (Meyer, 2003). Minority stress theory posits that sociocultural prejudice and discrimination promotes minority stressors that can have deleterious mental health implications for members of minority populations (Meyer, 2003) (Tebbe & Moradi, 2016).

This demonstrates the way in which TGNC individuals might be suffering from symptoms of stress, not only as a result of every day stressors but also as a result of belonging to a marginalised group. Bockting et al. (2013) note that the minority stress model indicates that the stress associated with stigma, prejudice, and discrimination will increase rates of psychological distress in the TGNC population. This indicates that the stress experienced by TGNC individuals is based on both external factors arising from societal norms as well as the stress of ordinary life and highlights the importance of including stress as a variable in future research.

*Implications*

The fact that a significant correlation was found between gender congruence and GRWLS demonstrates that Jones et al.'s (2018) GCLS scale is a useful measure to use when conducting research in the TGNC population in Ireland. This scale can be used by future researchers to determine the way in which a person's gender identity can impact on their wellbeing and life satisfaction. Despite the findings in this research, the literature suggests that gender congruence correlates with symptoms of anxiety, depression and stress and so it is worth continuing to attempt to find a relationship between these variables. This study also helps to show that qualitative research may be more suitable to the TGNC population in Ireland and Northern Ireland at this time. The lack of correlation between social support and anxiety and depression highlights an alternative to the idea suggested in literature that social support acts as a protective factor against anxiety and depression. The findings of this study suggest that it may be more complex than this and that peer-specific support is needed in order to avoid symptoms of anxiety and depression.

# Conclusion

This study demonstrates the positive relationship between gender congruence and GRWLS. It highlights the importance of needing to feel congruent in terms of gender identity for members of the TGNC community. The situation of this research in an Irish context is an important factor as little research has been done within Ireland and Northern Ireland to help understand the impact gender identity can have on mental wellbeing. Despite the findings of this study, research shows that social support can act as a protective factor from anxiety and depression that results from discrimination. This study helps to highlight the fact that social support alone may not be enough to protect TGNC individuals and that LGBTQ support groups play a significant role in the mental wellbeing of TGNC people. This research can be used to help educate both clinicians and the wider public on matters that are specific to members of the TGNC community and to encourage more research within this field.

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# Appendices

## Appendix 1: Cover Sheet

**Transgender Mental Health Research**

My name is Sara Holbrook and I am conducting research in the Department of Psychology in Dublin Business School that explores the impact that gender affirmation can have on depression, anxiety and self-esteem. This research is being conducted as part of my studies and will be submitted for examination.

You are invited to take part in this study and participation involves completing and returning the attached anonymous survey. While the survey asks some questions that might cause some minor negative feelings, it has been used widely in research. If any of the questions do raise difficult feelings for you, contact information for support services are included on the final page.

Participation is completely voluntary and so you are not obliged to take part.

Participation is anonymous and confidential. Thus, responses cannot be attributed to any one participant. For this reason, it will not be possible to withdraw from participation after the questionnaire has been collected.

The questionnaires will be securely stored and data from the questionnaires will be downloaded and stored on a password protected computer. The data may also be used in academic presentations or publications.

**It is important that you understand that by completing and submitting the questionnaire that you are consenting to participate in the study.**

Should you require any further information about the research, please contact me,

Sara Holbrook,

Thank you for taking the time to complete this survey.

Appendix 2: Debrief Sheet

Thank you for taking the time to participate in this study.

If you have any queries regarding this study please feel free to contact me, Sara Holbrook, at

If you have experienced any negative emotions as a result of the questions asked in this survey, please reach out for help at any of the services below.

Aware:

Phone: 1800 80 48 48

Email: supportmail@aware.ie

Samaritans in Ireland:

Call Freephone: 116 123

Text: 087 2 60 90 90 (standard text rates apply)

Email: jo@samaritans.ie

Transgender Equality Network Ireland:

Peer Support Groups:

http://teni.ie/support.aspx?filter=PSG

LGBT Hotline:

Please call 1890 929 539 or visit www.lgbt.ie

Pieta House:

Please call 1 800 247 247 or visit www.pieta.ie

## Appendix 3: Demographic Questions

- Do you consent to participate in this research?
    - Yes
    - No (If no is selected go to end of survey)
- Age
- Race
    - White
    - Black
    - Asian
    - Hispanic
    - Other
- Do you currently live in Ireland or Northern?
    - Yes
    - No
- Sex assigned at birth
    - Male
    - Female
    - Intersex

- Is your gender identity consistent with the sex you were assigned at birth?
    - Yes *(do not continue with the survey*)
    - No
- What is your current marital status?
    - Married
    - Single
    - Divorced
    - Legally recognized civil union
    - Partner
    - Separated
    - Widowed
    - Other
- What is your current gender identity?
    - Woman (with a trans history)
    - Man (with a trans history)
    - Woman
    - Man
    - Trans man
    - Trans woman
    - Non-binary
    - Intersex
    - Different identity (please state):
- At about what age did you begin to feel that your gender was “different” from your assigned birth sex?

- At about what age did you start to live in a gender that is different from the one assigned to you at birth?
- If you have begun coming out, please select who you have felt comfortable coming out to (select all that apply)
    - Immediate Family
    - Friends
    - Extended Family
    - College or Work
    - A support group or service
    - I am fully out
    - Other (please specify)

- As part of your transition, which of the following processes (if any) have you engaged in? (select all that apply)
    - Living/presenting some of the time as my acquired gender
    - Living/presenting full-time as my acquired gender
    - Hormone Intervention
    - Surgical breast augmentation (“Top” Surgery)
    - Gender reassignment surgery
    - Legal gender/name change (passport, PPS, etc.)
- Are you currently seeking support from any LGBTQ+ services?
    - Yes
    - No

## Appendix 4: Gender Congruence and Life Satisfaction Scale

Please rate each statement as: NEVER (N), RARELY (R), SOMETIMES (S), OFTEN (O), or ALWAYS (A). Please note that when talking about ‘‘gender identity” we mean one’s internal sense of one’s self as a man, a woman, or some other gender.

In the past 6 months, due to the distress about my gender (i.e., the distress caused as the gender I was assigned at birth does not match with my gender identity):

1. I have avoided social situations and/or social interactions N R S O A

2. I have not gone to school/college/work N R S O A

3. I have not been able to have emotional relationships with other people N R S O A

4. I have suffered from anxiety N R S O A

5. I have not been able to be physically intimate with other people N R S O A

6. I have been unable to leave the house N R S O A

7. I have found it difficult to make friends N R S O A

8. I have thought about cutting or hurting my chest, genitals, and/or surrounding areas N R S O A

9. I have felt that life is meaningless N R S O A

10. I have not enjoyed life N R S O A

11. I have not engaged in leisure activities N R S O A

12. I have suffered from low mood N R S O A

13. I have thought about hurting myself or taking my own life N R S O A

In the past 6 months:

14. I have felt distressed when touching my genitals as they do not match my gender

Identity NRSOA

15. I have felt so distressed about my chest that I have not been able to have a fulfilling

Life NRSOA

16. I have felt comfortable with how others have perceived my gender N R S O A

17. I have felt that my body hair conflicts with my gender identity, either because I have it and do not like it or because I would like to have it NRSOA

18. I have felt like my chest does not match my gender identity N R S O A

19. I have found it distressing that others do not address me according to my gender Identity NRSOA

20. I have felt satisfied with the pronouns that others use when talking about me N R S O A

21. I have felt unhappy about my genitalia since they do not match my gender identity N R S O A

22. I have felt comfortable with how other people perceive my gender based on my physical appearance NRSOA

23. I have felt that my voice has affected the way other people have perceived my gender identity which has been distressing for me NRSOA

24. I have felt that my facial hair conflicts with my gender identity, either because I have it and do not like it or because I would like to have it NRSOA

25. I have felt that my genitals do match with my gender identity N R S O A

26. I have felt that genital surgery will address the unhappiness I experience in relation to my gender NRSOA

&. Tick here if you have already had genital surgery (unless you feel you need more)

27. I have been unable to have a fulfilling life because of the distress relating to my genitalia NRSOA

28. I have felt extremely distressed when looking at my chest N R S O A

29. I have felt extremely distressed when looking at my genitals N R S O A

30. I have felt satisfied with my chest N R S O A

Next, we would like to know how satisfied you have been with your life for the last 6 months:

31. I have felt satisfied at school/college/work N R S O A

32. I have felt satisfied with my emotional relationship(s) N R S O A

33. I have felt satisfied with my sex life N R S O A

34. I have felt satisfied in my leisure activities and hobbies N R S O A

35. I have not felt satisfied with my friends N R S O A

36. I have felt satisfied with the support I have received from other significant people N R S O A

37. I have not felt satisfied with my health N R S O A

38. I have felt satisfied with life in general N R S O A

## Appendix 5: The Multidimensional Scale of Perceived Social Support

We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you Very Strongly Disagree

Circle the "2" if you Strongly Disagree

Circle the "3" if you Mildly Disagree

Circle the "4" if you are Neutral

Circle the "5" if you Mildly Agree

Circle the "6" if you Strongly Agree

Circle the "7" if you Very Strongly Agree

1. There is a special person who is around when I am in need. 1 2 3 4 5 6 7

2. There is a special person with whom I can share my joys and sorrows. 1 2 3 4 5 6 7

3. My family really tries to help me. 1 2 3 4 5 6 7

4. I get the emotional help and support I need from my family. 1 2 3 4 5 6 7

5. I have a special person who is a real source of comfort to me. 1 2 3 4 5 6 7

6. My friends really try to help me. 1 2 3 4 5 6 7

7. I can count on my friends when things go wrong. 1 2 3 4 5 6 7

8. I can talk about my problems with my family. 1 2 3 4 5 6 7

9. I have friends with whom I can share my joys and sorrows. 1 2 3 4 5 6 7

10. There is a special person in my life who cares about my feelings. 1 2 3 4 5 6 7

11. My family is willing to help me make decisions. 1 2 3 4 5 6 7

12. I can talk about my problems with my friends. 1 2 3 4 5 6 7

## Appendix 6: Anxiety and Depression subscales from the DASS

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:
0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

- I was aware of dryness of my mouth
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time
    - 3 Applied to me very much, or most of the time
- I couldn't seem to experience any positive feeling at all
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time
    - 3 Applied to me very much, or most of the time
- I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time
    - 3 Applied to me very much, or most of the time
- I found it difficult to work up the initiative to do things
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time
    - 3 Applied to me very much, or most of the time
- I experienced trembling (e.g., in the hands)
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time
    - 3 Applied to me very much, or most of the time
- I was worried about situations in which I might panic and make a fool of myself
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time

    - 3 Applied to me very much, or most of the time
- I felt that I had nothing to look forward to
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time
    - 3 Applied to me very much, or most of the time
- I felt down-hearted and blue
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time
    - 3 Applied to me very much, or most of the time
- I felt I was close to panic
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time
    - 3 Applied to me very much, or most of the time
- I was unable to become enthusiastic about anything
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time
    - 3 Applied to me very much, or most of the time
- I felt I wasn't worth much as a person
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time
    - 3 Applied to me very much, or most of the time
- I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time
    - 3 Applied to me very much, or most of the time
- I felt scared without any good reason
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time
    - 3 Applied to me very much, or most of the time
- I felt that life was meaningless
    - 0 Did not apply to me at all
    - 1 Applied to me to some degree, or some of the time
    - 2 Applied to me to a considerable degree, or a good part of time
    - 3 Applied to me very much, or most of the time