I Came Out of the Shadows:

South African Transgender Wellbeing and Liminality

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Declaration

I, Kirsten Lee Miller, Student number 30859077, declare that *I Came Out of the Shadows: South African Transgender Wellbeing and Liminality* is my own work; all the sources I have used or quoted have been indicated and acknowledged by means of complete referencing; and that this work has not been submitted before for any other degree at any other institution.

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Kirsten Lee Miller Date

Acknowledgements

When I first embarked on this research project, I had very little understanding of what it meant to be transgender. However, I knew that by giving myself the challenge of learning about something that I knew little of, I would grow personally and professionally in ways that cannot be measured. The respect I have for my participants is so vast. Their strength and resilience can serve as an example to anyone. I admire each one of you for the person that you are. I wished that I had more time to get to know each of you better. It felt as if our interviews were over too quickly, and I could see that there was so much more I wasn't able to learn. You inspire me and showed me that living authentically is possible with the right will and fortitude. My gratitude to you is endless.

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Abstract

This qualitative study set out to discover the lived experiences of South African transgender individuals within the liminal space of having been confirmed for gender affirming surgery, yet who have not completed their surgery. The aim included seeking out how participants' wellbeing was affected by being within this liminal space. Six participants were recruited in Johannesburg, Pretoria and Cape Town. Thematic analysis was used to derive themes from the transcripts. Themes included coming out; relationships; wellbeing; misgendering/misnaming; support; public and private medical care; and liminality. Recommendations for future studies are included, and recommendations on interventions and support are discussed.

Keywords: transgender; gender affirming surgery; liminality; relationships; wellbeing; misgendering/misnaming; support; transgender medical care.

Okungumqondo

Lolu cwaningo lohlobo lwekhethelo lenzelwe ukuthola noma ukubheka izinselelo zabantu abafuna ukushintsha ubulili babo baseNingizimu Afrika ababhekana nazo uma basohlelweni lokuyohlinzwa ngoDokotela ukuze bakhone ukushintsha ubulili babo. Inhloso yalolu cwaningo ukubheka ngqo kubantu abayihambile lena ndima ukuthi bahlukumezeka kanjani ngesikhathi basohlelweni lokuthi bashintshe ubulili babo. Abantu abayisithupha abazibandakanye nalolu cwaningo batholakale eGoli, ePitoli kanye naseKapa. Kusetshenziswe ucwaningo olubheka indikimba ukuze kutholwe izihloko ezivele embalweni osuselwe enkulumeni eqoshiweyo. Izihloko ezivelayo yilezi, ubudlelwano; impilo; ukubizwa ngobulili ongasibona/ukubizwa ngegama okungasilona elakho; ukwesekwa; usizo lwezibhedlela zikahulumeni nezibhedlela ezizimele; kanye nokuba sesimeni sokushintsha ubulili. Izincomo zocwaningo oluzayo zifakiwe nazo, kuphindwe kwakhulunywa noma kwabhekwa ukuthi kungangenelelwa kanjani ngosizo.

Okumqoka: ukushintshwa kobulili; igunya lokushintsha ubulili nguDokotela; ukuba sesimeni sokushintsha ubulili; ubudlelwano; impilo; ukubizwa ngobulili ongasibona/ukubizwa ngegama okungasilona elakho; ukusekwa; kanye nokulashwa kwabantu abashintsha ubulili babo.

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Chapter 1: Introduction

Background

Gender affirming surgery candidates are often subjected to lengthy waiting periods in South African state hospitals, which can extend to several years (Bateman, 2011; Furlong, 2015). At present, gender affirming surgery in South Africa has not been deemed necessary surgery by medical aids, but rather as something cosmetic (Wilson, Marais, De Villiers, Addinall, & Campbell, 2014). Consequently, most medical aids do not cover the costs thereof (Bateman, 2011; Psychological Society of South Africa [PsySSA] Sexuality and Gender Division, 2015). It costs some individuals who employ state services the same as private patients because the cost is based on their personal income (Bateman, 2011). Therefore, cost alone may be a barrier to gender affirmation. However, affirming one’s gender is vital to the wellbeing of those seeking gender affirming surgery because not being able to live as one’s gender physically can have an impact on several areas of one’s life (PsySSA Sexuality and Gender Division, 2015).

Those seeking gender affirming surgery may encounter many difficulties including biased treatment from medical professionals, discrimination, isolation and problems accessing medical services (Newman-Valentine & Duma, 2014; Nkoana & Nduna, 2012). Furthermore, there are several major psychological effects of not being able to affirm one’s gender timeously. For instance, some individuals experience trauma because of the discrimination and persecution they encounter in South Africa or their home countries in Africa (Theron, 2011). When the medical model of gender dysphoria or gender identity disorder is considered, being labelled as mentally ill takes on a non-affirmative stance towards gender identity and its fluidity (American Psychiatric Association, 2013; PsySSA, 2013; World Health Organisation, 1993; World Professional Association for Transgender Health [WPATH], 2011). Some individuals experience psychological disorders such as

depression, anxiety, suicidal ideation, somatoform disorders, schizophrenia, substance abuse and eating disorders prior to undergoing gender affirming surgery (Murad et al., 2010). In addition, these individuals generally experience a lower quality of life (Murad et al., 2010), which includes personal and sexual relationship satisfaction, happiness and contentment, financial status, and occupational and employment satisfaction.

The liminal space during the transition period offers individuals an opportunity to re-imagine their identity (Gately, 2010). However, during the liminal period, they may experience marginalisation from society and rejection from the spaces and relationships that they had previously held (Booth, 2011; Dentice & Dietert, 2015; MacDonald, 1998; The GLQ Forum, 2004; Wilson, 2002). Furthermore, individuals have to navigate the practicalities of their journey through the liminal space; these include dressing in new types of clothing, changing hairstyles, taking cross-sex hormones or altering their physical appearance in other ways, and finding new support systems (Booth, 2011; Dentice & Dietert, 2015; Gately, 2010; Wilson, 2002).

In essence, it is apparent that the liminal space in the transition process can be fraught with challenges that affect the individual physically and psychologically. However, this period can also provide an opportunity for growth and increasing wellbeing.

Conceptual Underpinnings

Theoretically, the phenomenon of *transgender* may be understood from various theoretical foundations. From the perspective of a medical model, individuals may have a biological or neurological basis for experiencing an incongruence between their natal gender and their experienced gender. However, this explanation is not sufficient and in the researcher’s opinion, correct to appreciate fully the gender spectrum that many people experience. Therefore, an affirmative and non-biological/medical stance was employed in the present study. To understand gender identity fully, the researcher viewed the phenomenon of

gender identity from a feminist and queer perspective. These perspectives were employed because of their affirmative and accepting stance on the fluidity of gender. Both perspectives understand gender as being on a spectrum, ranging from male to female and anything in between. Accordingly, gender binaries are viewed as misleading, and exclusionary.

Although feminist theory has been critiqued for having an essentialist stance (Alcoff, 1988; Nagoshi & Brzuzy, 2010; Shields, 2008), it has contributed to an understanding of the intersection of gender, power and patriarchy. Queer theory provides a social constructionist perspective on gender and identity (Nagoshi & Brzuzy, 2010) and as such creates the space for gender and identity to be described as a plurality and not as a binary. A full review of the theoretical foundations is provided in Chapter 2. The theoretical contributions towards how society views gender and identity is of importance. Furthermore, these theoretical underpinnings afford individuals the freedom to define their own gender and identities separate to societal norms and binaries.

Wellbeing within the liminal space was also examined in this study. Consequently, several theoretical perspectives of wellbeing were investigated including hedonic and eudaimonic wellbeing. It was apparent from the literature that wellbeing as a construct is difficult to define because of the many factors that contribute to wellbeing in general. However, for the purpose of this study, the researcher incorporated aspects from hedonic wellbeing and eudemonic wellbeing into the literature review to afford an enhanced understanding of the complexity of the construct.

Psychological Society of South Africa.

The Psychological Society of South Africa’s (PsySSA) Sexuality and Gender Division has been instrumental in driving standards of practice in South African in this area. PsySSA has made a significant contribution to the literature on transgender rights in South Africa. Moreover, PsySSA has been at the forefront of promoting equality and gender rights

for all. Their contribution has led to a comprehensive understanding of ethical practice with individuals who are seeking psychological and/or medical treatment for help in their gender affirmation process.

Personal position in the research.

The researcher defines herself as a cisgender, natal woman. Some may question if a cisgender individual can contribute to research in the transgender arena. However, as an emerging clinical psychologist, it is the researcher’s goal to provide ethical, empathetic and sensitive care to all her clients. She believes that if she does not avail herself to learning all that she can about gender and identity, she will be disadvantaging her future clients. The literature the researcher read described how even psychological professionals are either biased in their treatment of transgender individuals or do not fully understand how to treat transgender individuals because of a lack of training. Consequently, she has added her voice to the literature in the hope of providing some insight into the field. The researcher’s position is explored in Chapter 3.

Problem Statement

Individuals who are undergoing a process of gender affirmation are often subjected to many psychological, emotional and physical stressors. Within the liminal space of the affirmation phase, it is apparent that many factors can either contribute to or hinder wellbeing. The paucity of studies conducted have examined non-South African populations.

A consideration of the many unique challenges that South Africa faces as a whole suggests that individuals who are in the liminal space of gender affirmation experience wellbeing and the factors that contribute or detract from it differently to those who live in other countries. In South Africa, many people face extreme poverty and unemployment, which may hamper their efforts to acquire treatment. Furthermore, the public health system is in disarray and many people requiring surgery experience extremely lengthy waiting periods.

In addition, South Africa still subscribes to largely traditional patriarchal social structures, which by extension do not accept individuals who are not binary. Although this is changing through the work of organisations who promote gender fluidity, many individuals who identify as transgender still face challenges such as stigmas, violence, murder and exclusion.

While these issues may be present in other countries, they are extremely evident in South Africa. Issues of identity are still largely tied to culture in the country. It was not the researcher’s intention to attempt to define identity and culture in this study, but rather to explore the lived experiences of individuals in the liminal space who are awaiting gender affirming surgery. Very little is known about how these individuals approach the change and how they cope with the challenges that they encounter.

Purpose of the Study

The purpose of the study was to examine how individuals experience the liminal space during their journey towards gender affirming surgery as well as how they experience wellbeing. In her curiosity, the researcher attempted to remain objective, rather than having pre-conceived ideas about the findings. The researcher is of the view that being cisgender and a natal born female helped her to take a more neutral stance as she was not affiliated in any way to the transgender community in South Africa.

Besides the researcher’s curiosity, she also hoped to contribute to the increasing South African psychological literature to help psychology professionals gain a broader understanding of the lived experiences of individuals awaiting gender affirming surgery.

Research design and methodology.

A qualitative stance was adopted to allow the participant’s voices to speak for themselves. Semi-structured interviews were conducted. The questions were designed to serve as a guide so that the researcher could allow the participants the freedom to direct the

interview to gain a broader scope of information and data. However, the questions were used to keep the interviews within the scope of the project.

Thematic analysis was used to analyse the data. Common themes from the data were elicited and classified into themes and sub-themes. Further detail regarding the adoption of a qualitative stance, as well as the methodology are provided in Chapter 3.

Definitions of Key Terms

To provide a clear understanding of the key terms used in this study, several definitions follow.

Transgender.

The term *transgender* is often used as an umbrella term to describe individuals who have a *gender identity* that varies from that assigned to them at birth due to their external sex characteristics (PsySSA, 2017). It is also used to describe any person who chooses to identify with a gender that does not occur on the binary of female or male, but rather views gender as being fluid and falling on a spectrum. The term can also include those who define themselves as *transsexual*, *genderqueer*, *gender non-conforming*, *gender diverse* and/or *queer*. Although this list is not exhaustive, it is indicative of the variety of individuals who may describe themselves as transgender.

The terms employed by PsySSA (2017) are subsequently defined.

Transsexual is often used to describe individuals who seek to or have already altered their bodies surgically to match their experienced gender. However, it is becoming more common to avoid this term. Consequently, in this study, it is only employed if it reflects information that is provided in a literature study. *Genderqueer* is often used interchangeably with non-binary to describe individuals who do not identify as either male or female, but rather identify as being on the gender spectrum. It is also used interchangeably with androgynous, gender non-conforming, bigender, trigender, pangender, agender, non-

gendered, genderless, gender free, gender fluid or other gendered. *Queer* indicates individuals who feel marginalised because of their sex characteristics, sexual orientation, gender identity or sexual and gender diversity.

Although *transgender* has been defined in various ways, which include what this means for an individual who is transgender, in this study, *transgender* is employed when referring to any individual who does not identify with the gender that they were assigned at birth, but identifies with the opposite gender and wishes to affirm this gender through surgical intervention (PsySSA, 2017). Therefore, it refers to males who were assigned female at birth based on their external sex characteristics and to females who were assigned male at birth. Although this definition is somewhat simplistic and does not account for the various non-binary expressions of gender, it serves to simplify the understanding of transgender as it pertains to this study.

Transgender man and transgender woman.

A transgender man refers to a man who was previously assigned female at birth and who identifies as being male while *a transgender woman* refers to a woman who was previously assigned male at birth and who identifies as being female (PsySSA, 2017). In this study, the terms are used to describe those individuals who wish to or have already altered their bodies surgically to match their identified gender.

Gender affirming surgery.

Gender affirming surgery is defined in this study as any surgical intervention that allows individuals who are transgender to change their physical appearance to match their experienced gender (PsySSA, 2017). *Affirmation* is used to describe the process of affirming one’s gender through surgical methods. The outdated term *reassignment* is employed to indicate that individuals who decide to undergo surgery to alter their bodies physically is

already a person of their experienced gender. Therefore, the surgery is merely a way of physically affirming their true gender.

Liminality.

Liminality is defined as a transitional or initial stage of a process or as inhabiting a position at or on both sides of a boundary or edge (Liminal, n.d.). Within the transitional period of undergoing gender affirmation, the transgender liminal space refers to the period after *coming out* as one’s experienced gender as well as the time before the completion of the physical transition to the gender that the individual wishes to affirm.

Rites and rituals.

Rites of passage are used during transitional/liminal stages to symbolise the formal or informal transformation and journey that one experiences. Dentice and Dietert (2015) and Wilson (2002) stated that within the rites of passage that transgender individuals undertake during transitioning, several rituals are undertaken symbolically to move through this stage. These can include name changes, dressing in clothes that fit with one’s experienced gender identity, physically changing one’s appearance, and even the formation of new social groups such as friends, support groups and formal support structures. These rites and rituals may be psychological, physical and/or social.

Wellbeing.

Wellbeing may be defined as an individual’s optimal psychological functioning and experience (Ryan & Deci, 2001). There is no single, universally accepted definition of what constitutes wellbeing. However, generally, it is understood to include positive affect or mood, the absence of negative mood or emotions, feeling satisfied with life, and feeling good (Dodge, Daly, Huyton, & Sanders, 2012; Ryan & Deci, 2001). There are two main conceptions of wellbeing: Hedonic and eudaimonic wellbeing.

Hedonic wellbeing.

Hedonic wellbeing is defined as obtaining wellbeing through pleasure or happiness (Ryan & Deci, 2001). Diener, Oishi, and Lucas (2003) described this type of wellbeing as subjective wellbeing. Three facets are examined to determine subjective wellbeing: Positive affect, negative affect and life satisfaction. Although hedonic wellbeing is largely based on an individual’s subjective reports of wellbeing, much research has been conducted on the construct.

Eudaimonic wellbeing.

Eudaimonic wellbeing comprises of more than just happiness and the pursuit of pleasure, but rather is related to an individual’s ability to self-actualise through fulfilling one’s true nature (Ryan & Deci, 2001). It also relates to what it means to live a good life or to live well.

Summary and Conclusion

In this section, the research topic was outlined and the terms used in the literature review were defined. Furthermore, the methodology employed was noted. In Chapter 2, the literature that is pertinent to the study is reviewed. It not only includes literature that helps explain the concept *transgender*, but examines the theoretical understanding of the concept. The literature review also includes information about how wellbeing and liminality can be understood. In Chapter 3, the research design and methodology are described. In this chapter, information about the participants and how the interviews were structured is provided. The analysis and findings of the study are presented in Chapter 4. The findings of the study, how the researcher made sense thereof, and recommendations for practice and future studies are discussed in Chapter 5. Furthermore, the limitations of the study are outlined.

Chapter 2: Literature Review

A vast amount of research has been conducted on gender identity, transgender experiences, gender theory, liminality and wellbeing. However, in this literature review, the core concepts of this study are examined. These include gender identity, transgender, liminality and wellbeing.

The researcher became aware, when reviewing the literature, of the lack of South African studies on the wellbeing of individuals awaiting gender affirmation surgery. Therefore, the researcher has attempted to highlight the most important South African literature as well as international research on this concept.

Gender Identity

Gender identity may be defined as how individuals identify with their gender as either male or female. Furthermore, it is viewed as an internal experience of the overt expression of the gender role of individuals (Reber, Allen, & Reber, 2009). However, individuals’ gender identity may not match their biological sex assigned to them at birth (PsySSA, 2013). Gender role may be further explained as the overt expression of behaviours and attitudes that demonstrate individuals’ femaleness or maleness to the world (Reber, Allen, & Reber, 2009). Gender identity and sexual orientation are often used interchangeably. However, although concepts overlap in some instances, sexual orientation refers to one’s emotional, romantic and/or sexual attraction to others and involves being heterosexual, gay, lesbian, bisexual or asexual (PsySSA, 2013) whereas gender identity refers to the internal sense of gender with which one identifies.

Gender Theory

Feminist theory and queer theory have been employed in the literature to describe gender identity. In this section, feminism and queer theory are briefly introduced. An emerging sub-field of study, transgender studies, is presented. It is hoped that by providing

some background to the various theoretical approaches that tackle the concept *gender* theoretically and in particular, the concept *transgender*, there will be an understanding of how transgender studies have developed as an emerging sub-field from both feminism and queer theory.

Feminism.

Feminism emerged during the early 1960s (Corey, 2013) in part due to the women's movement, which saw women voicing their dissatisfaction with the traditional gender roles that had been placed on females through historical patriarchy. Although the feminist movement is very well documented, no single founders of feminism have been identified. Corey (2013) noted that feminist theories and movements developed as a collaborative effort by many individuals from fields such as psychology and sociology as well as women's rights activists and lay people.

Feminist theory is rooted in the intersections of gender, social location and power (Corey, 2013; Stryker, 2008). Nagoshi and Brzuzy (2010) and Shields (2008) stated that feminist theory addresses the cultural-historical context and biological premises of gender and includes issues of sexism, race, class, ethnicity, sexual orientation and oppression.

Stryker (2008) referred to three waves of feminism in transgender history. The first wave of feminism, which began in the 19th and early 20th centuries, was concerned with reforming dress codes for women, greater access to education, political equality between men and women, and the suffragette movement. Stryker described the second wave of feminism as the women's movement of the 1960s and 1970s when women sought equal pay, sexual and reproductive freedom, and recognition of women's unpaid domestic work. They addressed the sexuality of women in the media and fought against physical and emotional violence against women. This era has been described by some as being *essentialist*. The third wave of feminism concerned itself with addressing the essentialist ideology of second wave

feminism and viewed the intersection of race, class and gender as particularly important. Third wave feminism is also inclusive of what Stryker (2008) referred to as *transgender feminism.* Snyder (2008) stated that third wave feminism aims to accommodate a broader view of gender identity and as such, questions the gender binary labels of male and female. Snyder (2008) further stated that in third wave feminism issues of gender and sexuality are explored, and includes issues such as sexual orientation and being transgender as well as the intersections of these terms in the broader feminist movement.

Nagoshi and Brzuzy (2010) noted that feminists have attempted to theorise gender in numerous ways: Gender as a type of social organisation; gender as an attribute; and gender as an ideology towards sex roles, power differentials and analytic categories. Hausman (2001) argued that epistemologically, gender is a way of knowing and understanding the cultural operations of defining identities in which perceptions and experiences of the world are attributed to social constructionist narratives based on belonging to one of the gender binary categories.

Feminists have attempted to challenge the patriarchal view that femaleness is naturally fragile in comparison to the strong maleness of men (Alcoff, 1998). Alcoff, Nagoshi and Brzuzy (2010), Snyder (2008), and Yost and Smith (2014) discussed the essentialism of feminist theory, which posits that women can only be those who are born female and who have the ability to carry a child. The essentialist viewpoint developed from the French feminism's position on gender as being *natural*, where a woman's femaleness is essentially different from a man's maleness (Alcoff, 1998; Nagoshi & Brzuzy, 2010). Furthermore, according to essentialism in feminist theory, gender and sex are two constructs that can be easily defined and studied (Yost & Smith, 2014).

Second wave feminism concurs with the findings of Alcoff (1998), Nagoshi and Brzuzy (2010), and Stryker (2008). Stryker stated that feminists in the 1960s and 1970s

opposed the idea of transgender as a concept belonging to feminism. These feminists believed that wanting to alter one’s gender was merely a solution to the distress of gender-based oppression. Stryker explained that transgender men were perceived as attempting to escape their gender roles and unequal pay as women or were seeking the safety of operating as a man *in a man’s world*. Likewise, transgender women were perceived to be avoiding their inferior maleness by escaping to live as a female. These feminists were of the view transgender women should rather be concerned with fighting for the social acceptability of effeminate men in society rather than posing as *real* women. This second wave of feminism also rejected the idea of transsexualism, cross-dressing, hormonal treatment and the surgical altering of one’s body.

However, Halperin (2003) and Yost and Smith (2014) argued that academically, this essentialist viewpoint often does not concur with post-modern understanding of sex and gender, which queer theory attempts to bridge. Shields (2008) and Snyder (2008) noted that second wave essentialism was replaced with third wave feminist ideas of postmodernism with an emphasis on destabilising fixed ideas about gender and sexuality. Therefore, third wave feminism rejects the notion of *woman* and *feminism* being mutually dependent, and embraces ideas of how contradiction, multiplicity and ambiguity can be explored through feminism by employing postmodernist perspectives.

Nagoshi and Brzuzy (2010) described the postmodern perspective of gender binaries as being socially constructed. They further asserted that this has led to some tension between feminist theorists and queer theorists. They also expressed the view that feminist theory that asserts a binary conception of gender is unable to address the intersections of gender with other constructs such as oppression, sex, social structures and power differentials between groups. Nagoshi and Brzuzy argued that if gender is indeed binary, an autonomous self in such a system would be disempowered to resist oppression because the notion of binary

dictates the position of one’s gender in society and the patriarchy. This does not allow for the plurality of selves that are associated with multiple social identities, which are able to resist oppression in the multiple intersections in which these individuals exist. For example, a transgender person may identify as non-binary despite being assigned the label of female or male at birth. Ultimately, gender and sexuality will always intersect in transgender literature. However, as noted by Nagoshi and Brzuzy (2010), feminist theory and queer theory have at times deliberately attempted to separate the two identities of gender and sexuality.

Third wave feminism or transgender feminism moved from the essentialist position of feminism towards including transgender individuals (Snyder, 2008; Stryker, 2008) by endeavouring to dismantle the systems that use gender as a means of oppression. Snyder and Stryker further stated that third wave of feminism embraced the notion of being judgement free about people who did not identify with their gender assigned at birth. Similar to Nagoshi and Brzuzy (2010), Stryker expressed the view that gender is essentially a personal construct that can only be subjectively described and that transgender individuals are “just that way, though most people aren’t” (2008, p. 4). This is in line with the social constructionist viewpoint, which is discussed in Chapter 3.

Queer theory.

Queer theory developed from feminist and social constructionist theories, which hold that sexual behaviours and cognitions are social constructs. As noted previously, social constructionism was a rebellion against the essentialist ideologies of feminism, which linked gender roles, gender identity and sexual orientation within a binary understanding (Nagoshi, & Brzuzy, 2010). Yost and Smith (2014), in their evaluation of various major contributions of feminist psychology and transgender research, found that essentialist views still persist in feminist literature. Yost and Smith further stated that feminist scholars have neglected

research on the intersections of social identities such as race, ethnicity, social class, education, age and sexuality with transgender identities.

Heteronormative gender identity and sexuality are related to the idea that men must be cisgender, male, and heterosexual; and women must be cisgender, female, and heterosexual. For many years, this heteronormative view influenced researchers studying gender identity. However, Minton (1997), Nagoshi and Brzuzy (2010), and Yost and Smith (2014) argued that both feminist scholars and queer scholars should attempt to adopt a non-heteronormative stance in their research. Minton (1997) and Nagoshi and Brzuzy (2010) asserted that non-heteronormative gender identity and sexuality underpin the philosophical and political understandings of research in queer theory.

Minton (1997) and Nagoshi and Brzuzy (2010) defined the term *queer* as an identity, a theory of non-heteronormative sexuality, and a theoretical orientation to comprehend how identity is understood. Accordingly, queer theory aims to describe gender roles, gender identity and sexual orientation as socially constructed concepts. Thus, these constructs can be altered through critical questioning and self-construction in relation to what they mean for an individual.

Feminist and queer theory: Critique and contributions.

Several challenges have emerged in the light of this discussion on feminist theories and queer theories of gender identity.

While acknowledging the imbalance of power and the oppression of individuals because of gender, a feminist theoretical approach still maintains a somewhat essentialist stance (Alcoff, 1988; Nagoshi & Brzuzy, 2010; Shields, 2008). Bornstein (1994), Nagoshi and Brzuzy, and Whittle (2006a) explained that from this essentialist feminist stance, transgender men are perceived as essentially abandoning their oppressed identities and accordingly, do so to be in line with the patriarchy in a power move. Moreover, they

explained that transgender women, although relinquishing their patriarchal privilege and power, are still not considered real biological women who are born female and are able to reproduce.

It is of interest that Heyes (2003) revealed some groups of transgender women have developed a separate form of feminist consciousness to counteract their rejection from traditional, essentialist feminism. Bornstein (1994) described how she was called out by some feminists for still having *male energy*, which she subsequently found meant *male privilege*. These feminists asserted that she would always be a male because she had been socialised as a male and described her as a *castrated male*.

Queer theory, although more closely aligned with the social construction of gender identity and sexuality, has been criticised for still maintaining the stereotypes of gender roles through the promotion of gender categories. Nagoshi and Brzuzy (2010) stated that queer theory accepts the plurality of gender identities, feminine men and masculine women. However, by doing so, queer theory still subscribes to an assumption of female and male gender categories. In addition, Prosser (2006) argued that the inclusion of transgender in queer theory is tantamount to subsuming gender into sexuality because not all transgender individuals identify as gay, lesbian or bisexual but rather as heterosexual. Furthermore, Prosser (2006) asserted that if gender in queer theory is *assigned* and transgender is *performed*, he questioned how the notion of transgender can fit in queer theory by virtue of the fact that it is not assigned.

Thus, it appears that both feminist and queer theories have been able to contribute to the understanding of gender and gender identity. Despite the critique of feminist essentialism, gender as a construct as it intersects with power and patriarchy has been challenged. Traditional ideas of gender and gender roles have been challenged while feminist theories have paved the way for queer theories to emerge.

Queer theory, which is more fluid and non-binary, has contributed to the understanding of gender and gender identity. Queer theory has helped to define gender identity as a socially constructed concept that can be challenged both subjectively as well as in society and politics. Queer theory addresses the intersections of gender, identity, sexuality, power and politics in a way that has helped promote transgender rights globally more than at any other time in history.

Transgender studies.

Stryker (2006) described transgender studies as an academic field that includes transgender sexuality and cross-dressing, intersexuality, sexual orientation, gender diversity, gender atypicality, theories of sexed embodiment and subjective gender identity development, and law and public policy concerning gender expression. Stryker further explained that transgender studies are interdisciplinary in that they include fields such as psychology, social sciences, life sciences, art, medicine and law.

Transgender studies have been influenced by both feminist and queer theories. Furthermore, these studies have focused on issues that are particular to the transgender movement (Hausman, 2001; Heyes, 2003; Whitehead, Thomas, Forkner, & LaMonica, 2012; Whittle, 2006b). However, scholars remain divided as to whether this emerging area of interest is a sub-field of the queer and feminist field or a separate and emerging theoretical field. The literature has often noted two different uses of transgender studies, namely, as either a sub-field or a theory. Moreover, some scholars have used the terms interchangeably with queer and feminist theoretical descriptions (Elliot, 1998; Nagoshi & Brzuzy, 2010; Stryker, 2006; Stryker, 2008; The GLQ Forum, 2004).

Regardless of the way transgender studies are described in the literature, courses in this field are now offered at various universities in the United States such as Yale University

and the University of California because of the gap in academia regarding transgender literature.

Even though transgender is included under the broader banner of the LGBTI (Lesbian, Gay, Bisexual, Transgender, and Intersex) umbrella, transgender individuals face unique challenges mainly because gender identity is somewhat different to sexual orientation despite some overlap (Kunzel, 2014; PsySSA, 2013). Lesbian, gay and bisexual individuals’ sexual orientation is different to heteronormative sexual orientation. Yet, many transgender individuals who undergo a full surgical and hormonal transition may initially identify as gay or lesbian, but once the transition is complete may identify as heterosexual. Some intersex individuals are affected by gender diversity or sexual orientation issues. However, this may not necessarily hold true for all intersex individuals. Therefore, transgender individuals find themselves in a unique position because transgender relates specifically to gender identity.

Other issues are also relevant to transgender studies. These include renaming oneself (Dentice & Dietert, 2015). A change in one’s gender is often associated with the need to use a name that matches the experienced gender. In turn, this is accompanied by the challenges of getting new documentation. In addition, transgender individuals who have decided to transition biologically are required to take hormones for the rest of their lives (WPATH, 2011). These medications have potentially damaging side-effects in the long term and require ongoing medical assessments by doctors who prescribe these medications. Furthermore, transgender studies focus on the broad range of the gender spectrum and individuals’ identification on that spectrum, even though those who identify as gay, lesbian or bisexual may also face incongruence relating to their gender identity if they identify with a gender other than that assigned to them at birth or identify as gender non-conforming.

Therefore, it was from the lens of transgender studies, with influences from feminist and queer theories, that this study was conducted. In this study, the unique position of

transgender identity was explored within the broader theoretical understandings of feminism and queer theories. Despite the enhanced understanding of the phenomenon of transgender, individuals who choose to undergo gender affirming surgery still face many challenges.

Gendered Bodies

The first known surgical intervention to alter a person’s gender occurred in 1931 in Berlin. Dora Richter, a transgender woman, underwent the surgery, which was performed by Magnus Hirshfeld (Stryker, 2008). Surgery during those days was rather dangerous as the medical use of penicillin was still being researched and developed. Over time, surgical techniques and knowledge about hormonal treatment has rendered gender affirming surgery as fairly safe.

Currently, transgender individuals who wish to alter their physical bodies to match their internal sense of gender are able to undergo medical treatment to do so. This treatment includes the use of hormonal medication employed to feminise male bodies or masculinise female bodies. Furthermore, individuals who wish to alter their physical bodies may choose to undergo a variety of surgical interventions.

Cross-sex hormones.

Testosterone therapy is used to treat transgender men who wish to suppress their secondary sex characteristics and become more masculinised. This treatment involves using hormone replacement therapy that is traditionally used to treat natal men with hypogonadism (Unger, 2016). Hypogonadism is a condition in men in which the body fails to produce enough testosterone (Kumar, Kumar, Thakur, & Patidar, 2010). Kumar et al. further noted that while some transgender men begin treatment to gain maximum virilisation, others only seek treatment to suppress their natal secondary sex characteristics. However, the changes that can be expected within three months of beginning treatment may include cessation of menses, increased facial and body hair, skin changes with possible increased acne, changes in

bodily fat distribution, and increases in body mass (Unger, 2016). Unger further explained that later changes that may occur include deepening of the voice, the thinning and shrinking of vaginal tissue and decreased lubrication, and increased clitoral size. Male pattern hair loss may also occur.

Transgender women are treated with cross-sex hormones using oestrogen therapy that has been traditionally used for postmenopausal women. Often adjunctive anti-androgenic therapy is also used (Unger, 2016). The types of changes that can be expected include changing of body fat distribution, reduction of male pattern hair growth, breast tissue growth, decreased testicular size and erectile dysfunction. The estimated time period for these changes to occur is between 18 and 24 months (Unger, 2016).

Gender affirming surgery.

Transgender males seeking surgery are provided with several options, not all of which have to be chosen. Some individuals seek only partial surgical transition because of the inherent risks involved, particularly with genital surgery for transgender men, which often results in loss of fertility and difficulty reconstructing the urethra for upright urination (Monstrey, Ceulemans, & Hoebeke, 2011). Surgery usually occurs in stages. The first stage involves a subcutaneous mastectomy, which is sometimes performed in conjunction with a hysterectomy and/or a salpingo-oophorectomy, that is, the removal of the fallopian tubes and ovaries. The next phase involves genital transformation and can include a vaginectomy, which is the reconstruction of the urethra a scrotoplasty and a penile reconstruction. A penile erectile prosthesis and testicular prosthesis is offered approximately one year later at follow-up (Monstrey, Ceulemans, & Hoebeke, 2011; National Health Service, 2016).

Transgender females may also undergo a range of surgeries including an orchidectomy (removal of the testes), a penectomy (removal of the penis), a vaginoplasty (construction of a vagina), a vulvoplasty (construction of the vulva), a clitoroplasty

(construction of a clitoris with sensation) and breast augmentation (National Health Service, 2016). In conjunction with the surgical risks, there are other reasons that not all of these procedures may be sought; these include infertility, medical reasons for not being able to have a vaginoplasty, socioeconomic status, surgical availability, and personal reasons.

The process of undergoing a surgical transition is not quick or without complications. Furthermore, the physical pain involved may have an adverse effect on an individual’s wellbeing.

Affirming gender in South Africa.

South African transgender individuals who wish to undergo surgical procedures can opt to pay for the treatment privately. At present, most medical aids do not cover gender affirming surgeries. These surgeries and additional psychological and hormonal treatments become extremely expensive if individuals opt to pay for them privately (Bateman, 2011; Nkoana & Nduna, 2012). Nkoana and Nduna asserted that this private treatment is often not possible for poor, working class transgender people in South Africa. Consequently, some of these individuals may attempt to find this funding in ways that are underhanded or not in the best interests of the individual involved. These ways of finding funding are not within the scope of this study.

State-funded treatment is only available at some state hospitals. These include but are not limited to Groote Schuur Hospital in Cape Town; Baragwanath Hospital in Johannesburg; Helen Joseph Hospital in Johannesburg; Steve Biko Academic Hospital in Pretoria; Charlotte Maxeke Hospital in Johannesburg, Greys Hospital in Pietermaritzburg, and Universitas Academic Hospital in Bleomfontein. As noted previously, the cost of treatment at state hospitals to affirm one’s gender is calculated according to an income-related sliding scale (Western Cape Government [WCG], 2016). Thus, affordability of treatment at a state hospital could potentially be a barrier for individuals wishing to undergo surgery.

Dr Kevin Adams, a plastic surgeon at the Groote Schuur Hospital’s transgender unit, is allocated four slots per year to perform gender affirming surgeries (Bateman, 2011). However, there are usually approximately 30 patients awaiting surgery. According to Bateman, this could equate to approximately six years on the waiting list for surgery at Groote Schuur. Other estimates have been as high as 20 years (Newman-Valentine & Duma, 2014). Data for the other hospitals were not available at the time of writing this document.

Transgender patients awaiting surgery often experience isolation, discrimination and problems accessing medical services that may or may not relate to their transition (Newman-Valentine & Duma, 2014; Nkoana & Nduna, 2012). Nkoana and Nduna found that primary health care workers were often not trained to treat transgender patients. They often resorted to biased treatment and/or unnecessary referrals to tertiary health care institutions for conditions that could be treated at primary level. They further related that in some cases, transgender patients who are ready to be referred for surgery are often told to have a private psychiatric assessment in order to get approval for surgery. This is a very costly exercise for people who are not able to afford private health care.

There are some organisations who support transgender individuals in South Africa. A few of these organisations have been contacted by the researcher. However, some of these organisations were sourced from an online blog (DeLarch, n.d.). Some of these organisations include: Gender Dynamix, OUT, GALA, Transgender and Intersex Africa, Triangle Project, Pan Africa ILGA (PAI), Protea Psychosocial Support Project for Trans People, MySexualHealth, Trans Wellness Project, The Trans Collective, S.H.E. (Social, Health and Empowerment Feminist Collective of Transgender Women of South Africa), Rural Trans Love, Iranti.org, CtrlAltGender, Health4Trans (through Anova Health Institute), Action for Social Justice International, and Genderqueer/Genderfluid SA.

Gendered Minds

Individuals who do not fit into the international heteronormative and binary view of gender and sexuality are often subject to adverse experiences such as vulnerability to stigmas, discrimination, threats of murder, and victimisation because of their gender identity (Nel, 2014; PsySSA, 2017; Theron, 2011).

South African law.

The progressive laws in South Africa state that anyone who wishes to change their gender may do so legally, with or without having undergone surgery to do so, and is afforded the same rights and privileges as any other citizen (Theron, 2011). Ironically, the greater continent of Africa does not accept sexually and gender diverse individuals (Nel, 2014). The adverse impact of the trauma experienced by many on the African continent because of their gender identity is immense. Many have fled to South Africa as refugees because of the discrimination and violence that they are threatened with in their own countries (Theron, 2011).

Wellbeing and quality of life post-surgery.

Various studies from the Netherlands and Great Britain have revealed that individuals’ wellbeing and quality of life improve once surgery has been completed (Bouman et al., 2014; McNeil, Bailey, Ellis, Morton, & Regan, 2012). These areas of enhanced wellbeing and quality of life have included life satisfaction, improved bodily satisfaction in relation to gender, less avoidance of public and social spaces, a decrease in mental health service use, reduced depression, reduced self-harm, reduced suicidal ideation and attempts, more social support, and improvement in the quality of sexual relationships and encounters.

The mental health of transgender individuals.

Many transgender individuals may seek mental health care. Their endeavours may not necessarily be limited to their gender identity (WPATH, 2011). According to the WPATH,

these may include depression, anxiety, suicide, sexuality, family and social issues, occupational issues, and other comorbid and psychosocial issues that relate to the individual adjusting to their gender.

Gender Dysphoria is listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) (American Psychiatric Association, 2013) and Gender Identity Disorder is listed in the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* (ICD-10) (World Health Organisation, 1993). These disorders are described as the discomfort or distress that individuals experience between their gender identity and their gender assigned at birth. Although not all individuals experience this distress, this is the primary diagnosis individuals receive when they present for therapy (Campbell, Artz, & Stein, 2015; Cochran, et al., 2014). Furthermore, this diagnosis is often required for a person to be referred for hormonal and surgical interventions (McLachlan, 2019; PsySSA, 2013; WPATH, 2011).

The World Health Organisation (2018) has developed an 11th version of ICD codes (ICD-11), which will come into effect in 2022. This version of ICD codes has altered the way gender identity is coded. It has already been released for comment by the World Health Assembly (World Health Organisation, 2018). Gender identity disorder, also known as gender incongruence in the ICD-10 and ICD-11, has been removed from the mental health category and placed into a newly created category of sexual health conditions. The rationale of the World Health Organisation for making this change is that they feel that there is no scientific evidence that being transgender or having gender incongruence is a mental disorder. However, gender identity has been retained in the ICD-11 to help reduce stigmas and assist transgender individuals to gain better access to health care. The stigmas associated with mental health and being transgender has contributed to negative outcomes for many individuals (Reed et al., 2016). These negative outcomes include uncertain legal status,

human rights violations and barriers to appropriate health care. Reed et al. noted that individuals who are transgender, but who do not have a mental health disorder often find it difficult to access medical health services. They further stated that access to appropriate medical care is lacking even when countries have acknowledged the need for transgender-related health services because individuals have been unable to access medical care because private and public medical insurers have excluded coverage for transgender-related medical care. The World Health Organisation hopes that transgender individuals will be able to access more medically related health care services by changing the coding in the ICD-11.

WPATH and the Sexuality and Gender Division of PsySSA have expressed the firm view that labelling individuals with this diagnosis is intended to classify gender diversity as pathology (McLachlan, 2019; PsySSA, 2013; WPATH, 2011). Thus, it is recommended that a more affirmative stance be taken when addressing transgender issues. By pathologising gender, individuals are exposed to the stigma of suffering from a mental illness when in fact being transgender is not a mental illness, but an experienced incongruence with the identity assigned at birth and which can be altered if the person so wishes. Accordingly, individuals who consider themselves as being transgender self-determine their own gender identity. There are many transgender individuals who do not suffer from gender dysphoria or gender identity disorder and are mentally healthy, and yet who have to be labelled as mentally disordered in order to get approval for treatment (PsySSA, 2013; WPATH, 2011).

In South Africa, as in many parts of the world, individuals seek treatment to obtain approval from mental health professionals such as a psychiatrists and psychologists to undergo hormonal or surgical intervention (Wilson et al., 2014). However, such gatekeeping is no longer practised. Individuals may still need to provide a report drafted by a mental health professional to access services, but this is done from an informed consent model. This model requires a professional such as a doctor or endocrinologist to explain the risks and

benefits of treatment in detail, what is yet unknown regarding these treatments, and to provide alternatives to the individual (PsySSA, 2017).

Although not mandatory for any individual seeking surgery, psychological services are beneficial and may help with issues that arise as a result of transitioning (PsySSA, 2017). However, psychological treatment is expensive. In 2019, the average cost of seeing a psychologist privately in South Africa was between R951.40 and R1,285.00 per hour (Healthman Psychology Costing Guide, 2019). Although medical aids usually cover these costs, many in South Africa are unable to afford such cover. However, although the waiting period is lengthy, psychological services are available through state run clinics and hospitals.

In addition to the difficulties transgender individuals who seek psychological treatment experience, many clinicians and other health care professionals are not trained to work with transgender clients (Graves, 2013; Klein, 2008; Müller, 2013; PsySSA, 2017; Wilson et al., 2014). Transgender education is often not covered in medical or psychological training programmes (Bateman, 2011; Müller, 2013; PsySSA, 2013) and often professionals are unaware of the sensitivity required when treating a transgender individual. Furthermore, referrals have been denied because of professionals’ bias in relation to religious and/or moral grounds or simple ignorance (Bateman, 2011).

Gender Affirmation, Quality of Life and Psychosocial Outcomes

It is also imperative to understand the impact of gender affirmation on an individual’s wellbeing.

Murad et al. (2010) conducted a meta-analysis of quality of life and psychosocial outcomes for individuals who had received both hormonal therapy and gender affirming surgery. They conducted a search using electronic databases, bibliographies of included studies and expert files. All the study designs were included and there were no restrictions on the language in which the studies were written. Reviewers worked independently and in

pairs, and selected studies using predetermined inclusion and exclusion criteria where they extracted outcome and quality data. A random-effects meta-analysis was used to pool proportions from all the studies.

The meta-analysis identified 28 eligible studies. These studies included 1,093 transgender females and 801 transgender males with gender dysphoria[1]. These participants had undergone gender affirming surgery, which included hormonal therapy. All the studies included in the meta-analysis were observational and most lacked controls. Pooling across studies revealed that after gender affirming surgery, 80% of the individuals with gender dysphoria reported a significant improvement in their symptoms (95% CI = 68–89%; 8 studies; I^2 = 82%)[2]; 78% reported a significant improvement in their psychological symptoms (95% CI = 56–94%; 7 studies; I^2 = 86%); 80% reported a significant improvement in their quality of life (95% CI = 72–88%; 16 studies; I^2 = 78%); and 72% reported a significant improvement in their sexual function (95% CI = 60–81%; 15 studies; I^2 = 78%). These findings are subsequently discussed.

Limitations.

Murad et al. (2010) noted the limitations of their study. First, most of data were of European and Western origin. Consequently, cultural factors were not accounted for on a more global scale. Second, the authors acknowledged most of the studies lacked rigorous methodological application and referred in particular to a lack of randomisation and control studies. Some of the studies included self-report measures, which could have resulted in biased results.

[1] The term *gender dysphoria* was used by Murad et al. (2010). In this context it is used to describe a dysphoric mood that results from one’s identified gender not matching their natal gender.

[2] To quantify inconsistency in treatment effects across studies, Murad et al. (2010) used the I^2 statistic, which represents the proportion of variability across trials that is not attributable to random error or chance.

However, as noted by Murad et al. (2010), this was one of the first studies of its kind to conduct a meta-analysis of life satisfaction and psychosocial outcomes of individuals who had undergone gender affirming surgery and who were currently on hormonal treatment.

Murad et al. (2010) revealed the insights into quality of life and psychosocial outcomes included factors such as gender dysphoria, psychiatric comorbidities, quality of life and satisfaction with sexual function. These factors are noteworthy because the wellbeing of transgender individuals who have surgically transitioned is of interest.

Gender dysphoria.

Murad et al.’s (2010) findings revealed that once gender affirming surgery had been completed, 80% of the individuals experienced improvement if they suffered from gender dysphoria. The findings further showed that transgender women experienced a 71% improvement while transgender men experienced an 86% improvement. The participants reported feeling satisfied with their gender after transition, not having doubts about their gender roles and their ability to maintain their gender roles in the future. Furthermore, they experienced enhanced satisfaction with both primary sex characteristics, that is, the external genitalia and secondary sex characteristics, which include gendered features usually obtained during puberty, but in transgender individuals appear through hormonal and/or surgical intervention. Most individuals did not regret undergoing gender affirming procedures. However, in one study, three out of 17 individuals regretted undergoing gender affirmation surgery; of these, two-thirds sought reversal procedures. Furthermore, transgender females who identified as homosexual[3] reported more regrets than those who identified as heterosexual. Moreover, transgender females experienced more remaining dysphoria after the surgery than transgender males.

[3] Murad et al., 2010 used this descriptor in their report, which is not explained further other than referring to homosexual. Dr. M. H. Hassan (one of the authors of this paper) was contacted by the researcher to query this descriptor. However, he stated that the data was not recorded in a more nuanced way to include whether or not the individuals in the study were gay, lesbian or bisexual; or if this was their sexual orientation prior to their transition, or after their transition.

Psychiatric comorbidities.

Many individuals who are awaiting or undergoing gender affirmation experience comorbid psychiatric conditions including mood disorders, anxiety disorders, somatoform disorders, schizophrenia, substance abuse and eating disorders. However, in the meta-study, Murad et al. (2010) revealed that 78% of individuals reported significant improvement in their psychiatric symptoms; transgender women noted an average of a 70% improvement while transgender men reported an average of an 84% improvement. In addition, 76% of transgender women and 81% of transgender men related an improvement in their psychological functioning. Those who had been on hormone therapy for longer noted the highest rates of improvement. Although suicide attempt rates still remained high in comparison to that of the general population, these rates decreased post-surgery. In addition, individuals who experienced more severe psychiatric comorbidity prior to gender affirming surgery and treatment retained higher rates of comorbid psychiatric conditions. Furthermore, those individuals who identified as homosexual after gender affirmation surgery had a higher incidence of psychiatric comorbidity post-surgery.

Quality of life.

Quality of life has been linked with the construct of wellbeing. Consequently, it is imperative when exploring the wellbeing of transgender individuals. Murad et al. (2010) found overall 80% reported improvement in quality of life outcomes post-surgery. Transgender women reported experiencing an 84% increase and transgender men a 78% increase in quality of life. The aspects associated with improvement in quality of life included more stable relationships, better adjustment, satisfaction with gender affirmation, and overall happiness and contentment. Various studies reported other factors such as life becoming easier and more comfortable. Financial status, occupational satisfaction and employment status were also experienced as better.

On the contrary, some transgender women continued to feel socially isolated, have a poorer quality of life and were more dependent on social grants and assistance. These transgender women also found it difficult to enjoy financial and occupational success. Some of these transgender women reported feeling dissatisfied with hormonal therapy because it served as a reminder of their *condition* and at times, made them feel unwell.

Those individuals whose *symptoms* were experienced at a younger age, felt that they adjusted more easily to their affirmed gender roles post-surgery than those who experienced symptoms at a later age. Similarly, when affirming procedures were administered before adulthood, psychological functioning and social functioning were experienced as better than by those who underwent the procedures at a later age.

Satisfaction with sexual function.

Murad et al. (2010) revealed that almost 72% of individuals experienced improved sexual functioning after surgery. This included aspects such as sexual satisfaction, sexual health and sexual functioning.

Transgender Disclosure and Relationships.

Families, friends, colleagues and other social structures are important in providing support to individuals who identify as transgender. Research has shown that a lack of social support for transgender individuals can lead to higher incidences of depression and anxiety (Budge, Adelson, & Howard, 2013), and less familial social support when compared to cisgender siblings (Factor & Rothblum, 2007).

Being part of a family enables individuals to develop bonds, relate to the world and develop linkages of affection (Seibel et al., 2018). Parental relationships with their transgender children have a direct effect on their wellbeing. If transgender individuals are accepted by their families, then they are likely to have more positive health outcomes and greater self-esteem. Those individuals who are not accepted by their families tend to

experience higher levels of depression, substance abuse, suicidal ideation and suicide attempts.

Sibling relationships are often even more complex than parental relationships. When a transgender individual discloses themselves to their siblings, they may face passive or active rejection. This may take the form of passively rejecting the individual as transgender, choosing to overlook the individual’s identified gender in the context of the sibling relationship, and actively engaging in condemnation and ridicule of their transgender sibling (Factor & Rothblum, 2007). This behaviour tends to demoralise the transgender individual and may be perceived as hostile and dismissive (Nuttbrock et al., 2009). If individuals’ transgender identity is accepted by their siblings, they generally feel credible and valid.

Disclosure poses a risk to the stability of long-term romantic relationships in which transgender individuals may be involved. If this disclosure occurs at the beginning of a romantic relationship, the partner may become a source of support and affirmation (Nuttbrock et al., 2009). However, disclosure during a later of stage of a romantic relationship could result in the partner becoming confused about his/her own sexuality and gender role in the relationship and lead to the termination of the relationship.

Transgender individuals often find the most acceptance and validation in friendships, particularly if they have been rejected by other social support structures such as their parents and siblings (Galupo et al., 2014). Individuals who came out to friends prior to transitioning described their friend’s responses as generally positive. These positive responses took the form of using the correct pronouns, using their chosen names and affirming their identities (Galupo et al., 2014).

Nuttbrock et al. (2009) found that disclosing one’s transgender identity in the workplace poses unique challenges including the fear of losing one’s employment, failing to

pass at work, which refers to being perceived as one’s gender by others, name changes and being accepted.

Transgender Stage Theory of Identity Development

Childhood gender identity development.

In this section, childhood gender identity development is explored. It is noteworthy that each child is unique and develops in relation to many varying aspects of biology, socialisation, education, nurturance, culture and family circumstances. This section has been included to shed light on a developmental psychological approach to the theory that underpins the average gender identity formation in children.

Early childhood. Berk (2013), in a study of the emergence of gender identity in children, described a child’s development of gender identity from a cognitive-developmental theoretical approach. Berk stated that children in preschool develop gender constancy, which involves the child’s ability to understand the biological permanence of their gender fully. This combines three notions: Gender labelling, gender stability and gender consistency. Gender labelling entails preschool children being able to label their own sex and that of others correctly. Slightly older pre-school children develop gender stability, which is the understanding that their sex is stable over time. In late preschool and early primary school, children develop gender consistency, which is the ability to understand that sex is biologically based and remains unchanged even if someone dresses in clothing of the opposite sex or pursues activities that are not traditionally associated with their socially accepted gender roles.

Middle childhood. Berk (2013) stated that in middle childhood boys’ and girls’ gender identities follow different paths to each other. During primary school, from Grade 3 to Grade 6, boys tend to gravitate towards identifying with masculine roles. However, girls tend to form a more androgynous role identification. While girls may still identify with

traditionally feminine roles, they also pursue roles that are considered to belong to the other gender. These may include pursuing sports and science and considering occupational roles that are considered more traditionally male orientated such as astronauts or firefighters. During this stage, children make social comparisons and their gender identity begins to include self-evaluations of gender typicality, gender contentedness and pressure to conform to gender roles. Gender typicality is the extent of similarity that the child feels to other children of their gender. Egan and Perry (2001) found that children's psychological wellbeing depends, in some part, on feeling that they fit in with their same-sex peers regardless of whether these peers judge themselves to be highly gender-typed. Gender contentedness relates to the child's gender assignment and their levels of comfort with that assignment. Feeling that they do not relate to the gender to which they have been assigned can hinder happiness and satisfaction of the self. Finally, the pressure children perceive to conform to their gender roles by their parents and peers may be affected by whether their parents and peers approve or disapprove of their gender-related traits. If children feel pressurised to conform to gender roles, they are less likely to explore options that relate to their own interests and talents, and are more likely to be distressed and/or dissatisfied.

Adolescence. Steensma, Kreukels, de Vries and Cohen-Kettenis (2013) revealed that although there is some indication that gendered personality qualities and interests may have changed during adolescence from childhood, gender identity is usually stable and fixed from early childhood and concurs with the child's gender assigned at birth.

The fourteen-stage model of transgender identity development.

Devor (2004) developed a stage model of the various stages of identity development in transsexual[4] individuals. Devor noted that the model is a guide only and it may not apply

[4] Devor uses the word *transsexual* to describe individuals who are both transgender (identify with a gender different to the one assigned to them at birth) and to transitioning physically in order to affirm this expressed gender identity (transsexual). Devor identifies as a transman.

to all transgender individuals in its entirety. He added that only some of the stages may apply and if they are applicable, they may not be in any particular order. Devor developed his model to shed light on various psychological aspects that identity formation may entail as well as various struggles that individuals may experience in their journey of transgender identity development (Barr, Budge, & Adelson, 2016; Devor, 2004). This study has been used by other authors to help assist with understanding a developmental model of transgender identity development (Gozlan, 2018; Katz-Wise et al., 2017; Klein, Holtby, Cook, & Travers, 2015).

Stage 1: Abiding anxiety. In this stage, individuals experience anxiety about their gender and sex. Devor (2004) described individuals’ sense of knowing they are different to their social roles and/or bodies. He explained that these individuals may experience this sense or feeling from early childhood or it may develop over time. He noted that it is common for individuals to report that they have always felt this way, even if they did not have the language to describe what it was they were feeling. These feelings can include a general sense of discomfort around others, of not fitting in and of being socially awkward. Devor explained that over time these feelings become more focused, probably because these individuals come to realise that their preferences, including socialising and participating in activities, are aligned with those of people who are of the opposite gender to them.

Stage 2: Identity confusion about gender assigned at birth. In this stage, individuals begin to think about their assigned gender and sex, which may result in identity confusion. Children may feel that they are in the wrong body or may tell others that they are the opposite gender to that assigned to them at birth. However, owing to the nature of socialised gender roles, they may be told that they are imagining this or that they should not believe this of themselves. This places pressure on these children to conform to the gender roles that are expected of them, which relate to their gender assigned at birth. These children, in turn, may

then tend to hide their feelings from others or deny these feelings to themselves. They may await puberty in order to develop into the gender with which they identify. Devor (2004) stated that when puberty does not bring about the physical changes that these children expected, they may often experience mental health problems such as depression, substance abuse and suicidality.

Devor (2004) further explained that these individuals may respond to these gender anxieties by feeling confused about the appropriateness of their assigned gender at birth. He added they have probably internalised the social rules of the gender they were assigned at birth, which may result in their reluctance to express this confusion to others. They are likely to understand that stigmas towards individuals who identity with a gender not assigned to them at birth exist and that expressing a gender that is different could expose them to other people perceiving them as crazy. Consequently, children and adolescents may attempt to conform even more with the gender roles that are expected of their gender assigned at birth despite feeling inwardly that they do not conform to this gender.

Stage 3: Identity comparisons about gender assigned at birth. According to Devor (2004), during this stage, individuals may understand that their gender assigned at birth has implications for their gender status, the expectations of society and their own needs for self-expression. Because they are expected to conform to their assigned gender at birth, they may begin to express themselves in ways that remain socially acceptable yet allow them to express their gender identity. Consequently, they could express themselves as butch lesbians, sensitive artists or tomboys to name a few examples. Accordingly, individuals are able to express themselves with socially accepted forms of men or women, which allow them to be seen by others and see themselves in others. If these endeavours are unsuccessful, these individuals may proceed to experiment with different types of identity expression and comparison until they realise that they are seen and see themselves in others. Should further

attempts prove unsuccessful, many of these individuals may be rejected by their peer groups, family and/or society at large.

Being rejected by peer groups, family and/or society may have devastating consequences, which are often exacerbated during puberty when they experience the development of secondary sex characteristics that arise out of their assigned gender at birth. These consequences may include low self-esteem, isolation, mental health problems, bullying, physical abuse and social rejection. When adults, these individuals may pursue their experiments related to gender identity comparisons even more fervently. For example, in adulthood, tomboys may outwardly dress as butch lesbians despite feeling they identify more as a man than a woman. This can lead to confusion in their intimate relationships and dissatisfaction within themselves. At the same time, they may encounter the discrimination and experience the stigmas placed on openly lesbian women by some cultures and/or societies, which could further entrench the adverse psychological effects associated with this stage.

Stage 4: Discovery of transgender. Although some children learn about the concept of transgender at an early age, many discover what being transgender means through accidental contact. Devor (2004) asserted that when individuals discover what being transgender means, it often produces an awakening experience. He added that when this happens, individuals often find a space where they can identify themselves and find a language for what they are experiencing. However, others may take some time to absorb this new knowledge and alter how they identify. Consequently, some individuals may experience further confusion about their identity and comparisons with others. However, some individuals are able to accept this new knowledge immediately.

Stage 5: Identity confusion about transgender. Although the discovery of what it means to be transgender is significant in many individuals’ lives, it may take some time to

adapt to this new knowledge. Devor (2004) explained that when individuals first discover what is means to be transgender, they may sit with this new knowledge for some time and only consider it briefly occasionally to explore what it means for them. He noted that over time, these individuals may come to feel that they could identify as transgender. It is then that they may enter into the stage of identity confusion about being transgender and begin to examine their own feelings towards this identity and their external worlds for information and clarity. They could find information through the Internet, non-governmental organisations (NGOs), support groups and other transgender individuals. They may begin therapy and/or investigate what it means to transition medically and surgically.

Stage 6: Identity comparisons about transgender. Once an individual feels they identify as transgender, they then begin to make comparisons with other groups These comparisons help to clarify their new identity. The comparisons may be made between the individual and other transgender individuals, between the individual and those who are from the individual’s assigned gender at birth, and between the individual and people who identify with the gender towards which they may be moving.

A practical illustration of this stage, which is not representative of all individuals who identify as transgender, may be employed to clarify this stage. Individuals who were identified as female assigned at birth may compare themselves to other feminine females and find that they have less in common with them than masculine men assigned male at birth. If they identified as butch lesbian, they may compare themselves to this group and look for ways in which they are both similar and different to this social group. They may find that their interests intersect with more traditionally masculine pursuits than those of traditionally feminine pursuits. Through these comparisons, these individuals may tend to find a sense of congruence by identifying with trans men. Slowly, they may begin to adjust to their identity

by belonging to the group of transmen while simultaneously distancing themselves from being feminine or female in any sense.

Stage 7: Tolerance of transgender identity. Devor (2004) stated that some individuals may go through the identity confusion and identity comparison stages fairly quickly as they acquire a sense of relief in understanding their transgender identity. Others may move through these stages more gradually. Once these individuals have accepted that they identify as transgender, they will go through a stage Devor referred to as identity tolerance. During this stage, individuals come to accept that they are transgender and start to use that label when describing who they are. Devor explained that individuals in this stage are likely to say, “I am probably transgender.” Accordingly, these individuals are able to slowly come to terms with what this means for them. During this stage, individuals further distance themselves from the gender roles they adopted earlier in their lives and begin to acknowledge their new reality to themselves and to others. This new identity of being transgender starts to become prominent during this stage.

Stage 8: Delay before acceptance of transgender identity. Devor (2004) described this stage as a process of reality testing that individuals undertake. In this way, these individuals are able to gather enough information about being transgender so that they can be sure that this is how they identify and that it is the correct path for them. During this stage, individuals endeavour to be accepted for who they really are and often use their close relationships to test this.

Intimate relationships are the first relationships likely to be tested during this stage. If the individual is seen for who they are and accepted by their intimate partners, they often gain the most in all aspects of their lives in accepting their new identity and moving more rapidly into adopting this identity. However, if their transgender identities are not validated in their intimate relationships, these individuals may take longer to make the adjustment.

During this stage, individuals are also likely to test their own reality through interacting with other transgender individuals through support groups, friendships and/or other social contact. In this way, they can work through how they are feeling by comparing themselves to those who are like them and begin to solidify where their identity lies.

Stage 9: Acceptance of transgender identity. Coming to accept their identity as transgender may be relief and is often a new beginning for many transgender individuals. However, for many, this significant relief is accompanied by enormous challenges (Devor, 2004). When individuals come to accept their new identity, they often have to navigate the various aspects of their lives carefully; these include family, relationships, love, gender roles, work expectations and future plans. Because of the ramifications of how their identity will affect all the aspects of their lives, individuals in this stage have to decide whether to proceed further or to remain at this stage.

Stage 10: Delay before transition. Many individuals who come to accept that they are transgender do not take any further steps towards transitioning (Devor, 2004). Some may feel satisfied with merely identifying as transgender. While some may not want to undergo medical or physical transition, others may decide not to proceed further because of the immense sacrifices that they may need to undergo such as health, family, relationships, employment and finances.

Some transgender individuals postpone proceeding further because of practical reasons including not knowing enough about what is involved in transitioning; not knowing how to plan for each phase of transitioning; barriers such as requiring medical and/or psychiatric advice and clearance; financial planning and saving; ensuring family, colleagues and other people in their lives are aware of the changes that they will undergo; exploring psychological mental health; fear of stigmas and rejection; and having access to appropriate personal and professional support systems.

During this stage, individuals may also delay transitioning because they begin to experiment with social transitioning such as clothing, hair, using a new name and adapting to activities that are in line with the person’s gender identity. This experimentation helps the individual to adjust to their new identity slowly before moving forward as they finally shed the traditional gender identity roles that they were expected to perform previously. This social transition allows the individuals to adjust their relationships with others in all contexts as these significant others learn to adapt to the changes that are occurring.

Stage 11: Transition. This stage may differ for each individual (Devor, 2004). Some individuals may feel that their transition began the moment they accepted their transgender identity while others may perceive it began when specific events occurred. These may include seeking psychological services, seeking medical services, beginning to take cross-sex hormones and beginning to undergo surgical transition. What it means to transition may differ for individuals.

While some perceive transition to be complete if they are taking hormones only, others may feel transition has only been completed when they have taken advantage of every possible procedure or treatment they can. However, others believe that transition occurs through their lifetime as they seek self-reflection and personal growth regularly.

Because of the complexity in trying to define what it means to transition, individuals may experience it as an exciting time as well as a difficult and challenging time. There may be periods of time when individuals struggle to be recognised by others for who they are and/or they may face frustration at procedures or medical treatment being delayed. They may also grieve as they experience the loss of who they were before they identified as transgender, leading to feelings of melancholy. Similarly, their families may also grieve for the perceived loss of the person they had known until now. However, these individuals may

also experience this time as extremely liberating as they find themselves and are able to express themselves fully.

Because of the challenges that individuals face during this stage, their normal social activities may be affected, which may include going to restaurants and using public toilets. Shopping may be difficult because they may not know where to find appropriate clothing or where to get their hair cut. This may prove to be unsettling and difficult. Individuals may fear discrimination, violence and harm, which may result in them withdrawing from social engagements and social support. However, moving towards a more congruent and authentic expression of themselves may alleviate these feelings and enhance their mental health and feelings of happiness and wellbeing.

Devor (2004) stated that during this stage, transmen experience relatively rapid changes from the effects of increased testosterone. He noted that this includes a lowering of the voice, increased muscle mass and a change in hair growth patterns on the face, body and head. This allows transmen to be recognised socially as male relatively quickly without the need for surgical procedures. However, Devor explained that initially these effects are less apparent for transwomen because those who have gone through puberty often have masculine secondary sex characteristics, which cannot be reversed easily with hormonal treatment. This adds to their difficulty of being recognised as female. However, he added that once they have had some time to develop more feminine characteristics because of the hormonal intervention, transwomen can live as women successfully without surgical treatment.

Stage 12: Acceptance of post-transition gender identity. Acceptance of oneself is not necessarily based on having achieved a full transition. Acceptance of oneself may happen at any stage. However, during acceptance, individuals accept themselves as members of a different gender group or non-binary group, even if their bodies and lives do not yet fully present that way to others. Devor (2004) explained that some individuals may at first feel as

if they are frauds posing in a different body. They may feel that they cannot yet claim membership of their identified gender and that if they do claim membership they will be challenged. However, individuals begin to claim their space in their bodies and minds over the course of months and years. On a deeper level, they begin to process the profound meaning of what being this gender means. They are able to accomplish this through living as their gender in the world. With time, their sense of self-acceptance increases and they enter what Devor (2004) described as moving from gender dysphoric to gender euphoric.

Stage 13: Integration. Devor (2004) explained this stage as individuals arriving at an acceptance of their gender post-transition and reconciling traditional gender roles with who they are. For example, a transman may begin to struggle with ideas of what masculinity is and how he fits into this now that he has transitioned. A transwoman may begin to question femininity, feminism and her role in traditional female gender roles. With time, these feelings and reflections help inform who they are. Furthermore, Devor explained that at times individuals may come to integrate some of the traits or qualities that they possessed when they were living as the gender assigned to them at birth with their current identity. The process may be a slow progression or it can happen very quickly. However, he noted that often individuals view this as a transformative personal journey where they develop strengths and are able to draw from past experiences to help them get through life’s challenges.

Stage 14: Pride. Pride is the final stage in this model. Devor (2004) described this as a sense of personal pride and political pride. Individuals may feel proud of themselves for what they have accomplished and for coming through the transition process. They may also perceive that the pride they feel can be translated to advocacy for transgender individuals. This advocacy can take the form of quiet moments of advocacy with friends and family or larger scale advocacy by working through NGOs and large organisations.

Summary of the 14-stage model. As noted previously, Devor (2004) explained that these stages can happen in any order and furthermore, individuals may not experience all the stages. They can occur quickly, slowly or not at all. This model is merely employed to shed light on the identity development process that Devor observed through his academic and transgender advocacy work during the course of his career. A summary of the 14 Stage Model, adapted from Pardo and Devor (2017), is presented in Table 1.

Table 1:

14 Stage Model of Transgender Identity

Number	Stage	Some Characteristics	Some Actions
1	Abiding anxiety	Unfocused gender discomfort	Preference for other gender company and activities
2	Identity confusion about gender assigned at birth	First doubts about suitability of gender assigned at birth	Reactive gender conforming activities
3	Identity comparisons about gender assigned at birth	Seeking and considering alternative gender identities	Experimenting with alternative gender consistent identities
4	Discovery of transgender	Learning that transgender exists	Accidental contact with information about transgender
5	Identity confusion about transgender	First doubts about the authenticity of one's own transgender identity	Seeking more information

Number	Stage	Some Characteristics	Some Actions
6	Identity comparisons about transgender	Testing transgender identity using a transgender reference group	Starting to dis-identify with women and females if assigned female at birth or with men and males if assigned male at birth
7	Identity tolerance of transgender identity	Identifying as probably transgender	Increasingly dis-identify as gender assigned at birth
8	Delay before acceptance of transgender identity	Waiting for changed circumstances, looking for confirmation of transgender identity	Seeking more information about transgender, reality testing in intimate relationships and against information about transgender
9	Acceptance of transgender identity	Transgender identity established	Telling others about one's transgender identity
10	Delay before transition	Transgender identity deepens, final dis-identity of gender assigned at birth, anticipatory socialisation	Learning how to do transition, saving money, organising support systems
11	Transition	Changing genders	Gender affirmation
12	Acceptance of post-transition gender identity	Post-transition identity established	Successful post-transition living

Number	Stage	Some Characteristics	Some Actions
13	Integration	Transgender mostly invisible	Stigma management, identity integration
14	Pride	Openly transgender	Transgender advocacy

Critique of the 14-stage model. As a critique, this and other gender identity stage models have either been based on lesbian/gay coming out models, or they tend to blend gender identity and sexual orientation within the models (Budge, Adelson, & Howard, 2013). Therefore, this model of gender identity development should not be seen as the only or most correct model. However, what it does do is assist clinicians to form a general theoretical understanding of how gender identity is developed from a life stage perspective.

Transgender Liminal Space

Liminality may be defined as the transitional or initial stage of a process, or as inhabiting a position at, or on both sides of, a boundary or edge (Liminal, n.d.).

Although liminality was first theorised by Arnold Van Gennep in 1906, his work was largely unknown until it was revived by Victor Turner (Thomassen, 2009). Van Gennep differentiated between rites of passage that involve a change in status for an individual or social group in comparison to those which indicate transitions in time (Thomassen, 2009).

Van Gennep identified three components of liminality: Pre-liminal rites, liminal rites and post-liminal rites (Thomassen, 2009).

Pre-liminal rites, which are also referred to as rites of separation, relate to the metaphorical death of an individual who has to leave something behind by breaking with previously held practices and customs. An example thereof occurs when some young black South African boys are separated from their families and homes, generally at the age of onset of puberty, in order to undergo traditional circumcision as part of an initiation ceremony (Peltzer, 2009). In this example, the boys are asked to leave their boyhood behind,

metaphorically speaking, so that they can enter the transitional phase of becoming a man. This entails leaving behind those boyish aspects of self to make way for manhood (Vincent, 2008). Another example is when a woman chooses to become a Catholic nun. During the pre-liminal stage, she is required to join the community of nuns she has chosen to begin the process of leaving her worldly self behind (Vocation, n.d.).

The *liminal rites* stage, also known as transition rites, is the stage where transition takes place. In the example of traditional circumcision that some traditional cultures practise in South Africa, the boy is transported to a secret location and subjected to a period of rites and rituals led by elders (Vincent, 2008). These rites and rituals are undertaken to prepare the boy for the physical and mental changes that he will go through during circumcision and symbolically, to represent his status as a man in society. It is during this stage that the circumcision is performed. In the example of the woman who wishes to become a Catholic nun, during this stage, she undergoes several years of training and transitions through various stages including postulancy, novitiate and juniorate (Vocation, n.d.),

The *post-liminal stage,* also referred to as rites of incorporation, occurs when the individual re-enters society. It is also considered a re-birth of the individual. In this stage, the boy who has undergone circumcision returns to his home and his loved ones as a man. He has symbolically and metaphorically transformed. Society no longer views him as a boy, but as one of the men in his community (Vincent, 2008). It is also during this stage when the woman makes her final vows in the Catholic church (Vocation, n.d.).

Van Gennep believed that during the liminal stage individuals are faced with (re)discovering their self and identity. This stage is both deconstructive and constructive in that individuals have to deconstruct who they were to construct who they will become (Thomassen, 2009).

When Victor Turner rediscovered Van Gennep’s work, he began to explore liminality in much broader contexts (Thomassen, 2009). Turner’s contribution to the understanding of liminal spaces shed light on the importance of liminal space as well as individuals’ understanding of and reaction to this space. This includes how personality is shaped, the need for individual agency and the merging of thought and experience to form what will become the emergence of the new self once the liminal stage is complete (Thomassen, 2009).

Transgender individuals experience some sense of liminality during their transition (Dentice & Dietert, 2015; Gately, 2010; Thomassen, 2009; Wilson, 2002). Dentice and Dietert, (p. 70) described this liminal state with reference to transgender individuals as “an in-between status or what occurs before/during gender identity transition.” They added that transitional liminality may result in “a personal transformation that is helped along by ritual processes and the formation of supportive communities” (p. 70).

Many transgender individuals seek to remove themselves from the normative gender with the use of hormonal and/or surgical interventions. This new emergence of identity occurs during the liminal phase (Gately, 2010). During the liminal stage, as transgender individuals separate from the identity they have known and renegotiate and reconstitute a new identity, they are often marginalised from society and rejected from the spaces and relationships they had previously navigated (Booth, 2011; Dentice & Dietert, 2015; MacDonald, 1998; The GLQ Forum, 2004; Wilson, 2002).

In the liminal stage, symbolic rituals that constitute a rite of passage for transgender individuals may include changing one’s name, dressing in clothes that are different to those previously worn, changing hairstyles to match individuals’ subjective gender, taking cross-sex hormones and altering physical appearance in other ways (Booth, 2011; Dentice & Dietert, 2015: Wilson, 2002). Growing community support and the formation of new social groups either in an informal relationship or a more formal one such as support groups may

also occur during this stage (Booth, 2011; Dentice & Dietert, 2015; Gately, 2010; Wilson, 2002). The rites of passage involved in this stage are psychological, physical and social.

However, various difficulties and concerns are still evident during this stage. For instance, individuals who have undergone surgery and who do not manage to *pass* for their experienced and affirmed gender in public, may still be subjected to rejection and face higher rates of suicide and comorbid mental disorders (Dentice & Dietert, 2015; Wilson, 2002). Furthermore, some individuals may not be able to transition out of the liminal stage because of situations that are out of their control such as a lack of funds to complete treatment and unavailability of treatment. These effects contribute to a lack of wellbeing among transgender individuals (Wilson, 2002).

Wellbeing

Since Aristotle, theories of what constitutes wellbeing have been developed (Dodge et al., 2012). Ryan and Deci (2001) asserted that the way wellbeing is defined has both theoretical and practical implications. These implications include various spheres such as governmental policies, teaching practices, psychology and therapeutic interventions, and parenting practices.

Dodge et al. (2012) investigated the challenges of defining wellbeing. They noted that there are two general domains of wellbeing that are described in the literature: Hedonic wellbeing and eudaimonic wellbeing. However, Dodge et al. asserted that wellbeing described in the literature only provides the dimensions of wellbeing, but fails to define it. Dodge et al. defined wellbeing as the need to have balance between one’s resources and challenges. Resources include psychological, social and physical resources, which are balanced by psychological, social, and physical challenges. This description of wellbeing may be likened to sitting on a seesaw in the middle of both resources and challenges where individuals are driven to seek a balance between their resources and challenges. In other

words, they are driven by a need for homeostasis. Moving between these two extremes creates *flow,* which is based on Csikszentmihalyi’s (2002) conceptual understanding of the movement between the two extremes. Dodge et al. (2012, p. 230) stated that “stable wellbeing is when individuals have the psychological, social and physical resources they need to meet particular psychological, social and/or physical challenges. When individuals have more challenges than resources, the seesaw dips, along with their wellbeing and vice-versa.”

Hedonic wellbeing.

Hedonic wellbeing includes the constructs of happiness, positive affect and negative affect. Happiness is acquired when an individual experiences higher positive affect than negative affect (Dodge et al., 2012; Ryan & Deci, 2001). Hedonism was first described by Aristippus who was a Greek philosopher from the 4th century B.C. (Ryan & Deci, 2001). Aristippus believed that it was human nature to experience and seek the maximum amount of pleasure possible while avoiding as much pain as possible. He explained happiness as the sum of one’s hedonic experiences.

Hedonic wellbeing has been investigated extensively in psychology, and has focused on both the body and the mind. Ryan and Deci (2001) explained that hedonic wellbeing comprises subjective happiness. They asserted that hedonic wellbeing is not only the pursuit of physical happiness, but is also subjectively evaluated in relation to the attainment of goals or outcomes.

Diener et al. (2003) and Ryan and Deci (2001) described hedonic wellbeing as subjective wellbeing and identified three core facets, which they asserted determine subjective wellbeing: The presence of positive affect, the absence of negative affect and life satisfaction. In essence, these three facets are defined as happiness. Happiness and wellbeing are often used interchangeably to describe subjective wellbeing. However, as noted by Dodge

et al. (2012), wellbeing is far more complex to define. Thus, wellbeing from a hedonic viewpoint is somewhat simplistic.

The PERMA model. Seligman (2011) proposed employing a PERMA model to investigate wellbeing. PERMA is an acronym for the constructs: Positive emotion (P), engagement (E), relationships (R), meaning and purpose (M) and accomplishment (A) (Seligman, 2011). Forgeard, Jayawickreme, Kern, and Seligman (2011) examined the various facets of the PERMA model. Forgeard et al. revealed that these facets of subjective wellbeing are related yet distinct constructs that can be used to describe wellbeing. It is noteworthy that some of these facets also fall within the constructs examined in eudaimonic wellbeing.

Happiness. Although on face validity, asking individuals about their own happiness is clear, happiness can mean many things to many different people. Accordingly, Seligman (2011) stated that happiness as a construct should be deconstructed into a more nuanced understanding of what happiness means because happiness is equated with being in a happy mood. Yet moods fluctuate and according to Seligman, subjective happiness does not necessarily fluctuate in conjunction with an individual’s moods.

Positive emotion. Seligman (2011) defined positive emotion as hedonic feelings of happiness, which may include feeling joyful, content and cheerful (Kern, Waters, Adler, & White, 2015). According to Forgeard et al. (2011), this is one of the most researched constructs in subjective wellbeing studies because of its high face validity. Furthermore, it offers a complementary conceptualisation of the large body of literature on negative emotion.

Several self-report measures have been developed to measure positive emotion. These include the *Positive and Negative Affect Schedule* (Watson, Clark, & Tellegen, 1988) and the *Scale of Positive and Negative Experience* (Diener et al., 2010). Forgeard et al. (2011) claimed that participants who answer these measures may use their current state of positive emotion to extrapolate how they have felt over a long period of time. Furthermore, memory

bias may play a role as individuals are more likely to recall more recent experiences of positive emotions.

Consequently, other measures have been developed to measure positive emotion more accurately. The *Day Reconstruction Method* (Kahneman, Krueger, Schkade, Schwarz, & Stone, 2004) measures the frequency and intensity of a variety of positive and negative emotions over a period of time. The *Experience Sampling Method* (Csikszentmihalyi, Larson, & Prescott, 1977) was developed to improve the accuracy of emotions reported. The *Day Reconstruction Method* and the *Experience Sampling Method* measures allow for richer data to be gathered than self-report measures.

Engagement. When individuals are considered to be engaged, they are in a psychological state in which they are absorbed by and focused on what they are doing. Csikszentmihalyi (1997) described this as flow. It is also considered as *being in the zone*. High levels are engagement are characterised by having clear goals and being interested in a task, which presents challenges that match an individual’s level of skill. Furthermore, direct feedback is given to the individual who has a personal sense of control over the activity and becomes immersed in the task (Forgeard et al., 2011).

Meaning and purpose. Meaning and purpose were studied by humanistic psychologists such as Victor Frankl, and Irvin Yalom in particular in an attempt to understand how meaning and purpose can lead to psychological wellbeing. Although meaning and purpose are relevant for eudaimonic wellbeing, they are discussed in this section because they are part of the PERMA model.

Frankl (1959/2008) wrote about the existential search for meaning that gives purpose to one’s life. He stated that although an individual’s personal meaning in life may change over time, the meaning itself always remains. Frankl believed that meaning in life can be discovered in three ways: “1) by creating a work, or doing a deed; 2) by experiencing

something or encountering someone; and 3) by the attitude we take toward unavoidable suffering” (p. 115). The first way of finding meaning is related to achievement or accomplishment. The second way of finding meaning entails experiencing something good such as goodness, truth and beauty as well as by experiencing the uniqueness of another person and loving him or her. The third way of finding meaning is best described by Frankl: “When we are no longer able to change a situation … we are challenged to change ourselves” (p.116).

Yalom (1989/2013, p. 12) expressed the view that human beings are naturally attuned to seeking meaning because biologically “our nervous systems are organized in such a way that the brain automatically clusters incoming stimuli into configurations.” Yalom added that meaning provides individuals with a sense of mastery. He believed that humans feel helpless and confused when faced with random and un-patterned events. Yet humans endeavour to make sense of these events by organising and ordering them and accordingly, gain a sense of control over them. Furthermore, he stated that meaning gives rise to values and in turn, to a code of behaviour. Yalom asserted, “The answer to why questions (Why do I live?) supplies an answer to how questions (How do I live?)” (p. 12).

Although recent research has examined how meaning and purpose contribute to overall wellbeing, these constructs are considered to be a separate facet of wellbeing (Forgeard et al., 2011). In researching the PERMA model, Forgeard et al. found that although meaning and purpose is a facet of wellbeing, there are few measures of meaning. The *Meaning in Life Questionnaire* developed by Steger, Frazier, Oishi, and Kaler (2006) is one such measure. This instrument measures both the subjective presence of and the subjective search for meaning. However Steger et al. noted that measures of spirituality and/or faith may also tap into the construct of meaning.

Life satisfaction. Life satisfaction measures are widely employed in psychological research (Forgeard et al., 2011). Generally, these questionnaires assess how satisfied individuals are with their lives and are based on their own personal criteria (Shin & Johnson, 1978). This differs from asking individuals how they are feeling because it requires introspection and an evaluation of their life. Life satisfaction is understood subjectively as it is dependent on each individual’s own interpretation of a satisfying life.

However, Forgeard et al. (2011) revealed that measurement of life satisfaction also faces critique. As with positive emotion, individuals may respond according to how they are feeling in the present moment, which makes it difficult to measure because it does not allow for the longitudinal measurement of life satisfaction. Furthermore, Forgeard et al. noted that there may be bias in these types of measures due to social desirability as individuals may wish to project a socially desirable image of themselves. Consequently, the answers to questions may not represent their true feelings. Furthermore, life satisfaction has often been used interchangeably to describe overall wellbeing. This may result in the definitions of life satisfaction and wellbeing being confused, particularly with lay people who may not recognise the subtle differences between the two constructs.

Relationships as social support. Forgeard et al. (2011) described social support as believing that one is cared for, loved and valued. It is through relationships that individuals gain social support, which, in turn, influences their subjective wellbeing.

Accomplishment and competence. Accomplishment and competence was final facet of subjective wellbeing that Seligman (2011) described and Forgeard et al. (2011) investigated. The latter defined accomplishment as success and/or mastery at a high level within a specific domain. Accomplishment can occur by meeting certain standards of success in a field such as sport or business. Individual accomplishment can be achieved through reaching a desired state and achieving personal goals. Furthermore, competence may be defined as a sense of

efficacy individuals possess in relation to both the internal and external environments in which they are. Competence is also listed as one of the three basic psychological needs in Ryan and Deci’s (2000) *self-determination theory.*

A critique of hedonic wellbeing.

Waterman (2008), who described hedonic wellbeing as a subjective way of describing wellbeing, provided a critique thereof. What one individual experiences as hedonic, another may not. For instance, thrill-seeking behaviours may appeal to some but not to others. Consequently, merely employing subjective measures of wellbeing are inherently flawed because these measures do not account for an individual’s many different types of subjective possibilities in comparison with others.

Furthermore, Waterman (2008) stated that both positive and negative affect can be experienced by an individual at the same time. Consequently, to measure only hedonic wellbeing as pleasure rules out the complexity of affect, which may be multifaceted and nuanced at any given time.

Keyes and Annas (2009) asserted that philosophically, hedonia cannot be compared to eudemonia because hedonic happiness forms part of eudaimonic wellbeing and thus, it is not a separate measure of wellbeing. They also stated that hedonic wellbeing is often termed subjective wellbeing. However, eudemonia cannot be objective wellbeing because it comprises both subjective and objective aspects of overall wellbeing. This was supported by Ryff (1989) and Keyes (1998, 2002) who described eudaimonic wellbeing as being subjective in nature. Ryff and Keyes (1995) developed the concept of psychological and social wellbeing and subsequently, developed the *Ryff Scales* to measure six psychological facets of wellbeing.

Ryan and Deci (2001) explained that hedonic wellbeing and by extension the pursuit of happiness, cannot be employed to explain how wellbeing can be achieved in the absence

of happiness. They also noted that seeking pleasure may not result in happiness, but may at times become harmful. An example thereof is substance abuse: Users often pursue the pleasure gained from using substances even though this pursuit is generally harmful over time. Furthermore, Ryan and Deci described how theoretically, hedonic wellbeing focuses on wellbeing as a function of expecting to attain the outcomes that one values. However, these vary for each individual. Ryan and Deci compared aspects of hedonic theory to that of behaviourist theory including reward and punishment. This viewpoint denies individuals the ability to look for congruence, agency and living in accordance with their true self.

It is the researcher’s view that hedonic wellbeing cannot adequately be used to understand the concept of wellbeing fully. To realise a complete understanding of wellbeing, eudaimonic wellbeing must be examined.

Eudaimonic wellbeing.

Philosophers such as Aristotle, Plato and Zeno of Citium were the first to explore eudaimonic wellbeing (Henderson & Knight, 2012). Subsequently, various aspects of wellbeing that constitute eudaimonia have been examined (Henderson & Knight, 2012). Aristotle claimed that in order to live a *good life* one was required to live authentically or in truth to one’s *daimon* (Norton, 1976, as cited in Henderson & Knight, 2012, p. 197). Aristotle believed virtues such as justice, kindness, courage and honesty embodied eudaimonic wellbeing.

Ryff and Singer (2008, p. 16) described Aristotle’s definition of virtue as a “state of character concerned with choice in which deliberate actions are taken to avoid excess or deficiency.” In other words, individuals should balance a virtuous act; for example, neither becoming too vulgar and excessive nor wanting and beggarly in the search for money.

Aristotle believed being virtuous was seeking balance in all things. According to Ryff and Singer (2008), Aristotle developed his thoughts further by stating that human wellbeing

is achieved through personal growth and the realisation of an individual’s true and best self. Furthermore, living according to their daimon or true selves did not only mean living virtuously, but also taking care of themselves physically. This approach takes a longevity standpoint in that wellbeing is dependent on progressively self-actualising both individuals’ inner daimon and physical health.

Modern scholars have since studied eudaimonic wellbeing by examining constructs such as purpose, autonomy, competence, self-realisation, mindfulness, self-acceptance, authenticity, values congruence and social connectedness (Henderson & Knight, 2012). Eudaimonic wellbeing is more complex to explore than hedonic wellbeing because the former involves a continuous process while the latter views wellbeing as a goal to be achieved (Henderson & Knight, 2012).

Self-determination theory. Ryan and Deci (2001) stated that eudaimonic wellbeing is achieved when individuals’ activities are most congruent with their values and they are engaged in what they are doing. Ryan and Deci developed what is referred to as self-determination theory. This theory proposes three basic psychological needs: Autonomy, competence and relatedness. The theory further postulates that if individuals fulfil these needs, psychological growth will occur and they will experience more integrity and more wellbeing. In addition, through gaining mastery over these needs, individuals are able to experience vitality and congruence. Thus, it is a natural aim of individuals to fulfil their needs, which, in turn, influence the meaning and purpose of their actions.

Ryan and Deci’s (2001) self-determination theory also explains how conditions that facilitate wellness vary during different developmental periods and specific social contexts. However, they also noted that not all families, groups and cultures’ needs are equal. Consequently, context and culture play an important determinant in the way wellbeing is achieved across social and cultural contexts.

Six factors of psychological wellbeing. Ryff and Singer (2008) wrote about eudaimonic wellbeing extensively. They drew from developmental theories as well as from works by various humanists and existentialists such as Carl Rogers and Victor Frankl. According to Ryff and Singer, finding meaning and purpose during adversity is challenging, but can be achieved. However, happiness or hedonic wellbeing is not apparent during times of extreme adversity.

Ryff and Keyes (1995) developed *Ryff's six factors of psychological wellbeing,* an instrument to measure wellbeing. They proposed that six factors contribute to eudaimonic wellbeing: Self-acceptance, positive relations with others, personal growth, purpose in life, environmental mastery and autonomy. When individuals evaluate their life and past life positively, they experience *self-acceptance. Personal growth* involves having a sense of continued growth and development as a person. *Purpose in life* occurs when individuals feel they have a purpose in life and life is meaningful. *Positive relations with others* may be defined as enjoying quality relationships with others. *Environmental mastery* relates to individuals' capacity to manage their lives and the surrounding world effectively. *Autonomy* involves having a sense of self-determination.

Questionnaire for eudaimonic wellbeing. Waterman et al. (2010) developed the *Questionnaire for Eudaimonic Well-Being* to measure wellbeing in relation to the conceptualisation of eudaimonist philosophical and theoretical understanding. Factors such as self-discovery, perceived development of one's best potentials, a sense of purpose and meaning in life, intense involvement in activities, investment of significant effort and enjoyment of activities as personally expressive are included in the questionnaire. The presence of subjective expressions of eudaimonic wellbeing in the questionnaire is noteworthy.

Subjective wellbeing has been studied and defined in the section on the hedonic perspective of wellbeing. Waterman et al. (2010) differentiated between the subjective experiences of hedonic subjective wellbeing in which happiness is the end goal of pursuits and eudaimonic wellbeing, which understands the subjective experiences of eudaimonic wellbeing as a by-product of the expression of an individual’s best potentials and pursuit of intrinsic goals. The subjective experiences in eudaimonic wellbeing are indicators of one’s best potentials being realised, but are not the end goal in the pursuit of wellbeing.

The variables that are measured in the *Questionnaire for Eudaimonic Wellbeing* are subsequently defined.

Waterman et al. (2010) described *self-discovery* as the process of knowing what type of person one is. *Perceived development of one’s best potentials* relates to the idea that individuals should actively strive to identify the potentials that are within them and then take action to achieve them so as to be the best person they are able to become. In order to have a *sense of purpose and meaning in life*, individuals should be able to identify their talents and skills, and then decide to which life goals these skills could be directed. *Investment of significant effort in the pursuit of excellence* denotes that in order to reach eudaimonic wellbeing, individuals should place significant effort into developing their areas of excellence. *Intense involvement in activities* means that when individuals are engaged in meaningful activities, their level of effort should be greater than the effort used for more routine activities. *Enjoyment of activities as personally expressive* is directly related to the concept that individuals have of themselves; furthermore, these activities are pursued more often than other general activities.

Conclusion

Gender identity and the theories that have been discussed, namely, feminism, queer theory and the sub-field of transgender studies helped to inform the study in relation to how

gender identity is viewed in the literature. The researcher adopted an affirmative stance regarding gender and believes that it is a fluid concept that is subjectively constructed and given meaning. Accordingly, individuals’ gender identity may manifest in many different ways. There are various ways of expressing gender. Gender occurs on a continuum and accordingly, individuals’ description of their own gender should be affirmed and respected.

Many individuals who are transgender do not change their bodies by taking cross-sex hormones or seeking surgical or other medical interventions. There are many options available for those who do wish to change their bodies. However, the intention of this study was to shed light on the lived experiences of those individuals who chose to change their bodies through surgery and hormones to match their experienced gender.

Being confirmed for surgery and medical treatment is only the first step in a process that these individuals must go through in order to change their bodies. Those seeking treatment through state hospitals are often subjected to lengthy waiting periods. The medical system in South Africa is overwrought with more patients than the system can manage. Individuals seeking gender affirmation surgery are placed on long waiting lists. During this time, the hospitals tend to prioritise emergency operations due to the lack of theatre space available, which further increases the waiting period. Those seeking treatment from private medical professionals often have to face large financial costs. Medical aids in South Africa do not pay for gender affirmation surgery as they view it as an elective and non-essential procedure. Therefore, these individuals often have to wait in order to save enough money to have surgery. In addition, other health care professionals such as specialist doctors and mental health specialists also charge exorbitant fees. Furthermore, any medical procedure or treatment is risky. This is no different for transgender individuals who seek hormonal and surgical interventions. Therefore, treatment cannot proceed without considering the individual’s long-term health.

The literature revealed that those individuals who are awaiting gender affirming surgery may face many physical, mental and social challenges.

The physical challenges that transgender individuals face include medical and surgical interventions as well as their resulting side-effects for those who choose to use them. Furthermore, these individuals may face stigmas regardless of whether or not they choose to use cross-sex hormones or undergo surgical affirmation. Most of society has yet to embrace the idea that gender is a social construct and as such, is only real for the individual describing their own gender. Individuals who are awaiting surgery may face discrimination at work, from friends and family, in social settings and even by those professionals with whom they need to interact to receive care including medical treatment, psychological treatment and surgical treatment.

The psychological effects of having to wait for surgery include higher rates of comorbid mental disorders such as depression and anxiety, increased suicidal ideation, isolation and substance use disorders.

The improved outcomes of many transgender individuals who choose to undergo surgical affirmation procedures have also been discussed in the literature. The areas of resilience and psychosocial wellbeing that contribute to these individuals’ lives include family and social support; affirming and empathic care from professionals such as doctors and psychologists who are trained to work with issues of gender identity; being able to affirm their gender in daily living through the use of clothing, hairstyles, and other non-surgical and non-medical enhancements; changing one’s name; and seeking support from the transgender community.

It is in transgender individuals’ liminal space of affirming their gender that certain rites and rituals can contribute to or hinder their wellbeing. The liminal space is a space for the deconstruction of the old self and the reconstruction of the new self. It is the space where

individuals leave the previous life they were living and prepare to be *reborn* as their new self. This can include rites and rituals that help shed and deconstruct the old self and help construct the new self.

Wellbeing, as discussed in the literature, is a broad area of study. Two distinct areas of wellbeing have been studied: Hedonic wellbeing and eudaimonic wellbeing. Many of the facets used to describe hedonic wellbeing have been incorporated into eudaimonic wellbeing. Eudaimonic wellbeing is more than the pursuit of pleasure and avoidance of pain, which the literature on hedonic wellbeing has noted. It is the pursuit of something greater than oneself and seeks to create individual wellbeing through having meaning and purpose to one’s life and by feeling that life is worth living despite the challenges that one may face. It also incorporates hedonic wellbeing because happiness is a by-product of living well.

In order to focus on the way that the data were analysed, the researcher used the 14-Stage Model of Transgender Identity Formation (Devor, 2004) as a framework from which to identify various themes. However, the purpose of the study was also to explore the lived experiences in the liminal space of those individuals awaiting gender affirming surgery. It is hoped that this will provide greater insight into how wellbeing is maintained through the rites and rituals that these individuals undertake as well as their experiences of liminality in their own journey. Consequently, a qualitative study was conducted. The rationale and steps thereof are explored in the following chapter.

Chapter 3: Research Design and Methodology

In this chapter, the research problem, objectives, research framework and research design are outlined. The sampling technique and size, data collection methods, method of analysis, ethical considerations and limitations are provided. However, as noted in Chapter 1, a detailed insight into the researcher’s position in this research project is explained.

The Researcher

The researcher adopted a stance of curiosity to shed an enhanced understanding on the lived experiences of transgender individuals in South Africa. The researcher became interested in transgender psychological wellbeing when a school friend who had been assigned female at birth informed her that he was transitioning to male. They had several discussions about his transition and how it had affected him. This friend had begun his transition outside of South Africa. Consequently, because the researcher was interested in a South African lived experience, she chose to explore this topic in her dissertation for her master’s degree in clinical psychology. The researcher hopes to work and specialise in gender-related psychological practice and has a keen interest in the wellbeing of transgender individuals and their families and broader systems.

As a point of reflexivity, the researcher explored how being cisgender may influence the research project both positively and negatively. In her reflections, she noted that being cisgender could create distance in the rapport-building process when interviewing participants. As the transgender community has faced discrimination and persecution from many sectors in society, she was aware that being cisgender may be perceived as intruding into a sacred space. Furthermore, reflecting on the fact the researcher is a mother and in her forties, she felt that this maturity and motherly nurturance would stand her in good stead when attempting to build rapport and remain sensitive to nurturing and protecting the rights of the participants.

When planning the research project, the researcher spent a substantial amount of time studying appropriate research theories, models and methodologies. She sought advice from her supervisor, trainers, colleagues and the academics at the university at which she was studying. The researcher chose to use a qualitative research design as she wished to have an in-depth understanding of the participants’ lived experiences. Conducting one-on-one interviews would allow her to observe their body language and non-verbal communication, and develop a good relationship with them.

Personally, the researcher has a liberal and open stance on gender equality and freedom of expression. She believed that by conducting this study, she could help other professionals working in the psychological field in South Africa to have an enhanced understanding of transgender wellbeing. She also hoped that this would help other colleagues to have an informed approach when working with transgender clients.

Purpose of the Research

Individuals who subjectively experience their gender as different from their gender assigned at birth has significant implications to these individuals’ overall sense of wellbeing. Furthermore, in South Africa, those individuals who wish to alter their gender through medical interventions often encounter difficult obstacles. As revealed in the literature, these factors may contribute to these individuals experiencing higher levels of depression, anxiety, suicide attempts, low social and occupational function, and generally lower levels of wellbeing.

During the liminal stage of transitioning, individuals create or encounter rites of passage in which they participate. This assists them in the transitional stage of their transformation. However, these rites of passage cannot guarantee the outcome of affirming their gender surgically. Many individuals face stigmas both inside and outside of their social circles. Renegotiating identity is an arduous journey wherein many individuals face

challenges that can either detract from or contribute to their overall wellbeing. This study was conducted to understand the liminal space within the process of transitioning better, and shed light on how rites and rituals contributed towards wellbeing for those awaiting gender affirming surgery in South Africa.

Objectives of the Research

Only a paucity of studies have examined the experiences of individuals during the liminal stage prior to gender affirming surgery. Moreover, there is a scarcity of research that pertains particularly to the South African population, who may experience lengthy waiting periods in state hospitals or significant financial challenges if seeking private care. Furthermore, there are many psychosocial problems that may affect wellbeing during this stage as well as many types of rites and rituals, which can be enlisted to mitigate the negative effects of these psychosocial problems.

It was hoped this study would offer insight into how the liminal stage in transitioning for transgender individuals awaiting surgery in South Africa was experienced. The researcher also hoped to discover if individuals performed rites and rituals that contributed to their wellbeing and what factors they perceived either supported or prevented them from experiencing wellbeing.

Consequently, the following research questions were formulated: First, how do transgender individuals awaiting gender affirmation surgery in South Africa experience the liminal stage of transitioning? Second, how do the rites and rituals they undertake during this stage contribute to their wellbeing?

Research Design

Quantitative research versus qualitative research.

Quantitative research methods employ a realist and positivist ontology, which seeks to find a reality that is observable, measurable and scientifically valid (Raddon, 2010). While

a positivist method hopes to explain a phenomenon, an inductive qualitative approach hopes to understand a phenomenon.

Lived experiences are subjective and are formed from individuals’ experiences of their world. Therefore, these experiences cannot be understood objectively and can never represent a factual outcome, which is what is required in quantitative research designs. Quantitative research designs also do not allow for a flexible approach in data collection and/or analysis (Raddon, 2010). Because the nature of individuals’ gender identity is a subjective understanding of how they relate to gender, an objective understanding of how gender identity is experienced by individuals is not possible. Therefore, one can only hope to understand gender identity, but never scientifically describe it.

Qualitative research designs allow the process to bend and shape in accordance with the needs of the research and during the data collection stage (Terre Blanche, Durrheim, & Painter, 2011). Because interviewing participants about their lived experiences requires a degree of flexibility to allow the narrative to emerge, qualitative research designs are more suited to working with subjective textual data. During the interview process, questions may emerge from what is being discussed. A structured questionnaire would not allow for this flexibility. Terre Blanche et al. also stated that qualitative designs are not limited by purely technical limitations. Because gender identity is complex and there are many ways that individuals who are transgender describe themselves including non-binary, gender-fluid and transgender, technical limitations on language using quantitative, operationally defined variables would have impeded an in-depth understanding of how individuals perceive and describe themselves. Furthermore, the descriptors that individuals use to describe themselves are ever-changing and may also vary from community to community (TransgenderNI, n.d.; Vaden Health Centre, n.d.). Thus, a degree of flexibility in the research design was necessary.

Social constructionism.

A qualitative enquiry within a social constructionist framework was employed in this study. The social constructionist framework posits that reality and knowledge are socially and personally constructed (Andrews, 2012; de Vos, Strydom, Fouché, & Delport, 2016; Edley, 2001). Thus, it is through social interactions that meaning is constructed (Goldenberg & Goldenberg, 2008).

Becvar and Becvar (2013) described social constructionism as the deconstruction and reconstruction of meaning through language. The creation of narratives creates context. Consequently, a narrative approach was utilized to analyse the data. This approach assumes that individuals’ lived experiences are best understood from their own perspective. Furthermore, the focus is on individuals’ subjective experiences of their own lives (de Vos et al., 2016). This approach also assumes that the researcher cannot know the lived experience of another. Rather, the researcher gathers the data and presents it in a way that allows the participants’ stories to be self-evident (de Vos et al., 2016).

Interviews.

One-on-one interviews were conducted with the participants. According to Monette, Sullivan, and DeJong (2005), the interview is a social relationship, which is the researcher’s responsibility to understand and manage, to best elicit an exchange where information will flow. In essence, the researcher attempts to understand the lived experiences of the participant. Various challenges are inherent in this relationship. De Vos et al. (2016) stated that these challenges may include establishing rapport, coping with unanticipated problems and rewards of working in the field, and recording and managing a large amount of data.

To guide the interview process, a semi-structured interview schedule was created, which was based on the theoretical understanding of transgender as a phenomenon and transitioning during the liminal stage. This schedule can be found in Appendix D. A semi-

structured interview format was chosen because it allowed the researcher to guide the interview in a way that elicited the information required while still allowing for flexibility should further information be needed to expand on a theme or question (de Vos et al., 2016). This format was also chosen because the researcher felt that this structure would allow her to test the questions beforehand on a few select advisors of the study. Within this structure the researcher aimed to remain as flexible as possible to ensure that the interview was not perceived as too formal and instructive. Therefore, the questions were rehearsed prior to the interviews being conducted.

The interview questions explored topics such as types of activities the participants engaged in, creating a sense of wellbeing while awaiting surgery and any actions or rituals they undertook to help them feel more like their affirmed gender. The latter could include shopping for new clothes, seeking support from friends or networks, and participating in social activities.

To ensure that the interviews were effective, the following considerations were taken into account:

a) The Questions

The questions were open-ended to afford the participants the opportunity to express their full range of behaviours, thoughts, emotions, memories, and other important stories that they wished to relate. Seidman (1998) stated that to be truly open-ended, it was imperative for questions to be written in such a way that there are no pre-determined answers. Furthermore, open-ended questions require more than a *yes* or *no* response. The questions also need to be sensitive to the participant’s situation and the researcher should avoid asking any deep and personal questions without first building rapport. Therefore, Seidman

recommended asking questions about experiences and behaviours before asking questions about opinions and feelings. In addition, questions should be created to move from more general topics to more specific topics. The researcher used this information to develop an interview schedule.

b) Communication Techniques

Mutual attentiveness, monitoring and responsiveness aided in helping the interview to proceed smoothly. De Vos et al. (2016) listed several techniques that can be employed to ensure an effective interview including minimal verbal responses such as *yes I see* or *mmm,* paraphrasing, clarifying, reflecting, encouraging, commenting, spurring on, summarising reflectively, listening, probing, showing understanding, allowing time for elaboration, acknowledging, direct questioning and procuring details. By enlisting these tools, the researcher hoped to encourage a flow of dialogue between the participants and herself.

c) Although each interview was expected to last approximately 90 minutes, the researcher remained flexible to see what information emerged as a result of this flexibility.

Participants

Snowball and convenience sampling techniques were employed to get participants. These sampling techniques were used because of the limited population of transgender individuals. Furthermore, access was restricted because of the sensitivity of the topic being researched. The inclusion criteria included residing in South Africa, having been confirmed for surgery and awaiting surgery. The inclusion criteria did not specify any age group, gender or method of medical treatment, more specifically, state versus private medical treatment.

Six participants were recruited for the study using contacts at Gender Dynamix and through contact with other transgender individuals. Gender Dynamix is an NGO that focuses

particularly on advocacy and research, capacity enhancement, facilitating of community access to direct services and organisation development within the transgender and gender diverse community (www.genderdynamix.org.za). Gender Dynamix operates in South Africa and across southern Africa, and has been instrumental in developing an affirmative stance towards transgender and gender diverse communities.

Of the six participants, three were from Cape Town in the Western Cape province, two were from Johannesburg in Gauteng and one was from Pretoria in Gauteng. Participants from other provinces were not included because of the limited scope of the study and limited availability of participants.

Efforts to recruit participants were made over several months by contacting NGOs, individuals and state hospitals. Their names have not been included as they did not participate in the study. The researcher had hoped to find a demographically representative sample of participants. However, the response from these various stakeholders was either not forthcoming or they stated that they did not provide the names of possible participants for research due to ethical considerations. Therefore, the researcher decided that no further attempts to recruit a representative sample could be made through these channels because of time constraints and because the many possible channels to obtain participants had been closed. Therefore, the researcher proceeded with the study with only the available participants. It is recommended that a large sample be employed in future studies.

The interviews with the participant(s) from Cape Town, Pretoria and Johannesburg were held at Regus Offices in Cape Town, UNISA in Pretoria and Third Space in Johannesburg, respectively. All interviews were conducted in private conference rooms or in private office spaces. The interviews lasted between 70 and 90 minutes. This excluded the time before the interviews to build rapport and after the interviews to debrief the participants.

Description of the participants.

The participants were recruited from three major cities in South Africa. The participants in Cape Town included two transmen and one transwoman, those in Johannesburg included two transmen and the participant from Pretoria was a transwoman. All the participants had begun taking hormonal treatment and only one participant (a transman in Johannesburg) had undergone any surgical transformation. This surgery involved a hysterectomy. At the time of the interviews, all the participants were awaiting surgery.

The demographics of the participants revealed four were white one was coloured and one was black. Five were South African nationals and one was a refugee from East Africa. All the participants with the exception of the refugee were employed formally in full-time positions. The refugee was employed informally as a sex worker and volunteered for a transgender advocacy organisation. While five South African participants all had private medical aids, the refugee relied on state-funded medical treatment. All the participants had completed high school and two had university degrees. At the time of the interviews, two of the participants were in a romantic relationship; one had been romantically involved since before coming out as transgender.

Participants’ details.

The participants’ details as well as clinical impressions that were observed during their interviews, which are based on the Mental Status Exam (MSE), follow. The MSE is a clinical tool, which is employed as an observational assessment of an individual’s mental status at the time of interviewing (Sadock, Sadock, & Ruiz, 2015). The MSE takes into consideration the clinician’s general observations, which include the interviewee’s appearance, speech, behaviour, attitude and cooperativeness. The MSE also includes observations in relation to the person’s thinking including their thought processes, thought content and perceptions. Emotional states are explored by examining the person’s mood

(objectively expressed by the person) and their affect (subjectively seen by the observer). Finally, the individual’s cognitive functioning is considered and includes information about being oriented to person, time and place, their level of attention, memory, insight, and judgement. These observations allow a clinician to make accurate descriptions of an individual’s functioning at the time of the interview and provide insight into their general level of functioning. Each participant’s MSE is included in this section to allow the reader to know the participants as seen through the eyes of the researcher.

Participant 1 (P1.). P1 was a 35-year-old transwoman who shared a flat with another transwoman. She sought treatment at a state hospital. She was confirmed for surgery when she was 30 years of age. She worked as a volunteer in an advocacy role for Gender Dynamix. She was also a sex worker. She had come to South Africa from East Africa as a refugee when she was in her early twenties. She was single. She was also a member of the Sisterhood for Sex Workers. However, she did not specify which organisation this falls under. P1 also belonged to a transgender support group.

Clinical impressions of P1 revealed that she was pleasant and cooperative. She appeared to be her stated age and was well groomed with good hygiene. Her general state of physical health appeared to be good. P1 displayed a dramatic attitude where she presented as being emotional and flamboyant. Her facial expressions were appropriate to the context. Her speech was normal in volume, but elevated in rate and tone. However, it was noted that English was not her first language and she struggled to convey herself easily in English. Her psychomotor behaviour was increased with fidgety behaviour observed. P1’s affect was appropriate to the context and her mood was dysphoric. She showed no deficits in her perception and cognition. She reported no problems with sleep apart from not being able to get enough rest owing to erratic work hours. Her eating habits and weight were normal. P1 also appeared to have good insight and judgement.

Participant 2 (P2). P2 was a 29-year-old transwoman. She was seeking private care and was confirmed for surgery in August 2018. She lived on her own and was currently single. P2 was a lecturer at a university. She was a member of an online support group.

During the interview, P2 was pleasant and cooperative. She also had the ability to sustain attention. She appeared to be her stated age and had a good state of general health. She was dressed neatly in work-casual clothing. She was neat and well groomed. P2 had an open attitude. Her facial expressions were appropriate to the situation. Her speech was normal in rate, tone and volume. P2 showed no abnormalities in her behaviour or psychomotor activity. Her mood was euthymic and her affect was appropriate for the context. P2 had no disorders of perception or cognition. She also reported no somatic complaints. She was oriented to person, time and place. She had good insight and judgement.

Participant 3 (P3.). P3 was a transman. He was 26 years old and lived with his father and stepmother. At the stage of the interview he was single. He worked as a consultant. He was a member of support groups on Facebook and WhatsApp. He was seeking treatment privately and had undergone a hysterectomy. He was confirmed for surgery in 2017. P3 and Participant 6 (P6) arrived at their interviews together and stated that they were best friends. However, they were interviewed separately.

During the interview, P3 was observed to be pleasant and cooperative. He was also attentive. As the interview was held on a Saturday morning, P3 was dressed casually and appeared neat and well groomed. He had several tattoos and piercings. He appeared his stated age and had a good state of physical health. P3 had an open attitude and his facial expressions were happy and appropriate for the situation. His speech was normal in rate, tone and volume. He had no abnormalities in his behaviour and psychomotor activity. His mood was euthymic and he had an appropriate affect. P3 had no abnormalities of perception or cognition. He reported no somatic complaints. He also had good insight and judgement.

Participant 4 (P4). P4 was a 33-year-old transman. He was seeking treatment privately and was confirmed for surgery in May 2018. Prior to his transition, he was married to a cisgender male. However, when P4 began to transition, he divorced his husband because he stated that his husband did not want to be married to a man. He currently lived with his girlfriend. He was employed by a government department in a major South African city. He stated that he was a member of a support group, but did not indicate which one.

P4 displayed a high level of cooperation and pleasant attitude during the interview. He appeared to be his stated age and had a good state of physical health. He was neat and well groomed. P4 was open during the interview and his facial expressions were appropriate for the context. His speech was normal in rate, tone and volume. He had no abnormalities in his behaviour and psychomotor activities. His mood was euthymic and he had a mood-congruent affect. He showed no dysfunction in his perception and cognition, and reported no somatic complaints, apart from being overweight. He was oriented to person, time and place. He showed good insight and judgment.

Participant 5 (P5.). P5 was a 31-year-old transman. He was s not married, but lived with his life partner in a committed partnership. He was employed in client service. He was confirmed for surgery in April 2018 and was seeking treatment privately. He was a member of a support group, but did not indicate which one.

A friend of P5’s accompanied him to the interview. P5 stated that he had asked his friend to attend the interview with him because he wanted her support and he felt safer with her there. P5 was cooperative and attentive during the interview. He was well dressed and well groomed. He appeared to pay particular attention to his fashion style and had a modern dress sense. He was clean shaven. He appeared to be his stated age and was observed to have a good state of general health. P5 had an open attitude during the interview. His facial expressions were appropriate for the situation. His speech was normal in rate and tone. His

volume of speech was increased and he tended to share information in an elaborate way. There appeared to be no abnormalities in his behaviour or psychomotor activity. His mood was euthymic and he had a mood congruent affect. P5 had no abnormalities of perception and cognition. P5 reported that he suffered from diabetes, which was controlled. However, he also acknowledged that he had been told by his doctor to lose weight prior to having surgery. He was oriented to person, time and place. He also had good insight and judgement.

Participant 6 (P6). P6 was 26-year-old a transman who lived with his brother. He was employed as a salesperson in a retail establishment. He was single. Although P6 had been confirmed for surgery privately, he did not indicate when he was confirmed for surgery. He also did not indicate if he was a member of any support groups.

Clinical impressions of P6 were that he was pleasant and cooperative, and could sustain attention. He appeared younger than his stated age. He was casually dressed, but was neat and well groomed. He had several tattoos and piercings. P6 had an open attitude towards the interview and his facial expressions were appropriate for the context. His speech was normal in rate, tone and volume. P6 displayed no abnormalities in behaviour or psychomotor activity. His mood was euthymic and he had an appropriate affect. P6 had no disturbances of perception and cognition. He reported no somatic complaints. He was oriented to person, time and place. He also showed good insight and judgement.

Ethical Considerations

In as far as possible, it was a primary ethical consideration to do no harm to anyone participating in this research study. Therefore, the following considerations were made to mitigate any harmful effects that this study may have had on the participants, stakeholders and researcher.

As this study was conducted on a minority population, issues of vulnerability were considered. Consequently, it was imperative to obtain ethical clearance from the University

of South Africa’s ethics committee in the Department of Psychology prior to beginning any data gathering. The researcher received ethical clearance for this study in November 2017.

The researcher informed the participants of their rights and responsibilities as well as of her own rights and responsibilities. The participants were also informed of any potential negative psychological effects that could be expected such as the re-surfacing of painful memories. They were given an opportunity to discuss this with the researcher. Furthermore, the researcher was honest about the purposes of the study and did not intentionally mislead participants or misrepresent the institution with which she is affiliated.

In addition, a letter of consent from each participant was required to ensure that their participation was voluntary and that they would be free to withdraw from the study at any point should they have wished to do so. The signed letters of consent have not been included in this document to protect the participant’s identities. However, they have been stored securely. An example of a letter of consent may be found in Appendix A.

All the data and information relating to the study have been held securely. Furthermore, any identifying information was not disclosed to anyone other than the researcher. This was done to protect the identities of the participants and to avoid any unwanted effects that such attention may cause.

As the population was a vulnerable one, the researcher debriefed the participants after their interview and offered to refer them to a psychotherapy clinic should they have felt that they required further psychological care. During the debriefing the participants were asked if they felt distressed in any way about what had been discussed and if they wished to explore this distress. In addition, any areas of concern such as suicidality that had been mentioned were explored. All the participants stated that they did not experience distress and therefore, declined any further discussion regarding distress. None of the participants indicated that they were feeling suicidal or that they suffered from suicidal ideation after the interviews. Should

the participants have wanted further counselling or psychotherapy, the researcher would have referred them to the counselling services offered through Gender Dynamix in Cape Town and the UNISA Psychotherapy Clinic in Pretoria.

Once the researcher had obtained informed consent from the participants, interviews were arranged with them at a time and place that was convenient and safe for both parties.

Methodology

To build rapport, the researcher first administered a biographical questionnaire, which can be found in Appendix C, and explained the research objectives and rationale to the participants. They were informed that their identifying information would not be used in the research report. The biographical questionnaire included no information that identified the individual, but did include the institution at which they were on the waiting list for surgery. Although no names were included, the questionnaire also included with whom they lived and whether they were employed or not.

The participants had the opportunity to ask the researcher any questions that they wanted to regarding the study. This allowed the participants to feel more comfortable speaking to the researcher. The researcher requested permission to record the interview. The participants were assured that these recordings would only be used to transcribe the interviews. Thereafter, these recordings would be placed in secure storage and destroyed after a period of five years.

Once the interviews had been conducted, the recordings were transcribed using Microsoft® Word for Mac (version 15.4.1.). Thereafter, the researcher analysed the transcripts for emerging themes, which included collective themes and distinct themes. This was conducted by employing thematic coding using AtlasTi (version 8.4.2.). The transcripts were uploaded on AtlasTi. Each transcript was read through individually and assigned relevant codes. These codes were then analysed jointly and subsequently integrated. This

included colour coding each category. This integration comprised the merging of codes that were similar or identical. This ensured that codes represented accurate data and were not repeated. This enhanced the reliability of the coding and analysis. Renaming codes across each transcript was conducted to ensure uniformity and align codes. Thematic analysis was conducted by arranging the codes into main themes and subthemes. One of the benefits of using thematic analysis is that it is flexible and can be applied across a range of theoretical or epistemological approaches (Braun & Clarke, 2006). Thematic analysis aided the researcher to identify, analyse and report the patterns or themes within the data. The researcher defined themes based on incidences of repetitive or patterned responses across the entire data set. The data were analysed by employing a theoretical or deductive method. Braun and Clarke noted that deductive analysis of themes is specifically used when a researcher wishes to use the analysis to make comparisons with previous literature and/or theory. This method allowed the researcher to provide a more detailed analysis of specific aspects of the data, which could be related to theory and previous research.

Findings of Analysis

Themes.

As noted previously, transcripts were created from the recordings of the interviews. These transcripts were created twice to ensure that each transcription was accurate. Subsequently, the two versions of each transcript were analysed and edited into one concise transcript. The transcripts were then read while playing the recordings back to ensure that all the information had been transcribed.

Thereafter, the researcher read the completed transcripts several times over a three-month period. She jotted down rough notes about various themes and reflected to understand the various main themes and sub-themes that could emerge during coding.

Although coding was done using open coding in AtlasTi and various themes emerged, the researcher was forced to code the data a second time because all the data from the researcher’s AtlasTi programme were accidentally deleted during a hardware update. The themes that emerged during the second coding exercise concurred with what those in the first coding exercise. This coding was done by utilising an open coding format where transcripts were read and themes allocated to various portions of the text in each transcript individually. Thereafter, the researcher analysed the codes using AtlasTi by comparing the codes between transcripts. These various codes were then sorted into themes and sub-themes through inductive coding. Inductive coding allows the theory to emerge from the data rather theory being sought from the data, which occurs when employing a deductive approach (Terre Blanche et al., 2011).

Conclusion.

In this chapter, the researcher’s position in relation to the study was discussed. Furthermore, the purpose of the study and objectives thereof were outlined. The reasons a qualitative methodology was employed rather than a quantitative methodology are provided. The advantages of semi-structured interviews were explained. The sampling technique that was employed is also outlined. Finally, a short description of each participant is provided. In Chapter 4, the detailed findings of the analysis are described and the various themes and subthemes defined. Relevant portions of the transcripts are included in Chapter 4 to provide the reader with a detailed understanding of the experiences of the participants. The presentation of themes is arranged according to the themes that emerged. The researcher also related the themes to previous literature.

Chapter 4: Findings

Introduction: The Study

The study.

In this chapter, the findings of the study are outlined and insight into how the themes were understood in relation to the literature is provided.

All the participants' quotations are shown in ***bold italics*** to differentiate these quotes from the main text of this research document. Where words have been replaced to protect the privacy of participants, square brackets are used **[*as such*]**. Any comments the researcher has made, have been placed within the quotations from the participants and indicated in parentheses (as such).

Themes and subthemes.

Although there were many co-occurring codes that overlapped, the researcher sorted through the codes to identify overarching themes and then allocated sub-themes to the main themes. The themes that were identified are as follows:

Table 2:

Themes and Subthemes

Themes	*Subthemes*
Coming Out	Always knowing
	Sexual orientation
	School
	Work
	Discovery of self
Relationships	Fathers
	Mothers
	Siblings

Themes	*Subthemes*
	Romantic relationships
	Friends
Wellbeing	Psychological wellbeing
	Eudaimonic wellbeing
Misgendering/Misnaming	
Support	
Medical Care	Public or Private care
	Medical Aids
Liminality	
Surgery, Hormones and Dreams	
Rites and Rituals	

Theme: Coming Out

Coming out is a term that the participants used to describe how they understood their identity and their experiences when they disclosed these shifts. They also used the term to describe their sense of knowing that they felt different to other children and their exploration of their sexual orientation. Furthermore, it was employed to acknowledge identifying as transgender. In addition, it was utilised to explain the role of these factors when they came out to their family, friends, work colleagues and school friends. Because relationships emerged as a main theme, the data that is related to coming out in relationships is explored in a subsequent section. The sub-themes of *coming out* included always knowing that they were different, identifying as lesbian, gay or bisexual, coming out at school, coming out at work and coming out as transgender.

Always knowing.

When participants were asked about their journey thus far, many related that they had always felt different to their assigned gender.

P4 said, "***Ok, um, from young I always knew that something was up. That I was different***."

P3 related that he had always identified as male:

> ***So, obviously assigned female at birth. Um. I knew like intrinsically there was something that didn't match up. I've got an older sister, an older brother, and a younger sister. And from early I used to say to my gran, 'Where's my penis?' And I used to try and bust in on my brother in the shower so I could see his body and understand why our bodies were different. I always used to, when my mom would take us both shopping, I would go straight to the boy's department. She would say, 'That's s not where you shop when you come here.' And I used to steal my brother's clothes, and his caps, which would drive him insane***.

P5 explained that he had always felt different to his assigned gender:

> ***Well, um sounds like such a cliché to say I have always felt this way, but I have. And when I was smaller my father would cut the grass outside and I could not wait for those days as I would always be in shorts and no shirt and it was like so much fun for me***.

P2 shared:

> ***Um, and usually when I used to play with my brothers I always used to be the girl or whatever the case may be. You know, take the more feminine, not necessarily submissive role, but definitely the feminine role. I always used to sing along to the girl characters in the Disney movies, and pick the girl***

> ***characters for video games you know. Very sort of um, well, to me it was completely natural because that's what it was***.

P6 explained:

> ***I was about five when I realised I was different and I was the same as them. I had an older brother. He passed away. He and I could be twins. We were 17 months apart. Um, I realised I was trans when I was a kid***.

P1 related that she felt she knew she was a transgender from childhood. She explained, "***When I was a child, I feel like I don't belong***".

This sense of somehow being different to other children was often confusing. Some of the participants knew from childhood that their assigned gender at birth did not match their identified gender. However, others knew that there was something different about them, but that they had no idea or conceptualisation of why.

Sexual orientation.

As noted in the literature, gender identity and sexual orientation are different (Kunzel, 2014; PsySSA, 2013). Because of the difficulty of being raised without any knowledge of what being transgender meant or having the language to express this, many participants stated that they had believed they were either lesbian, gay or bisexual.

P4 related:

> ***I think I accepted my orientation, look I identify as bi so… I thought ok, that's fine, that's ok. And I just thought I'm a masculine female. But I couldn't see myself as a lesbian or as a butch lesbian. It just didn't make sense to me***.

P3 shared, "***I just knew, ok, I'm not a girl. I like girls so I must be a lesbian… I came out as a lesbian. Um. I didn't know transgender existed***."

P5 stated, "***As most of the guys that I know, you live as like a lesbian because that is more accepted and people are still ok with that and it went on like that for years***."

P6 related that he always knew he was not female, but that ***"… so I just didn't have any words***."

P2 explained, "***So, in my frame of reference you know you could be gay and that was it. There was no idea of you know, transgender***."

P1 was the only participant who did not indicate if she initially identified as gay, lesbian or bisexual.

School.

Only P3 discussed coming out as lesbian at school. However, it is noteworthy that because of coming out he experienced discrimination and bullying, which affected him psychologically. The bullying became so severe that he was eventually moved to a girls only school.

He thus related his experience:

> ***And then I was outed at school and I started, I was really badly bullied at [high school].*** (Researcher asked: Who outed you?)***. Funnily enough, I was very religious and I went to a home cell. And, this particular night I was the only one at home cell. And I told the home cell leader and she told her younger sister, who was two years above me. And when I got to school on the Monday everyone knew. I wasn't me anymore. I was that lesbian in Grade 9. I started being really badly bullied, and then my parents pulled me out of [high school] and put me in [girls only school].***

P3 thus described attending the girls only school:

> ***Because identifying as a lesbian in an all-girl's school, it was irrelevant. People didn't care. And I still had long hair, and in two months of being***

> ***there I cut my hair short. And people were like, 'Are you a lesbian? And I was like, 'Ja.' And they were like, 'Oh, ok cool', and moved on. No one cared***.

Work.

Several participants spoke about coming out as transgender at work. Comments from the participants regarding coming out at work were related to safety, ridicule, discrimination, fear, rejection, misidentification, which means not knowing that the individual had changed names, misunderstanding what being transgender is and using dead names. The latter refers to the names the individuals had been given at birth, but no longer used.

P4 reported that despite many accepting him at work he still faced discrimination from some colleagues. He said that he worked in a predominantly male field and that he had been scared to come out. Although most of his colleagues had accepted him, he still faced challenges from a small group of his superiors:

> ***Coming out at work, I actually changed sections because I believe that the section I was in wouldn't be safe for me. You know, I've been ridiculed and discriminated against. Even though the law says you may not be discriminated against, no matter what… orientation, identity… It still happens within my workplace***.

P5 acknowledged that coming out at work was difficult at first. He thus described changing his name on his email address at work:

> ***I was just like, what if I do it and they reject it. That will break me, crush me. And I updated it and all my stuff has been updated at work. And people are like are you still working here, I can't find you on e-mail***.

At the time of the interview, P6 had not come out at work. He explained: ***I don't want to tell people all the time that I am transgender, as it's none of***

> ***their business at the end of the day. But you know, let's say my colleagues, my colleagues don't know that I am transgender, but my boss does. I worked with her previously. She knows everything. But the rest of my colleagues don't know, because I've seen their reactions to transgenders and I'm like no, I don't want to get involved with that sort of thing***.

P6 related an incident at work where his colleagues were reading a headline in the newspaper about a transgender female and were making derogatory remarks:

> ***And she came out as transgender, and I think the headlines stated she was a man or something like that. And it was a vulgar statement, and I thought why? Why do people have to do this sort of thing to the trans community? Like, you know, and one of my colleagues, she was actually like, 'He is a woman.' And I was like, 'Ok yeah, you don't even need to know about me.' Like that sort of thing***.

P1 was a sex worker. She experienced coming out at work differently. Her clients knew that she was transgender and accepted her. She related that many of her clients told her how beautiful she was. She used her real photograph when advertising online; she noted that other sex workers did not use their photographs. However, she did not allow others to photograph her because she wanted to protect herself and her clients, some of whom were married. She explained:

> ***I do internet people. People say, 'Oh you are so beautiful in that picture. You are so amazing. Can I come to meeting?' And some of them are married. And some of them very push for picture. But me say, 'No, please, when you picture it's only for us.' Anything can happen in media. My crowd be trusting me. Because when people advertise on the internet they put the picture of the other person, and when he come to see they find it's another***

> ***person. ... Everywhere in sexual work they all see my picture there. ... When they come to see me they say, ‘You are so amazing, you are beautiful.’ When I take out my clothes people say to me, ‘Oh you so very beautiful. One thing is miss. You don’t have all nipples and a vagina. That’s all. But your body, your face, everything you are a woman**.’*

P2 had worked as a teacher in a high school for eight years and did not transition outwardly in relation to dressing as her identified gender during that time. She felt afraid to express her gender because she was cognisant of the fact that some parents might find it threatening and she was afraid of losing her job as an educator. She worked in a conservative environment. She thus described her experience:

> ***No, no, no I was playing the male all the way. I was playing the male all the way. … ‘Not now.’ That was what I kept saying to myself in my head all the time. ‘Not now. You are not ready. You can’t afford this. You can’t lose your job now. You can’t.’ You know, it’s a bunch of social reasons as it were. I mean, because safety is such a paramount issue or whatever you want to call it, it is very important. … I mean dysphoria was the nature of my existence for eight years because I sort of had to pretend to be the male, and I did that quite well. I played the male very well.***

P2 added that she had a name for the clothes she wore as a man and that she dressed in blue to adhere to the social norms that were expected of her at the time. She explained:

> ***Ja, it was always what I call the civil uniform. You know, baggy jeans and a tee shirt. Or baggy jeans and the picnic table button-up shirt. You know, 50 shades of blue as it were. That was basically my wardrobe. With the exception of one or two orange shirts it was 50 shades of Blue.***

It was only when she became a lecturer at a university that she felt able to express her gender identity. She related:

> ***The woman who ran the school said to me, 'You have a job if you want it.' I'm like 'fucking hey.' I did my Honours blah, blah, blah. Sort of stuck it out for a while. Slowly but surely building a life for myself. Eventually landed up here*** (the university)***, which then meant I could be me. It takes one arsehole of a parent to say, 'Oh my child is being taught by someone who is transgender or whatever the case may be, I need to report this because child molestation or whatever the case may be.'***

Discovery of self and coming out.

The participants experienced coming out as transgender as multifaceted and complex. Coming out to significant others including friends, family and partners is discussed in a subsequent section. However, other factors in relation to coming out were significant.

P4 related that it took some time to understand himself. Despite time in therapy he had never explored his gender identity. He explained:

> ***I had seen several therapists before and I never dared cover you know my gender identity, even though they could pick up stuff and they questioned me on it. But I just said no, I just enjoy dressing this way and being in a dress is fine for me. Which actually it wasn't because I would literally feel like a freak in a dress. Um, and I couldn't understand why so…***

P4 only began to think about his gender identity when a therapist addressed his masculinity in his female body. Prior to this, he did not have the language or knowledge to help him navigate how he was feeling. He acknowledged:

> ***Um, and something came up. What dawned on me, when the realisation came, I was sitting to talking to the therapist, it was a male therapist and he***

> ***um, he was asking, you know, about the workplace and everything. And I was well 'You know I'm a [job description] so it's a male dominant environment. And I'm quite happy working with men. I feel like I fit right in. You know despite the physical appearance and everything.' And I said to him that a lot of people see that as a problem or weird. So, he said like 'No, you just know you are very comfortable within your masculinity.' And something just clicked. Like, ok I need to explore this.***
>
> P4 explained what happened when he came out: ***Um ja, I would say that the greatest thing for me was gaining a sense of independence. I've actually become very independent very quickly. After being told for many years that you know these co-dependency issues that I can't stand on my own two feet, it felt fantastic***.

P6 found it difficult to live as his assigned gender at birth. He described how that felt before he knew about the concept of transgender:

> ***I came out at 24, so it's very recent. I had been struggling with it. Fighting every single day with it. Fighting with the skin, fighting with my body image, fighting with my mind, that sort of thing. You know, it hurt most of the time. I was such a horrible person, you know, as a female. I was a horrible, horrible person. … Like, you know, I wouldn't treat other people with respect, and stuff like that. I kind of went around hating every single thing, and I didn't want to live like that. I wanted to be comfortable. I was trying to find my identity. Just trying to find myself, that sort of thing.***

P6 subsequently related what it meant to him to come out finally and live as his experienced gender:

> ***I came out and I am the happiest person about that sort of thing. I can actually put a smile on my face, like, 'Hey how're you doing.' That sort of thing***.

P2 described the moment she began to come out:

> ***But um, you know, eventually sort of got the go ahead, started hormones blah, blah, blah. So, February this year*** (2018) ***I started hormone replacement therapy. It's fantastic. It's absolutely fantastic. A lot of the psychiatric symptoms sort of subsided, I don't get those bad bouts of depression anymore. Colours have brightened. It's like a fucking Disney movie. It's hard to explain this to someone. It's really, it was a fantastic. Within three days I felt really fantastic.***

Coming out to oneself and coming out to others appeared to be a heavy burden. While some of the participants were reluctant to acknowledge their gender identity for some time, others delayed coming out and played a role in society that they felt was more socially acceptable.

Theme: Relationships

Because the participants spoke of their relationships with significant others a great deal, this theme was classified as a main theme. Although it is a theme on its own, it intersects with other themes throughout the data. The researcher has attempted to present the integration of these themes as accurately and clearly as possible in this section. However, relationships had many layers and at times, overlapped with other sub-themes. In addition, because relationships are important in ensuring the individual has a support structure, the challenges and triumphs of the participants' stories are thus outlined.

Fathers.

Some of the participants noted that their fathers were more supportive than their other family members. This indicates that the participants felt supported mostly by their fathers. Initially, some fathers had not been supportive, but eventually became supportive.

P4 thus related coming out to his father as a lesbian:

> ***And my dad came and sat next to me, and he said, ‘Whether you like boys or girls, I don’t care who you love, as long as you love yourself first.’ He took to it like a duck to water. And my dad has always been my biggest supporter and my best friend and he is, if I can be half the man he is, I would have done something right in my life. Because he is just the most incredible person. … So, I lucked out in the dad department***.

After being admitted to a psychiatric hospital after a suicide attempt, P4 explored his gender identity and came out to his father and siblings. He shared that his father had said to him that he would do whatever he needed to do to help him and he was behind him. His father told him that he would help him find medical care too. He also described his stepmother as being very supportive and together with his father, they supported him unconditionally.

P2 described her father as being very supportive both when she came out as gay and then as a transwoman. She shared:

> ***My dad, he’s quite cool with the whole thing. When I came out as a gay man to dad, we sort of sat around the dinner table, just him and me, you know. Lateish Friday night. I said to him, well you know this is what it is, and you know no big dramatic scene. We hugged. I just remember, ‘I love you.’ It was what he said to me and um. Last year November I actually came out*** (as transgender) ***on Facebook, and said, ‘Well, this is me’ whatever the case may***

> ***be. Lots of love from everyone on social media. I'm going to try and say this without crying. My folks of course saw this post, but they knew it was coming because at least have the decency to come out to your parents before you tell the rest of the world. It's good advice for everyone. So, they knew this was coming, and they weren't surprised. So, after I do the whole Facebook post, I sort of awaken you know, expecting a tense atmosphere in the house. Mommy was in the kitchen making breakfast. I said, 'Hi, how's it going?'… Um, I asked where is dad and she said well, he is outside. Rather odd. So, as I am looking for dad he waltzes into the house carrying scissors and flowers and I am wondering, 'What the hell is this now?' He turns to me and says, 'I want to be the first man to give you flowers.' He gave me them and just hugged me and once again said, 'I love you.' All of that. My dad is fantastic. Without him, I don't know where I would be without him to be honest.***

When coming out as a transman, P6 said that his father took it well. He said that he learned how to be a man from his father when he was growing up:

> ***I think my dad showed me a lot of the male ways when I was growing up. He taught me how to throw a rugby ball. I was like treated like my brothers. Especially my big brother. … My dad was a very, very big influence in my life growing up. I was like daddy's little girl. … I bonded with my dad 100%.***

P4's parents thought that he had been brainwashed by his husband when he came out as a transman. He said:

> ***And then I came out to my mom and dad. My mom and dad thought that it was a phase, because naturally now I am getting divorced, and they had***

> ***believed that my spouse had actually brainwashed me. And I’m like ‘No, no.’***

However, he then stated that his father is now supportive and “***on board***” even though when he first discussed having surgery, specifically, a mastectomy and chest reconstruction, his father was very upset and angry. However, over time, his father had calmed down.

Mothers.

The participants’ relationships with their mothers were not as warm or close as their relationships with their fathers. Some participants perceived their mothers’ reactions as volatile and rejecting. These reactions ranged from disowning their children to feeling shocked and upset. Some transmen felt that their mothers had reacted this way because they felt that they had lost the girl that they had wanted so badly. Other perceived that their mothers had their children’s lives planned and they experienced any deviation from this as shocking.

P3 described coming out as lesbian at the age of 14 to his mother and remembered that “***she lost her frikken mind.***” He then added:

> ***Then my mom threw her toys out the cot. She told me pack my stuff and leave. And it was, the night I came out was the night before I went on a leadership camp. And so, I already had packed bags. So, I took my packed bags and I sat in the driveway and I just sobbed.***

P3 shared that his mother only began accepting he was lesbian when he began dating his first girlfriend when he was 19 years old. When he came out as a transman to his mother, she told him that she believed that he was transgender because he was molested when he was a little girl. P3 stated that his relationship with his mother disintegrated despite some intervention from his stepfather. He related:

> ***She was finished. She was like, ‘I can’t do this.’ She’s like, ‘I’ve been dreading this day. Your siblings told me this day was going to come’ blah, blah, blah. She just, she’s like, ‘Because of what he did to you.’ I was like, ‘No mom. The two things are not mutually exclusive.’ And my stepdad was quite like, ‘This is still your child. Your child is not going away. But your child is going to be happy.’ She started asking questions after I had already started binding*** (referring to the act of binding the breasts to flatten them using constrictive materials or binders***, and she was like ‘Is that why your boobs are so flat?’… So, I lost my relationship with my mom. So, she wants nothing to do with me.***

P3 then described that it was the death of his maternal grandmother that had ensured him and his mother had contact again. He stated that it was only recently that she had begun to accept him back in her life and that she had since arranged to have Christmas lunch with his best friend’s family and himself. He believed that this maternal relationship had suffered because his mother had always wanted a little girl and that is the reason she was so upset when he came out. He also said that his mother was besotted with his niece.

P2, who came from a conservative, white Afrikaans family, said that her mother was the only person who was surprised when he came out as gay. He shared that she did not take this very well:

> ***Mom, what happened was when I told her I am a gay man, I actually said ‘Well, let’s tell her in a car.’, Which is, my dad got the idea off the support group because, well, if she’s going kill me I can at least take the bitch with me. Good sense of humour is apparently one of the diagnostic criteria for bipolar so maybe it’s not wrong. So, we sort of started quoting scripture at each other. After I said, ‘Mom, I’m gay’ quote, quote, quote, quote whatever***

> ***the case may be, we didn't speak to each other for about two weeks. And a couple of weeks later, this is probably the oddest thing anyone has ever told me, a couple of weeks after that we sat in the same car. She said to me, 'I always thought you were going to bring home a black woman.' To this day, I have no idea what that means, or what she was trying to say. I just sort of let it go.***

P2 described her relationship with her mother as follows:

> ***My mother and I don't get on. She is a big trigger point, very big trigger point … I don't get on with my mother. I don't. Don't ask me why. She probably needs to have a couple of sessions with the shrink. I'm a lot more like my grandmother than I am my mother.***

P6 described his mother's reaction when he came out as a transman as follows:

> ***My dad took it well. My mom was a bit shocked. She is still kind of getting used to it, using a different name, because she's like, 'You know what, I gave you this name and it was passed down through the family.' And I was like 'Ma, I will pass this down to my kids. It's not me. I did not identify with it. It wasn't me. It wasn't my name.' And every now and again I still kind of hear my name. And sort of when they see me they still use my name. … Look, my mom's been supportive. She's very supportive. It's just the name. It's just trying to make the name a habit. It's really not an issue with her per se, with me doing the transition. But you know, she still struggles here and there, because I was the only girl in the family between the boys. She still sees me as her little girl. I might have been born female, but I am not female. I don't feel female. I do not identify with the gender.***

P4 shared that his mother reacted badly when he came out as a transman to his parents:

> ***My mom is still struggling. I think she's reached the point where she's kind of like, 'Ok, this isn't a phase, this is now real. P4 is real' (giggles). So, she's like, no she wants to talk to somebody, but she does not want to talk to a man. I'm like, 'Mom, that's the only person in [City], my folks are in [City], this is the only person who can help you with gender identity issues and so on.' So that's sort of coming along. And coming out to my folks about the surgery. My dad was very upset. I had to explain to my mom, 'Look Mom, I knew growing up that girls get boobs and I know this, but I didn't know this was going to happen to me. I didn't expect it to happen to me. I thought my chest was going to stay flat forever.' So, my mom was like, 'Ok, as long as the person that does it is a professional, fine.' Which surprised me.***

P5 was only able to speak to his mother as his father had passed away by the time he came out as a transman. He thus described his mother as being very supportive and giving him the confidence to come out to family and proceed with his journey:

> ***My mother passed away in October and I didn't know [Cousin] had actually spoken to my mom about this. And my mother calls me, and we are alone at home and she says, 'I believe there is something you want to tell me.' I am like, 'What now, what do you mean?' She says to me, 'If you want to change then change' she tells me. I am thinking, 'Ok, what are you talking about.' And she's like '[Cousin] spoke to me and she said there is something you would like to discuss and stuff.' I'm like getting ready for the rejection part, and she says to me, 'You didn't ask to be this way'. She said to me, 'You were that person since you were small and if this is who you are then be who***

> ***you are.' And my mother cursed a lot and she's like 'Fuck family. If they don't want to accept you, you are my child and I will fight for you till the death you know.' I was like, my mom and I like cried and stuff and it was amazing, I said to her, 'I'm just scared about family.' And she's like 'Families are this, that and the other' and she says, 'You do what you need to do.' And my mother was a nurse and she was in the military. … And she said that uh, my mother is not familiar with transgender terms and kak, and she said, 'If this is what you want to do I also had a patient that had a sex change. I found it so funny as in her own way she was trying to tell me it's ok. That for me was like the final push that I needed to be just like you know what, I'm going be ok.***

Siblings.

Sibling relationships appeared to be more complex than that of the parent's relationships with the participants. This is possibly because there were more relationships to consider for each participant. Furthermore, some of these relationships included in-laws.

When coming out as lesbian, P3 related:

> ***My brother battled, because he is very narrow-minded, very old school. My older sister was great. She's always been great. My younger sister, there's only 14 months between us, so she didn't understand. But she's like, 'I love you so it doesn't matter.'***

However, when P3 came out as a transman to his siblings, his relationships with his siblings changed:

> ***My brother said straight, 'Don't ever message me again. I want nothing to do with you.'… My brother could not look at me. He just, he would avoid eye contact completely. … And ja, I still don't have a relationship with him.***

> ***… And my oldest sister in the meantime, my older sister moved to [Country]. So, I think she had been gone for about eight months when everything started happening fast. And my younger sister, who everyone thought would be the one to support me was like (clapping hands), 'I'm out. I'm not doing this.' And she got very nasty. She said I must delete her friends and her new family, because she got married, on Facebook. And that was really hard for me, especially given that we were all so close.***

P6 shared that he was very close to his sibling:

> ***My little brother, I think he's closer to my mom. Him and I really used to fight and stuff. … You know, we still get on each other's nerves here and there. … Yeah, he is very, very supportive. I think that if my big brother*** (deceased) ***was here as well we would be three peas in a frikkin pod. … Ja, I am very, very grateful for that.***

P1's parents were deceased. She said that she was part of a large sibling group. However, not all her siblings were supportive of her identifying as a transwoman:

> ***I am born of five children. I have one sister and four boy. So now I can say we are two sisters, but not 100%. But my sister, she don't feel to be what I am. I have my brother, my first born, but he don't judge me. He say, 'Whatever you are is you. You have to love who you are. I can't change you just go ahead, do it. Only God knows.'… My sister love me. But when become for my gender is very Christian so she push behind me. So always I love her. So, I can't just judge her. So, I thought let me just give her time. One day you accept me. So, other one, my young brother was passed away when he was in [Country]. And there*** (he) ***was one who love me and there was one supporting me. He was, when I here, I say I'm in horrible life, and***

> ***he sometimes send money. He want to know what I doing in South Africa, and he want to come visit me. So was caring.*** (He passed away from a heart attack). ***He was young. He was 25. So, I feel like cry, I feel like I lost someone. But I feel like I always, in spirit he was always with me.***

Referring to her older brother she said:

> ***And he said to me, 'I know you sister and the people calling you sister, and you are beautiful. But for me, when we are together and I call you, you are still my brother.'***

P1 added that her siblings did not know that she was a sex worker. She said that they thought she was working for an NGO. She shared that she felt that she did not want to rely on her siblings financially because they had children of their own and struggled to support their families on the little they earned in her country of origin.

Although P4 received support from his siblings, it took time for his siblings to adjust to no longer having a sister. Furthermore, one of his siblings still struggled with the adjustment. P4's sister-in-law was supportive and encouraging when he came out as a transman. He remembered:

> ***And then I came out to my sister. And my sister, look, she always knew that I was different. And it actually took a while for my sister to accept you know, that she won't have a sister anymore. She'll have a brother. I came out to my brother, and his wife actually accepted me. And she was like 'No matter what, little sister, brother whatever.' My brother still finds it very difficult but he hasn't researched anything. My sister is now more comfortable. Although when I told her about the surgery she was very worried.***

P5 described the relationship with his siblings as complicated when he came out as a transman:

> ***And my sisters, my baby sister, we are very close. She said to me, 'Oh that is what you wanted to tell me. I've know that long ago this is who you want to be and stuff.' She says, 'No you have to do it.'***

P5 also said that his youngest sister had suggested that they go for counselling as a sibling group because P5's transition was as much a change for them as it was for him. However, they never got to that point. He acknowledged that he did not share as much of his transition with his siblings as he could have because he felt that they had not made enough effort to use correct pronouns. He also said that his eldest sister did not accept his transition because she was Christian and it was against her beliefs. She reasoned that she did not want P5 to teach her children to go against these values. Of his eldest sister, P5 shared:

> ***[Eldest Sister] would still refer to me by my dead name and stuff and it bothers me. When it was Mother's Day she's like 'Happy Mother's Day to you' because I am very close to my nieces. I sent a private message and I said, 'I don't know if you like don't want to know this but I am transgender and it's not going to change because of one transphobic person because this is who I am.' And I said to her 'You can call me P5 or [Nickname]. P5 I don't mind but not [Dead Name].' And she sent messages to the family group and said she doesn't know who P5 is and she feels like she needs to leave the group because of a difference of opinion, as her sister can't accept her opinions. And I was thinking what a horrible thing to do. And you know like the funniest thing for me is she's divorced. That's also going against God. And I said to her, 'You made a decision that you felt was the best thing for you at that time and I supported you. I didn't judge you. I didn't tell you are going against God and stuff because that is what you needed to do to be ok, and this is what I need to do to be ok.' She still does not see it that way. I***

> ***think maybe she's having a change of heart. But I don't think so. So, um, ja!***

Romantic relationships.

The participants found it complex to describe their romantic relationships. Because many of the participants had first identified as lesbian or gay, they had entered into relationships with same-sex partners. However, coming out as transgender affected their relationships.

P3 explained his lesbian relationship:

> ***I kind of I dated someone for about a year and half and found out that she was cheating on me with like everyone, with everyone. Um, and then after that relationship fell apart, because I still kept holding back*** (referring to holding back on coming out as transgender)***. I don't know, it was like self-loathing. Because I didn't think anyone would love me.***

P3 perceived that he would not be loved if he was to come out as a transman. He added that he had been in several unsuccessful lesbian relationships because, **"*how could I make someone happy, or be happy with someone, when I was so unhappy within myself?"*** He subsequently described a long-term relationship, which ended when he came out as a transman. He said, "***And when I told [Girlfriend] she fell apart. She was like, 'I can't do this. I don't want to be with men.'"***

When discussing the future and how he would feel about being in a relationship once he had fully transitioned he acknowledged:

> ***The trans experience is all about freedom to be, freedom to exist, freedom to love. And I think I'll feel more confident about meeting people once I'm complete, and I won't be so afraid about being in a committed relationship.***

P6 described being supported by one of his ex-girlfriends when he came out as a transman to her. He explained,

> ***I didn’t really think that there was happiness in life until my ex-girlfriend, she helped me with the research and stuff, she kind of just helped me. She just got me out of that step. Instead of just kind of curving away from it she would push me in that direction. She was like, ‘No you’ve got to go and do this and that sort of thing.’ So, she did help me with that.***

P1 related that presently she struggled to be in a relationship because she was HIV positive and a sex worker. She felt that she would like to get married some day and would like a husband to take care of her: “***Then someone must come say it’s my priority I have to take care for you***.”

P4 was the only participant who had been married. He stated that he had married a cisgender man when was 23 years of age. However, the marriage had ended because his husband had cheated on him several times. He said that his husband wanted somebody who was more feminine:

> ***I took on the masculine role within the marriage and it’s kind of like, ‘I will care for you, I will provide for you’, everything like that. I made all the decisions. And he also picked up on it but he couldn’t put his finger on it.***

P4 also related that his marriage was difficult. He perceived having to fulfil a traditional female role in the marriage as challenging:

> ***Look, he is also very narcissistic and abusive. I tried to do the right thing, you know, be the submissive wife and just fulfil a societal role of what good wife should be. The traditional role, even from a Christian point of view like the Proverbs 31 woman, you know. She’s like this and like that, and she is***

> ***industrious and she wakes up first in the morning and she does this and she does that and da da da.***

P4 said that after he had been cheated on several times, he decided to explore his gender identity further. He began seeing a psychologist. P4 acknowledged coming out to his husband was very difficult. He even stated that he would have maintained the relationship if his husband had been able to accept him as he was:

> ***And I then came out to my partner, well, to my then husband. And I was like this is it. And he of course was so heartbroken and everything like that. And I would have stayed with him if he had accepted to be seen as a gay man. But of course, he is not gay. Ja, I had a lot of flak from him.***

In relation to intimate relationships as a transman, P4 said that he found it difficult to be intimate with his current partner. He shared, "***I can't take my shirt off. I don't want her to touch my chest. We have been going out for nine months. Not once has she touched my chest. I said I can't***."

P5 was the only participant that had maintained his relationship with his romantic partner prior to coming out as a transman. Although they were not married, they had lived together for many years in a committed relationship. He shared how he had been supported by his partner throughout his transition. However, he stated that he struggled with intimacy:

> ***My partner and I, her name is [Name], she's working abroad in [Another Country], we've been together for 13 years now. I always used to tell her I don't feel comfortable. When we were intimate I never wanted her to touch me and like stuff because I'm like my body just feels so bad and I told her this is what I want to do. I wouldn't say she was supportive from the get go because her family are a very religious family and they had just gotten used to our relationship as this lesbian couple. Eventually she said if this is***

> ***really what you want to do, you have to do it, you can't live for anyone else but yourself. There I thought, I am going do it.***

Despite the support that P5 had received from his partner, he still felt that they experienced various challenges including misnaming and having to come out as a transman to her religious family. He explained:

> ***And it was a struggle with [Name] and I, because she found herself referring to [Dead Name] and it would slip out. And I was like '[Name], you know we spoke about this.' And she was like 'I'm sorry, it's going to take time for me, I work away from home so when I come back it's difficult for me.' I said to her, 'My standard for you is different than for other people so you of all people I feel should get it right.' It was hard for me to say to her, 'If you feel you cannot go on this journey with me then tell me before the time, instead of me having to go through all of this thinking that you are on board, and then find out that you are not on board. It's not easy for me to say this but if you can't that is also ok. But I feel like we should just communicate about this and keep the communication lines open and just be straightforward with each other.' I think that was an eye-opener for her because now, even with her family, they will ask her who's P5.***

Friends.

As noted previously, P3 and P6 were friends. The two participants came to the interviews together, but were interviewed separately. P3 reported:

> ***P6 and I can't go a week without seeing each other. We actually have withdrawals. It's like the first weekend in months that we haven't seen each other. Seeing P6 like keeps me on track and keeps me sane because he, he's my biggest support. And I don't know how we went so long, because if we***

> ***had met at like 14 and started chatting we probably would have done this like 12 years ago.***

P6 shared:

> ***Funny story. We actually ran in the same circles when we were female, and um, we ran in the same sort of lesbian/gay community circle. I mean we are friends of friends. P3 was still with his ex and a mutual friend asked … and he was like, 'Who's P6?' Because he didn't know me by that name.***

Subsequently, it was P3 who had first contacted P6. It had taken a while for P6 to get back to P3. P6 had started socially transitioning about 16 months ahead of P3. It was at that point they began talking to each other and seeing each other. P3 said it was "**cool to have someone socially to be with**."

P6 related that some of his friends had not accepted him when he came out as a transman:

> ***I think some of them I don't interact with because obviously they don't recognise me from before. But I think some of the people, most of them, have been supportive and stuff. But I haven't really had any negative feedback that sort of thing. … The thing is that I have tried to surround myself with positive people for sure.***

P1 experienced support and friendship from someone she met when she first came to South Africa as an immigrant:

> ***I can say at the moment I can say thank you God that when I come to South Africa, I be meeting one woman who is become in my life. She was in the conference. … So, that woman she is the one, she was interpret for me and because we be friend, she is an activist trans community and as well in the academic university … and I can say she's close to me. She is my family***

> ***now. So, whenever I have a problem, she support me all the time. Each time. Each moment when I'm in the programme, sometime when I'm crying, sometime I don't have a solution to do, I don't know what to say, she just say, 'Do you need something?'***

P4 elucidated that he had battled to make friends before he came out as a transman:

> ***Look I actually, the friends that I did have were um my ex's friends and they know. I don't know how much they do know. They haven't contacted me at all. … Before that I didn't really have friends. I'm that type of person I keeps people at a distance. Because, um, it's kind of like I don't trust easily. So, the few people that I do have as friends, they're very close. But I don't have a lot of friends. And ja, with them, they have never contacted me. Um, they obviously believe his side of the story of what's happened. That I am this bad person. So, I don't think any of them want to talk to me but that's ok.***

However, after coming out as a transman, P4 managed to make new friends and had been successfully maintaining these relationships:

> ***I have made friends here. Like I have a lot of trans friends obviously. I've met my girlfriend who I'm very close to. And I have another friend that I have made. We're actually quite close. A cisgender male that I worked with for a bit, and then started working for [Company Name], but we've remained close.***

P5 thus described a friendship with a friend: "***Even when [Friend] and I speak we greet each other like grown-ups. He has never made me feel uncomfortable or anything like that which I appreciate. I love that***."

Theme: Wellbeing

Wellbeing was discussed at length in the interviews. Two main sub-themes emerged from wellbeing. The first was psychological wellbeing, which concerned the participants' mental and psychological health. The second was wellbeing as it pertained to eudaimonic wellbeing.

Psychological wellbeing.

Psychological wellbeing related to the participants' mental state at any time in their lives and how that affected them over time.

P3's Story:

P3 was sexually abused as a young child. He stated that he was groomed by his abuser who told him that his mother had given him permission to abuse him. Consequently, he initially did not disclose this abuse to his mother. During his early teen years, P3 identified as lesbian and shortly after coming out as lesbian to his parents, he told his sibling he had been abused. His sibling told his mother who then sought help from a specialised child abuse clinic in Johannesburg. P3 reported that this was traumatic for him. He was exposed to *regression therapy* where it was revealed that his abuser had groomed him to believe that his mother had approved of the abuse. He explained that he had shut it out of his mind until then. He added that he regretted going through the regression therapy because of the psychological effect it had on him.

Subsequently, P3's mother filed charges against P3's abuser and a court case ensued. P3 experienced this as extremely distressing. Soon after the court case had begun, P3 began experiencing epileptic seizures and became very ill. He was forced to spend most of his adolescence away from school to recover. He said, "***So I lost 4 years of my life. I couldn't drive. I couldn't go to school. So, when I got my driver's and my matric it was a party. Because no one thought I was going to do it***." P3 stated that he had been admitted to

medical, not psychiatric, hospitals in Johannesburg 17 times one year. He related that this became too much for him. At the same time, his mother had had an affair and his parents’ marriage had fallen apart. P3 shared that he had become psychologically distressed to the point of self-harming and attempting suicide:

> ***I was a cutter and I self-harmed a lot. And I tried to commit suicide a lot. And then a serious one I don’t know if you can see a red mark. My mom had moved out the house and it was just my dad and I at home. They went to bed and I took my sleeping tablets, tied a cable around my neck and hung myself. And it took twelve paramedics, because I was wedged between my bed and my windows, it took 12 paramedics to get me out to resuscitate me. And I was put into a medically induced coma, and I was on a ventilator, and that little stint got me sent to [State Psychiatric Hospital]. You need counselling after being in [State Psychiatric Hospital]. That was, no ways, not a nice place.***

When asked what the suicide attempt had been about P3 shared:

> ***I didn’t understand who I was. I didn’t know who I was. I felt lost in who I was. Uh, I felt like that childhood trauma was never going to be resolved. I felt like my family were never going to like, understand me. And I just wanted out. I had had enough. And there have been days where I wish I succeeded. But I mean, now hindsight is 20:20, and I am living my best life.***

P3 related that at the time of this suicide attempt he felt as if his family would not understand him. He was struggling with his gender identity versus his sexual orientation. His mother had all but rejected him and he felt as though he was unsupported. Furthermore, he was dealing with childhood trauma and experienced significant confusion about his identity. He said that two years later when he was admitted to a private psychiatric hospital in

Johannesburg, he met a psychiatrist who he could open up to and with whom he could explore his gender identity. P3 stated that thereafter he was able to function psychologically and experienced his life as satisfying. He asserted, "***I no longer think about suicide. I look in the mirror and I think like, yeah, the world does not need to lose this (laughing). I am a gift to the world now***."

P2's story

P2 had a history of self-harm, suicide attempts and bipolar disorder. She stated that she had been in therapy since she was approximately 12 years old. She felt that it was because she did not get along with her mother. Her first attempt at suicide was during her first year at university. She remembered:

> ***I go, 'Let's go to res.' Biggest mistake ever … I sort of felt out of place … because at that point in time I thought gay man, I thought this is completely unnatural. I feel like a complete outsider in the male res. I sort of tried to fit in. Didn't. … Because I tried to commit suicide at least three times in the span of those six months. … I mean, the one night I slit my wrists. Not exactly very deep (shows scars) but still the idea was there. Swallowed a bunch of pills. Um, the next day I was off to [Psychiatric Hospital] where I met [Psychologist]. A couple of months later I am back again, because this time I nearly succeeded. But I mean, during those therapy sessions, and that time [Psychologist] felt it was necessary to tell my parents, 'Listen, this is what the problem is. This is why this is happening. She's not necessarily going to transition now. Now she's not psychologically ready for it. Maybe in her late twenties, early thirties.' Guess where we are now.***

P2 added:

> ***But it got a lot better since then. That was the last time obviously. Sort of started working on issues … That was the last attempt. By no means the last of the self-mutilation. Not at all.***

P2 related that after the last suicide attempt, she put all her self-harming on hold. She explained that she focused on getting her career started and focused on her studies. However, she said that although she was not self-harming, her gender identity still concerned her. She began self-medicating with alcohol during this time. After coming out, she reflected on her diagnosis of bipolar disorder. She believed that her symptoms were misdiagnosed because she felt dysphoric because of her unexpressed gender identity. She acknowledged:

> ***I drink close to home. Because your best pub is your closest pub. Because then you don't have to go through roadblocks, whatever the case may be. I am not necessarily saying that I have a drinking problem, but (laughs) um, it's something that needs to be … I mean, alcoholism is in the family. Family addiction, whatever the case may be. Um, I am however a very responsible drinker.***

P2 explained that she had not been given clearance to begin hormone treatment until recently because her doctor had been concerned about her bipolar disorder and self-harm. However, she stated that since starting on hormonal treatment, she felt that many of her psychological symptoms had subsided. She added that she no longer experienced episodes of depression anymore and she believed that her world was brighter and happier now.

However, P2 acknowledged that since beginning her transition, she experienced some insecurity regarding her appearance. She felt self-conscious about having chest hair and facial hair and had attempted to address this through regular hair removal. However, she compared this insecurity to teenage angst and felt that she could manage it if she viewed it in this way. She felt that in some ways she was going through puberty.

P4's story

In the past, P4 had sought psychological treatment for depression and marital problems. However, he acknowledged that he never felt brave enough to tackle his gender identity in therapy. In the past, when he had been confronted about his gender identity in therapy, he would avoid discussing it by focusing on other issues he was going through. However, he stated that after several infidelities on his husband's part, he began to feel that he should start exploring his gender identity. He was experiencing depression and experienced the third time his husband cheated on him as the final straw. When he shared that his therapist had mentioned how comfortable he was with his masculinity, he said, "***And something just clicked. Like, ok, I need to explore this***." Although it took P4 several years to feel confident enough to explore his gender identity, through therapy he was able to find the answers he needed. However, P4 mentioned that at times he felt dysphoric. He mentioned not being able to walk into a gym to exercise because he wore a binder, which constricted his movements. He felt self-conscious about using a male change room. Furthermore, because of his outward appearance, he could not enter a female change room because outwardly he looked male. He also experienced psychological distress when he was intimate with his partner. He did not want his partner to see his chest and consequently, he covered it up by wearing a shirt. This impeded his ability to become truly intimate with his partner.

Since beginning his transition, P4 still struggled to feel psychologically well. He stated that it was incredibly difficult before beginning his transition and acknowledged that although he felt much better he still found it difficult at times:

> ***But you know transition, it's not easy. You take a person that you've been for at that stage 32 years. You break. You literally break. And then you build the person you knew you always were, always hiding inside of you, and now you've got to bring that person out. You have to rebuild yourself. So, I***

> ***should probably have more grey hair on top of my head (giggles). You break. And I think after a year I do feel more confident. But there's more building to happen in the near future. It's not easy.***

P5's story

Before P5 came out to his family he described his mental state as follows: "***It got to the point when like you feel like you are having an anxiety attack because you can't breathe. It's like when you have on something tight when you just want to rip it off, like that***."

P5 also mentioned how he felt prior to coming out and how he felt currently about being able to pass for male in public:

> ***So that is the only thing that will make it ok. To pass. I don't want to sound suicidal because it's not how I am feeling. But I feel it is a possibility that it could lead in that direction if I don't get the surgery, as I can't live like this you know. … Because if I can't live as me completely then almost like, 'What the hell am I doing here.' I feel like now I can't be like, 'I'm suicidal' and I didn't even give myself a chance to get to the point where I am ready for surgery.*** (Researcher asked: Are you feeling suicidal now?). ***No, no. That's why I'm saying, I was suicidal before I saw the surgeon, as that has always crossed my mind. My father committed suicide, so I had those tendencies when I was younger.***

P5 had been approved for surgery and had been on hormones for some time. However, at his last check-up prior to being interviewed he described how he felt after being told he had to wait a bit longer for his surgery. Because he suffered from diabetes the doctor told him that for his safety, he had to lose a bit of weight before he could have surgery. He shared:

> ***I went there in high hopes, but because I am diabetic, and because of me feeling a lot of emotions, depression, and all that, I have not been looking after my health. But I still expected the doctor to say you know, 'Let's go for it' and all that and stuff. … I was sitting there and I was like, 'This is bad really saying this to me' you know. … And I was so down and out after that. I was like really, it was a horrible experience.***

P5 stated that he was very hard on himself and that he beat himself up about his life. He added that he put a lot of pressure on himself to achieve. He was working full-time, attempting to lose weight and was studying towards a degree. He explained,

> ***My mind is not switched off. Even when it is time for me to sleep, my mind does not switch off. I am just thinking, 'Tomorrow I have to deal with this, that, and that, and do this. If I get up in the morning and train, if I train in the evening, if I can train three times on a weekend.' It is insane the amount of things I am expecting of myself and I need to find a balance. To be kind to myself.***

Eudaimonic wellbeing.

The factors that related to eudaimonic wellbeing were coded together and presented as a sub-theme of wellbeing.

P6 said that he believed he was not a label. He saw himself as every other person. He added that his external features were merely representative of himself as male, but that he felt that he was similar to most people:

> ***Me, I don't really want to put a label on me. I want to be just me. … I want to be seen as a man, but this is my outside. This is me. I want to go home, be comfortable, sit in my chair, watch a movie. I want to be like every other person. … I don't want to go out there and stick myself with a label. I don't***

> ***want to be labelled. Yes, I am transitioning from female to male, and yes, people will see me as transgender. But I don't want to identify with any label. I just want to be there. Just want to be P6. If you don't like me, you don't like me hey.***

P1 said her transgender advocacy work was fulfilling:

> ***Some people who don't get that opportunity. As a trans from East Africa, and a sex worker in Africa. So, I come from far away, and I belong here. I've been fighting advocacy and my right. … Yes. I'm my own power. You know when people say feminism, I can say I am feminine because I have work in the journey in my life.***

P4 said that although he had a cisgender male friend who helped him, he found it came naturally to him to be male. However, he also noted that he still had some things that he had to learn, but he was able to acknowledge this and he relied on his friends for support. He asserted that he perceived his autonomy was the most important thing in his life. He believed that although he was still on a journey of personal growth, he had begun to self-actualise and master his environment:

> ***Um ja, I would say that the greatest thing for me was gaining a sense of independence. I've actually become very independent very quickly. After being told for many years that you know these co-dependency issues that I can't stand on my own two feet, it felt fantastic. I have only recently started living with my girlfriend. But before I just wanted that time to live for myself and transition and grow up.*** (Researcher reflected that he had held that space for himself) ***Ja, like it's my time, my space and I, it's like it's my territory. … I would say the hormones helped. But once I started realising and going for therapy and realising who I am and who I want to be and the type of man I***

> ***want to be. … I was naturally an aggressive person. Like the ugly aggressive, but I kind of with the hormones became more assertive. That is where it came in. It was kind of, like when people gave me a lot of crap. In the past, it's not like I didn't have a backbone. It was like, 'Ok I'm wrong, I'll cave.' And it's kind of like, 'No, that's not going to happen like that anymore.' Together with the social transitioning, the therapy and the hormones. The hormones were like the final slap on the back like here we go, you can do this.***

P5 stated that he felt defeated when he was told that he would have to get his weight and diabetes under control before he could have surgery. However, he drew from his sense of purpose in life, his autonomy and competence to become intensely involved in activities and invest in his health:

> ***I thought like you know what I am feeling is like shit. It was bad news. But if I'm not going to do anything about it, I could either let this depression take over the whole situation or I can really work for it and I can really do something about it. And I have like lost six kgs.***

Theme: Misgendering/Misnaming

P3 had already undergone a hysterectomy and had been placed in a female ward in the hospital. He remembered:

> ***It was kak because um, it was Miss So and So. I was in a room with females so that was tough. And they were so confused because they were like 'You are coming for a hysterectomy.' So, they were a bit confused. … And I had an old lady, she must have been in her 60s and she was like, 'The first time in all my years I have been in a ward with a man.' And I was like 'At least I am quiet' and carried on. So that was … Shew that recovery was tough.***

He added that because he had been in that hospital quite often in the past the nursing staff knew him. He said that they were respectful and they closed the curtains around his bed to protect his privacy. However, he stated that he no longer got misgendered. However, he still feared using the men's bathroom:

> ***I just want to like go into the bathroom. It's a scary time. So that's why when we're out I am very aware of where I am and who I'm with and people like around me. Especially if people can like overhear a conversation. I don't want people to know I am transgender, and if I go to the bathroom and something happens, no thanks. I'm hyper aware and I think just practising general common sense.***

P2 said that she was largely unaware of being misgendered. She mentioned that in the past, when she had still been presenting as male, she used to tell the shop assistants that she was shopping for a friend. However, she added that overall her experience had not been troubling:

> ***To be honest with you, I am too blasé or stupid or whatever the case may be, insert adjective here, to realise when people are staring at me. You know, every now and then you see it but I mean it's minimal. To me it's absolutely minimal.***

P1 easily passed for female in public and in her experience, rarely got misgendered. However, she said that she desired to have her name on her Identity Document changed:

> ***When my ID being changed I will be female. Because my ID show I'm male, and I present as a female. So everywhere I work they ask my ID, and how I look, one look at my picture, my picture say it is me but when you look at my ID it says man. … When my ID change it be more my dream. … Because my work I'm doing, when I'm serving my client's service, because sometime***

> ***I travel for the hotel. Sometime they ask me ID and see it's a man. Sometime it's confidential with my clients because they maybe know they meeting with a woman and now the confidential is going to be out somehow as all the male stuff is there. Some people can just do mistake. And people can say like yes, this bitch. And take picture, and put in there someone. And so, your work, you lose the job, you lost family. I want to be changed everything.***

On the other hand, P4 had struggled immensely at work. He worked in a male dominated environment in which there were many stigmas. Although his boss had accepted his name change and gender identity, he experienced difficulty with another supervisor who misgendered and misnamed him despite his protests. Because his job had a high risk of danger, being misgendered could place him in a position where his safety was compromised in public. He explained:

> ***The other female supervisor refuses point blank. And she actually plays with me. She calls me P4 and she calls me the other name. And then she refers to me as she. … So, she does it to me in a public space so it's infuriating. Whenever she does it to me I say, 'As per that manager, my name is P4 and it is male pronouns.' I said 'You can't keep on misgendering me looking like this. It confuses people and you put me at risk.' Now she referred me to the E.A.P., the Employee Assistants Programme. Because she believes I have an issue. But it's fine. I have e-mails and diary entries so I will make sure she goes for gender sensitivity training.***

P4 added that he did not go to the gym consistently for fear of being misgendered:

> ***Because obviously, I am wearing a binder. I can't gym with a binder on, and that means I have to wear a sports bra. That means everybody has to see this on a person that has visible breasts. And you can even wear a tight sports***

> ***bra but you need to be able to breathe as well, because obviously this restricts you. At the same time, it feeds my dysphoria walking into the gym.***

P4 shared that he did not shave because he was afraid of being misgendered in public toilets:

> ***And obviously I don't want to shave. I can't shave my skin. With breasts, I can't walk into the male change room, and I don't belong in the female change room. If I walk in like this there would be um, all hell would break loose. Going into the male bathroom to use the toilets or whatever. You walk in, you do your thing, and you walk out. Nobody is checking you out. It's very much like a female thing to look. It sounds like a stereotype, but it really is like that. And that's what I've noticed. As I went through my changes and I started presenting more male, that's how I gauged 'Ok, it's now time to leave the female bathroom and go into the male bathroom.' Because I would get looked at. It's like, 'Sorry, am I in the right bathroom.' And then I'd feel like 'Yes you are.' Whatever. I don't think I will ever shave it off because having all of it off does make me feel very dysphoric. I actually do this to pass, because if it is not on, there are actually a few people who do misgender me. Until I open my mouth.***

P5 related that he isolated himself to avoid being misgendered:

> ***So when I'm alone, that's why I am alone a lot. There's no possibility that somebody can misgender me. They can refer to me as she because I am also, I am safe, and I need to give people time and whatever. It affects me negatively, even if by accident they misgender me.***

P5 explained that at times, his family, colleagues and friends still misnamed him, which caused him to further isolate himself. However, he acknowledged that he appreciated it when people acknowledged when they had misnamed him:

> ***But sometimes I have to realise she is just my sister and sometimes she also gets it wrong. It's like '[Dead Name], ag sorry I mean P5.' It's stuff like that. I appreciate it more that when like people just [Dead Name] me, I appreciate it when people acknowledge their mistake. That also makes me not interact with people as much as I would like to.***

P5 described an occasion when his niece phoned him to wish him a happy Father's Day. He had assumed a fatherly role with his niece and described how he felt when he was correctly gendered and named by his niece. He remembered:

> ***When it was Father's Day I phoned my niece to see how she's doing because her father is not very involved in her life. So, I said 'You know we love you. Even if you don't want to phone him that's also ok. Don't feel bad. But if you want to phone him that's also ok.' A couple of minutes later, about 20 minutes or so, she calls me back and she says to me, 'Hi P5, you know you said that you are our uncle.' And I said like 'Yes [Niece].' And she said well, 'Happy Father's Day P5.' And I was like wow. That's obviously her mother who let her phone me, so her mother must have approved. I don't know what went through my sister's mind but she did not say anything about it. But that meant such a lot to me and it was just amazing. It made me emotional because she was the only one that said that to me. So, um, ja.***

At work, P5 coped with being misnamed by ignoring colleagues who used his dead name.

> ***I do because it's an automatic reaction that I block it out immediately. Because it can ruin my day. It's like, for that second that person does not exist to me. So, I would just focus on people who call me P5 all the time. I find myself, I don't want to be that crazy person who says, 'Call me P5, call me P5, call me P5.'***

At the time of his interview, P5 had already changed his name at the Department of Home Affairs. When he got misnamed, he informed the person that his name was P5. However, he added that he did not want to hurt other's feelings if he continuously had to correct them:

> ***I find myself responding too when they call me [Dead Name]. I feel like I care more about other people than what they care about me. It's getting to the point where I am telling myself 'I'm going to start ignoring those people.' Sometimes I do tell people to call me P5. … And I was like, 'Guys, it's actually P5. You can go confirm it with Home Affairs.' Like in a joking way, I will do that. But I'm actually serious. But I don't want to hurt other people's feelings. I think more about their feelings than what they think about me. I think if I start ignoring them, they will probably say I'm rude and all that stuff.***

When the researcher asked P5 how it affected him when it happened so frequently and he did not say anything to correct them, he responded:

> ***It's bad because I make them think it is ok. And then I go home and I beat myself up about it. I think about the situation and play it over in my mind, and think, 'Fuck, you didn't even protect yourself, and is this really important to you.'… And I have no mercy on myself to the point where I can***

> ***go home in high spirits or I can go home and sleep crying because I make myself feel so horrible. And that’s obviously not a good thing.***

P3’s family was no longer using his Dead Name. However, his mother was not using any name to interact with him. However, he stated that his family was making an effort to use his name and the correct pronouns. Their acknowledgement when they used the incorrect name and/or pronouns meant a great deal to him:

> ***And my mom is slowly, she’s not using my birth name anymore but she’s not using P3. … She just says ‘My child.’ See, that’s fine, she’s not even. … She’s trying with the pronouns. Like she’ll say ‘she’ or ‘her’ and like ‘sorry.’ Just sorry. But she’s doing that, which is a big thing. My dad, my stepmom, and my older sister, they’ve just been like ‘He, him, his, P3.’ Done! And what’s amazing to me is, even when I’m not in the room and my dad and stepmom are speaking to each other about me it’s ‘P3.’ They, even my 82-year-old gran was just like, ‘I saw this coming.’ She’s amazing. She’s like ‘Cool I’ve got a grandson.’***

P3 then described how he had applied for his name change and what this meant for him. Not being able to change his gender marker was frustrating for him, particularly when he had to deal with companies. Gender marker refers to the gender that is stated on one’s identity document. This is usually the gender that that is assigned at birth. However, one can apply to have one’s gender marker changed at the Department of Home Affairs. P3 explained:

> ***I try to get my ducks in a row. I applied in January for my name change. I’m still waiting. … I still have to do the gender marker, as they don’t let you do it at the same time. … Because apparently there are two separate departments as one has to be approved first, and then the other. And I’m***

> ***like, ‘So I’m going to be walking around Ms P3.’ Every time they fill out a bank card I have to like cover. I think probably when I have to deal with my medical aid or things that are still in my birth name. That’s really frustrating and unsettling. Every time. Like my bank card. I’m scared people are going to see it. My driver’s licence.***

P3 described an occasion where he was asked to present his ID at a pub and the door man laughed when he saw P3’s ID. He felt that this meant that he was being watched and spoken about. He shared:

> ***And that’s a big thing. And then people that openly try and suss me out and I don’t know if that’s actually happening or if it’s just my perception. I think it’s being clocked. I wonder if people are clocking me.***

P6 said that it affected him when he was misnamed by his family even though he acknowledged that it could take some time:

> ***She’s*** (his mother) ***still kind of getting used to it, using a different name. Because she’s like, ‘You know what, I gave you this [Dead Name], and it was passed down through the family.’ And I was like ‘Ma, I will pass this down to my kids. It’s not me. I didn’t identify with it. It wasn’t me. It wasn’t my name.’ And every now and again I still kind of hear my [Dead Name]. And sort of, when they see me they still use my name. I don’t know. I normally let stuff pass. But it’s just, that wasn’t me. So, it kind of like sort of breaks my spirit, that sort of thing you know. It’s not me. When you are calling me by name, I want you to call me by this name you know. Not my old name. Sometimes people do slip up. Like I know. I understand that. I give them courtesy as far as I can. Let’s say after two years you kind of have to use my name.***

Theme: Support

Dentice and Dietert (2015) stated that during the liminal stage of transitioning, individuals form supportive communities. These can take the form of support from friends and/or families as well as more formal structures such as support groups and NGOs (DeLarch, n.d.).

P3 stated that he received support for his family. When speaking about his father and stepmother, he noted:

> ***They just said, let us know what name you want us to use. And when, so ja, I moved to [City] and my extended family were incredible. All my mom's family. My dad doesn't have much family. ... And through all of this they were just like, 'It makes no difference. If you are happy, you have struggled for so long, if you're happy, sweet.'***

P2 thus spoke about support from her friends:

> ***One of the sort of couples I grew to know quite well over the years, because I taught all three of their kids you know. We still chat and she's very interested in you know, 'How is everything going' blah, blah, blah. ... That's another thing, my friends they are very near and dear to me***.

P2 also received support from her family:

> ***My dad, he's quite cool with the whole thing. ... I just remember, 'I love you.' It was what he said to me and um. ... My dad is fantastic, without him, I don't know where I would be without him to be honestly.***

P2 also received support when she came out on social media:

> ***Last year November I actually came out on Facebook, and said well, this is me, whatever the case may be. Lots of love from everyone on social media.***

P6 received support from friends and by surrounding himself with positive people as well as from his father:

> ***Ja, but you know bonding with my dad, he taught me the ways of how to be a man, that sort of thing. He always used to say to me, 'When you are walking on the side of the road don't let the woman walk in the road. You let her walk on the sidewalk.'***

Speaking of his brother, P6 said, "***Yeah, he is very very supportive. I think that if my big brother was here as well we would be three peas in a frikkin pod***."

P1 found most of her support from the NGOs she volunteered for. She said, "***We also doing support group for Gender Dynamix and for Sisterhood for Sex Workers. Also, there is support group for trans project."***

Although P4 had lost most of his friends after his divorce, he related that things had changed:

> ***I have made friends here. Like I have a lot of trans friends obviously. I've met my girlfriend who I'm very close to. And I have another friend that I have made. We're actually quite close. A cisgender male that I worked with for a bit, and then started working for the [Company], but we've remained close.***

P5 said that his partner had not been supportive at first because her family was very religious. However, she subsequently supported his decision to transition and come out. He said that his partner had remained in a relationship with him throughout his transition. However, he did state that when he had surgery he had been concerned that he may have nobody to support him during his recovery period as his partner worked abroad. He acknowledged that he had many friends who supported him and encouraged him; they had

even gone on a diet with him to help him lose weight. He said, "***[Partner] is not here so I rely on my friends for support***."

Theme: Public or Private Medical Care and Medical Aids

There were several sub-themes that emerged from the data in relation to seeking treatment privately or through public medical services.

P3 stated his reasons for seeking private care despite the cost being so high:

> ***Well, financially it's a big thing for us, because all we want to do is look in the mirror and see what we feel. ... Especially because surgery for us is still considered cosmetic, so that's a big thing. I won't go state. I've seen a friend of mine. They butchered his chest. I won't touch state. He went state because he could afford it. It was like R20,000.00 versus R60,000.00. No ways. I would rather take out a loan and do it privately.***

P2 knew that surgery could be very costly, but added that she was frustrated at not knowing just how much she would need to save:

> ***I just need a price. That's the only thing I need from that man at this point in time. I think often transgender men choose not to have phaloplasty or metoidioplasty because it is, the last time I heard anything, it was like R200,000.00 to R300,000.00.***

P1 said that although she was aware of the concept of medical aid she was not sure how it worked:

> ***So she tell me in future, if you insure yourself, but I don't know if this insurance things is true things or fraud things. People get insurance for in future. I don't know how the insurances work. Because people say 'I have a medical aid.' So how people doing insurance for medical aid. Some people say I have medical aid for my parent. And for myself, I ask how they do that.***

P1 sought care through a state hospital. She said that when she enquired about saving her sperm so that she could potentially have a child in the future, she was unclear about the information that was provided to her:

> ***I am at [State Hospital]. I started to take hormones in 2013. And then before I apply to do surgery, I asked if I can have sperm saved to have a child. And I was not understood very well. After one year they sent me to maternity, and they said to me my sperm could not be properly saved because it’s long since I take hormones.***

P1 also explained that she knew that there were long waiting periods for surgery and that she felt terrible and frustrated. She added that she felt powerless and hopeless:

> ***In the hospital they say, when you do surgery in the vagina, so you be waiting 20 years. When you do the plastic breasts they say 10 years. And for me, my age it is this, I say it is terrible. How can I be waiting so long for this? And I feel like I don’t have power and hope. … So they have surgery and we see how it is going on my body. … From here to there it could take long in [State Hospital]. And I don’t know why they do that. Maybe because it is public hospital. I’m with [Doctor]. I spoke to [Doctor], and he said it is the same for everybody, and there is only a certain amount of time he can operate, and if a heart attack guy comes to him he has to fix him or else he will die. He has got no time to do all the surgery. Let’s just say 2013, there is a problem and they are trying to work on it but I don’t know.***

P1 felt that she would consider travelling overseas to receive surgery because she had heard of other individuals who had got infections and poor care in South Africa when they had had surgery:

> ***As when I heard the people say Thailand is a good surgery. So, I just find out about this travel. Because you need private. And you don't have surgery in South Africa. … Maybe it is not professional. Maybe you feel like it is not good help. … Because if each surgery, it go infection, each surgery it got issue.… Because some people public always the same. I can say public surgery, I can say people they don't care. They don't take care because free things.***

P4 voiced his frustration at the medical aid he was on for not covering surgery, which he believed was essential:

> ***It's absolutely infuriating, and at the same time just exhausting. ... I've been fighting since day one just to be myself and to affirm my gender. I take offence to the whole thing that medical aids see this as gender reassignment surgery. I am not reassigning my gender. I am affirming my gender, or confirming it or whatever.***

P4 also stated that he found it difficult to save the required amount of money from his salary and that is why he had appealed to his medical aid:

> ***And having to wait and raise, it's about R75,000.00 that I need to raise. I can't borrow this money from any sort of institution. I don't earn that kind of money. I am a public servant, so it's, I don't earn this fantastic salary. And the other route is to raise money. But sometimes it doesn't always work. So I am basically having to make an appeal to the medical aid, ... which is just basically to say, please could you find, um, would you motivate them to fund half. Or, I am prepared to meet them half way. ... Many trans people have gone this route, where they go to a private surgeon, and they like, look you know. And he's like well, this is the cost. And it's not like they are trying***

> ***to, I mean, this has been the cost for roughly the last five or six years. So you can’t say they are charging these exorbitant amount of fees because they want to make money out of you. I mean really, that’s the cost. You just want help. Um, so ja it’s exhausting.***

P4 also spoke of how transgender individuals get labelled and diagnosed, and what the implications were for him since the World Health Organisation had depathologised gender identity:

> ***They just believe it’s not a necessary surgery. Obviously, things have changed. I can’t remember which year it was. They called it gender identity disorder, and then it was changed, and it’s no longer seen as a disorder. So the medical aids no longer pay for any affirming surgeries. So now they call it gender reassignment surgery. But now it’s a new thing with the World Health Organisation. They’ve taken it off completely. Now any sort of mental illness, and you kind of think to yourself you know, that yes, it’s not a mental illness. But how is this going to help other trans people in the long run? Because now we are going to have to suffer. We’re paying for a medical aid that is supposed to be there to help you.***

When the researcher asked P4 if he felt that by depathologising gender dysphoria it would influence his medical aid’s decision to pay for the surgery, he shared:

> ***I know it sounds very, I don’t know. It helps, but it doesn’t help. ... It’s not our fault that we are born this way. ... And with transgender people, with all respect to intersexed people really, it’s also not our fault. I can’t help that this is the way I am, this is the way I think and carry on with my life, my day to day life. And we should just be afforded the same opportunities surgery wise. But obviously, ours is seen as cosmetic and theirs isn’t.***

P4 added:

> ***But like I say I am still waiting for the letter and I will submit it with my documentation and see what they have to say. They could blow me away and be like, 'Ok fine we'll fund your surgery, we've looked at your reasons wada wada, let's do this.' Or they can be like 'We'll cover half.' Or it's kind of just a flat no. If it's a flat out no, then it's going to be like 'I'll challenge you.' And don't come with gender re-assignment because, damn, I am not reassigning my gender. I am affirming who I am.***

P6 also voiced his concern about having to fund his surgery:

> ***I dunno it's costly at the end of the day. Oh ja, I am still trying to find a surgeon that can do the surgery for me. And that, just doing the top surgery really is like pretty much my annual salary. That's initially what it is. ... I've just started a fundraising page, um, and I have been trying to share it on social media. I've got a few friends who have donated to the page. But it's just not getting the exposure because, ja, people don't want to help you, that sort of thing. I don't think it's a case of they don't want to help. It's more about well 'I've got my own problems.' Ja, so you know I've had a few friends donate to the page which is great, but it's still trying to reach that milestone of hitting those certain points.***

P6 also shared why he was seeking care through a private doctor rather than going through a state facility:

> ***I don't want to do it through a public hospital you know, because they hack at your chest. I would rather go through private. It's a long wait, especially for surgeries in the state. I read some stories where some people are waiting and are on a 25-year list, and I'm like I would rather save money for the***

> ***next 25 years than wait that long. Or rather save up money for the next five years, than wait 25 years for a surgery. I guess some people are different. They will wait the 25 years. Whereas I wouldn't want to.***

P5 explained that he also struggled to save money for his care because he did not want to place himself in financial trouble:

> ***Obviously, everything's costly you know. So the surgery itself is going to be over R100,000.00. So I'm working towards that. I'm thinking that is just for the surgery. All the other things that I am going to need for the care after the surgery is also going to cost money. So I want to also be in a position that I don't financially cripple myself. That is even more reason, you know you don't only want the surgery, you need the surgery. And you need to have money so you need to work very thrifty with your money. So that's also the other aspect I want to be ready. My financial needs need to meet my surgery needs, my surgery deadline.***

Theme: Liminality

During the analysis, two sub-themes related to liminality emerged. The first was liminality as it pertained to taking hormones and the changes the participants had experienced, having surgery and their dreams of how it would feel after they had completed their transitions. The second theme of liminality concerned rites and rituals they had already performed, were performing or were planning to perform post-transition.

Liminality: Surgery, hormones and dreams.

All the participants discussed how being in the transition stage had affected them.

When discussing the changes he had experienced since beginning to take cross-sex hormones, P3 said, "***So, the advantages of being on testosterone is having more stamina. So now where I could do three push ups I'm now doing thirty***." P3 was the only participant

who had undergone any surgery at the time of the interviews. He noted, “***I had a hysterectomy in June. It was the most amazing feeling***.” He also said that because he had undergone a hysterectomy he was experiencing puberty and menopause at the same time. However, he added that taking testosterone had helped with the symptoms of menopause.

When P3 discussed he surgery, he asserted: ***And for me like top surgery is the biggest thing for me right now. Especially when it’s so hot and I have to wear a binder, like I feel I can’t be without binders. Like I just taped for private and that was the most unbelievable experience. ... But wearing shirts that like show my form more make me feel really confident. I don’t feel the need to drown myself in big shirts.***

P3 also explained that getting male secondary sex characteristics from his hormonal treatment was affirming:

And just seeing body hair is just like so reaffirming so I tend to want to wear shorts and T-shirts so that people can see that leg hair is growing. Especially because my facial hair is taking its sweet time.

Furthermore, P3 had kept a video and photographic record of his appearance over time. He used the word mind-blowing to describe this endeavour:

I made a video, stuck it on YouTube. ... I still have that video. So on my one year I watched that video, and it was mind-blowing. Absolutely mind-blowing. I mean there is even a photo of S and I from March last year, where he was like 13 months on T (T means testosterone) ***and I hadn’t started T. And when I came back from [City] in March we took a photo, and we put them side by side and it was just huge. So I mean doing the comparisons, that’s a big like confidence booster. It’s just that for me, that’s how I like I’ve stopped kind of doing the monthly things*** (referring to making

videos of his transition on a monthly basis). ***I've passed that. But I still sometimes just for myself I do a comparison of like this time last year versus now. I love it, just the freedom.***

When P3 was asked what it would mean for him when he had all his surgeries and fully transitioned, he shared:

> ***Freedom. I won't worry about what I look like in a pair of pants. I won't worry about if my binder sticks out in a shirt. I'll be able to wear a white shirt, just a white shirt. I mean one of my friends had top surgery on Thursday and the smile on his face was just like, 'Dude, I have never felt like.' All I want is that feeling. I just want to be able to, on a hot day, take my shirt off. I mean just that pride. And wearing a button-down shirt, and wearing my shirt open. Thanks to P6 he was like 'Just take it off.' And feeling that breeze up my shirt and up my back, and feeling my chest hair like tickle. I want that on a permanent basis. I want to get home from work and just be like, this is life. I am doing that now because I am in my flat but I don't want that excess stuff.***

P2 described her journey when she began to take hormones and how that had changed her:

> ***So February this year, I started hormone replacement therapy. It's fantastic. It's absolutely fantastic. ... Within three days I felt really fantastic. But of course you have to take the good with the bad. Um, transgender women, I don't know whether you actually know this, actually do have a 28ish day hormone cycle. And I'm on day two (laughs). ... So that's one psychological thing I have sort of handled you know. Because mood swings are ok. So I am used to this. But it's, you know, when in the old days I sort of had, ok I***

> ***can have three emotions in a week and now I have three emotions in the span of two hours. It's brilliant, it really is. And it's a bit of an adjustment. But I'm much happier now than I ever have been. And then of course the other physiological symptoms like growing pains and testicular atrophy, whatever the case may be. Great. But, um, I am me now. So I'm happy. ... I felt fantastic. Even people at my brother's wedding, even though I was wearing suit, they said to me, 'But she looks happy, she really does. I have never seen her that happy.' And that was a month and a half of hormones. So brilliant.***

When the researcher asked P2 how she experienced having to wait for surgery, she stated:

> ***I think, because I am expressing myself right now as me, it's a lot better than it was before the wardrobe, before the shoes, before whatever. Now the impatient me comes in, waiting for 'the girls' to grow*** ('the girls' refers to breasts)***, and waiting for money to have gender confirmation surgery.***

However, P2 also expressed her frustration at having to wait:

> ***Oh yes, it's finances and time. Because a very good guideline for top surgery in transgender women is you wait for 12 to 18 months before you have top surgery. It's not because they are gate keeping. Because they are being mean, whatever the case may be. It's so that the hormones can grow your breasts naturally, and then see what you have to work with. ... Given all the changes I've been going through it still remains to be seen whether this will happen or not. When [Doctor] said to me, 'If you had the choice would you do top or bottom surgery first?' I said bottom. I didn't even know you had a choice.***

P6 related his experience of waiting for surgery:

> ***In terms of surgery, it's still a waiting period. It sucks. ... And it's just trying to just, you know, instead of thinking about, you know, the surgeries, you know, I kinda just wake up every day you know, put my tape on my chest, move on with life, do my injections that sort of thing once a week. I am happy with that until I can save up enough money for surgeries. I kind of just have to go with that for now. ... You know what, I think for the next couple of years I might as well just make myself happy.***

P6 related the effects of his hormonal treatment:

> ***Yeah, and even though I still looked female in the mirror I just saw that black hair and I was like 'Oh my God, I don't need to shave anymore. This is the best thing ever. I am never shaving ever again.'***

P6 shared what it would mean to him to complete his surgery and transition:

> ***I think it would mean a sense of accomplishment. It would be like, I'm not accomplished being me because obviously I learn about myself every single day. It's like 'Ah I didn't know that about me' sort of thing. So, I think it would just be more of … I could look at myself in the mirror again you know, that sort of thing. I won't have to you know, be uncomfortable you know, looking at my chest, looking at the rest of my body. I won't have to feel uncomfortable. I think at the end of the day you know, having the surgery would be great you know. It would be something that I have achieved in my life by myself, and I didn't have to ask anyone you know, that sort of thing. I would just ask for their support and that's it.***

P1 related her experience of the care offered to her:

> ***I was in endocrine, I am meeting some Professor before. I have seeing some doctor because I have some questions to ask. Because the doctor does not give me good answer. For me I want just someone who can tell me the advice. So for me is something because the primer you take it, when I had in social work in trans people he say primer is not good. So always ask oestrogen. That’s very good. The best. So I never ask in [State Hospital] if I can get. And I don’t know if it can give. Because I heard it only been given in private doctor.***

P1 added that she would like surgery because she had not developed breasts through taking cross-sex hormones only despite the dosage being increased. She used artificial fillers in her bra to help her feel like herself. However, she was told by her doctor that it would be better for her to save the money and have her surgery abroad.

P4 explained how he felt about not having had surgery:

> ***Like when I’m intimate with my partner I can’t take my shirt off. I don’t want her to touch my chest. We have been going out for nine months. Not once has she touched my chest. I said I can’t.***

P4 added that because he had not had surgery as yet he battled to find a space where he could relax and be himself. He related being able to go to a male changing room at the gym:

> ***Because then getting dressed or undressed won’t be an issue. Because, I mean, I’ll have a flat chest. But yes there will still be scars, but you know, guys don’t look at you in a change room. ... Going into the male bathroom to use the toilets or whatever, you walk in, you do your thing and you walk out. Nobody is checking you out. ... And that’s what I’ve noticed, as I went through my changes and I started presenting more male, that’s how I***

> ***gauged 'Ok, it's now time to leave the female bathroom and go into the male bathroom.' Because I would get looked at.***

P4 also described how he experienced the adjustment from going from female to male in relation to gender stereotypes:

> ***It definitely was amusing, very amusing. ... You kind of, when this whole process starts you do something about those things. You do think about what type of man would I like to be. Sensitive? Macho? You know you sort of kind of want to fall into this stereotypical misogynistic. ... Because you want to overcompensate. Because obviously at the very beginning it is very difficult because you don't pass right way. You're on testosterone. You're going through all these feelings, these emotional changes. Your brain chemistry is changing as well. So you do start thinking differently. You can't multi-task anymore, so just forget about it. ... Like if I'm doing something, the focus that I have on that one thing is unbelievable. I can focus and get it done and I can concentrate. But don't come and talk to me because I will not know what you're saying.***

P4 also shared his feelings about waiting for surgery: ***But having to wait for the surgery, I mean it kills you on the inside. It's kind of like, this is just going to happen once in my life. I have been confirmed for surgery by the surgeon, provided I've dropped the required amount of weight, and of course from my psychologist because she needs to give a letter. It's kind of like why do I have to fight for this. Why must I. You cannot help but get upset with them sometimes and lose your shit a little bit. And you kind of fall into that what they believe is the stereotypical transgender person, we're emotionally unstable and mentally unstable. It grates me every day and I***

> ***have to be patient, cool, calm and collected all the time. It exhausts you it makes you tired. ...***

P5 had been told that he had to get his diabetes under control and lose some weight before he could have surgery. He explained how this devastated him:

> ***Regarding my surgery things, I went to [Doctor]. I went there in high hopes but because I am diabetic, and because of me feeling a lot of emotions, depression and all that, I haven't been looking after my health. But I still expected the doctor to say you know 'Let's go for it' and all that and stuff. And even though it's like I just wanted him to give me a date and I was like when I go there, he said to me, 'Well, it's very dangerous if we do the surgery because you could die because of the diabetes.' I was sitting there and I was like, this is bad really saying this to me you know. And I was so down and out after that. I was like really, it was a horrible experience. And then he says to me, 'You know what as motivation I will only charge you half the consultation fee. When you come back you can pay me the other half.' And I'm like, 'OK thank you.' It was disheartening in the beginning. ... And I was complaining a lot about the surgery stuff and how horrible it made me feel. ... Because I told the doctor I would be back at the end of the year. And he said to me, 'You won't be ready. If you lose weight in a healthy way you won't be ready.' I said to myself, 'You know what, I am going to show this fucker, I am going to show him.'***

Subsequently, P5 explained why he felt he needed the surgery to remain mentally well:

> ***In public, people, what gets to me is say when I go to the garage and the petrol attendant comes to me and like 'Hi sir.' And then they get to the car***

> ***and their eyes fall on this area and then they are 'Sorry ma'am' and that just argh. Having a chest while presenting as male makes me extremely uncomfortable. Like in summer at home I take my shirt off. It feels so liberating, and I don't know how to explain to people that I literally don't see this part of my chest. My mind is like, just focused on how the cool air feels on my back and this part of my chest. So the surgery for me is like, I need it. And I was saying to my therapist that the feelings like before I came out to people, I am experiencing those feelings again.***

When the researcher asked him how he would feel if the doctor told him at his next appointment that he could not have surgery, he stated:

> ***If I can't live as me completely then almost like, what the hell am I doing here. I feel like now I can't be like I'm suicidal, and I didn't even give myself a chance to get to the point where I am ready for surgery.***

When asked if he was feeling suicidal at that moment, he shared:

> ***No, no. That's why I'm saying, I was suicidal before I saw the surgeon as that has always crossed my mind. My father committed suicide so I had those tendencies when I was younger. But now with the surgery I have something to look forward to. ... It won't be fair to myself if I have those tendencies and you didn't even put in the work but you just want to die. But that's not fair on you. On the life you could have lived.***

Liminality: Rites and rituals.

The participants were in the liminal stage of transitioning. They were asked if there were any rites of passage or rituals they had already performed or would perform once their transition had been completed.

P3 noted that once his surgeries were complete:

> ***I’m going to have a bonfire, burn my binder, burn my packer*** (packer is referred to here as using an object to create the appearance of a penis or male bulge in one’s pants)***, just burn everything. My tape*** (used for binding)***, burn everything that symbolises what was, and there are no words for what it will mean.***

When asked if there are any metaphorical or symbolic rituals that had helped her to feel more affirmed after coming out, P2 related:

> ***What I did after my brother’s wedding, I killed off [Dead Name]. [Dead Name] is a cunt. I hated [Dead Name]. But his existence was necessary for me to be able to be me. He was a means to an end. It sounds very white supremacist, but it exactly what it is. So I killed him off in my head. And after the shopping trip ... a bunch of us had a wake at the pub. We literally had a wake. I delivered a little speech. The president of the club delivered a little speech. A very good friend of mine. And then there was another guy who said, ‘Listen, every now and then we are going to slip up. Use the dead name.’ So we sort of had a bit of a laugh at that because he illustrated his point brilliantly. I get that it is a process. You have to sort of accept the fact that people are going to misgender you at some point in time. People are going to ‘dead name’ you. But it will get better. In my experience it has. The wake was for friends in [City]. It was more for me than for anything else. We had one in [City] and one in [City]. Obviously my parents wouldn’t have got the whole idea of, let’s have a wake for [Dead Name]. They wouldn’t. But for my birthday this year I did dress up. Because everyone knows this is going to happen. So I dressed up, had a braai, so the people can get used to the idea of P2 as opposed to [Dead Name]. It was fantastic. It was brilliant. I***

> ***was much more relaxed. I wasn't running around like a headless chicken. It was fun. And of course there are no sort of other rituals that are needed with the coming out. I sort of said, this is happening. So let's do it. I may have gone shopping with the one. I may have said to the other one lets go for shoes, let's do make up. They're used to me. They never knew [Dead Name] as it were. Two or three of them did, but they hated him as much as I do.***

P2 shared how she would symbolically celebrate her transition after it was complete:

> ***Um, a friend of mine, and I'm actually quite partial to this idea, suggested a birthday or a vagina shower. That's what she called it. I'm quite keen on the idea. Before surgery, or after surgery. I'm thinking after. All the girls have a cake, like a bachelorette. But you know, as opposed to getting a man in my life, I'm getting rid of a man in my life. Which is fantastic. Which is why I lost all the weight.***

P6 explained that coming out felt like a symbolic rebirth:

> ***Ja, it was technically. Like, I came out of the shadows. And it was like, there's light (laughs). Like there is light at the end of the tunnel. ... Um, I think when I started transitioning I literally took a bag of my female clothes and threw all of them in there and gave it to my domestic worker, gave it to my ex-girlfriend. And was like 'Take it, I don't want it.' I thought like, that was not for you. It felt amazing, I am not going to lie to you. It was literally like a weight off my shoulders.***

P6 elucidated that being in this liminal space brought him a sense of feeling that he was himself:

> ***Um, I haven't shaved yet. I'm still trying to grow a beard. This is a good year and a half. I think just getting dressed in the morning, making myself look presentable. It's not a fashion statement. It's not a, 'Hey, I'm a guy look at me.' It's more of just waking up, and you know, putting on my clothes, and you know, just putting some music in my ears and going like this. I think it's just you know, I don't know if you understand what I am trying to say. It is just getting up and just you know, then saying you know, 'You are a man, and that beard' sort of thing. I check my beard and check how it is growing. I put on some beard oil, and it's so cool just like doing the things I should have been doing my whole life.***

When the researcher asked P6 if he would do anything to mark the end of his transition, he stated:

> ***No, nope. I think I would just celebrate it like being a rebirth, like being reborn you know. Pretty much like my birthday.***

P4 explained how he perceived a rite of passage:

> ***Going to the barber. I have a barber that I go to. I don't know if he's figured out yet that I'm trans because obviously he had to do something with my shirt and I don't know if he spotted the binder. But I don't think he would know. Or maybe he does but he just doesn't give a crap. It would be going to the barber getting the hair done.***

P4 described going to the barber as a type of ritual he underwent that affirmed him. However, he added that he would like to go to the barber for a shave:

> ***It's a ritual. There's actually a barber in the [Shopping Centre]. But I'm waiting until, you know obviously, more of my throat is covered. Because I don't have an Adam's apple and I don't know if that will be thing for them***

> ***and if they pick it up it's weird. I know most cisgender men have an Adam's apple so you know. But that would be thing for me to go and just feel like, just trim it for me.***

P4 shared that once he had completed his transition, he would do certain things that he could not do at present or only did when he was alone:

> ***There are a few other things I would like to do. But I would like to do them post op. And that would be then to take my shirt off. Because that's a thing. Another, I suppose you could call it a rite of passage or affirming thing to do, obviously not when I'm with my girlfriend, is to actually sleep with my shirt off. That to me is affirming.***

P4 shared his thoughts about celebrating the end of his transition:

> ***I haven't thought that far ahead concerning once everything is done. For me top surgery won't be the end of it. Um, but I think look, I think post top, top surgery obviously, I would get a tattoo, and I would like to put that on my chest. Um, so that's the only big thing I have thought of so far. Concerning the end of my journey, I don't think one ever stops transitioning hey. You know, whether you are trans or not, transition is always growing. You are always transitioning. There will always be nothing to mark the end of that.***

P5 related that while in the liminal space he pursued fitness to help him keep going:

> ***I feel that while waiting for surgery the only thing I can do is fitness. Because the fitter I am the smaller this area is going to be*** (referring to his chest) ***and the better my clothes will fit and the more I will pass as male.***

P5 added, "***And I have used a male bathroom before when no one is around so there is no chance of somebody being like what are you doing.***"

When asked if there was anything he had done to date or considered doing to mark the end of his transition, P5 stated:

> ***I have thought about it. And when I was on testosterone for one year, which was on [Date], my friends all wanted to celebrate as this was a big milestone for me, as I was proud of myself. And I just wish that my mom was here to experience it with them. But honestly my dream goal is to know what it feels like to one day, when I have my surgery and I can do that, find some way to generate some income. I would like to help guys get top surgery because I know how it feels, and I know the dark place and for me. If I can get someone else some help through surgery, or at least help them, that would be amazing for me. That’s what I would be doing. After surgery, I want to help someone else get surgery as well. Being a mentor would be amazing***.

Conclusion

In this chapter, the findings of the study were outlined. The findings were substantiated by excerpts from the interviews. In Chapter 5, the findings are discussed in discussed in relation to the literature. Furthermore, recommendations for practice and future studies are made. Finally, the limitations of the present study are briefly outlined.

Chapter 5: Discussion, Limitations and Conclusion

In this chapter, findings of the study are discussed in relation to the literature to shed light on the lived experiences of the six participants. This study was unique in that all the participants were living in South Africa. Consequently, the interviews provided a glimpse into the lives of transgender individuals seeking care in this country.

The purpose of the research was to examine how transgender individuals awaiting gender affirmation surgery in South Africa experience the liminal stage of transitioning. A further purpose was to examine how the rites and rituals undertaken during this stage contribute to their wellbeing. However, in the process of analysing the data, a great deal about the individuals’ personal stories revealed that it was also their experiences prior to coming out that had affected them. These effects were both supportive and non-supportive.

It was apparent that coming out played a major role in their stories. There were many factors leading up to their coming out that still affected them in the liminal stage. Relationships were key points that helped these individuals navigate the changes they were experiencing and helped mitigate any distress they may have been feeling. Eudaimonic wellbeing was important. Psychological wellbeing was also a major theme. This included the participants’ psychological wellbeing prior to coming out. Finally, their experience of this liminal stage included not only the present, but also their future hopes and dreams.

Coming Out

Coming out to oneself and/or to colleagues, friends and family is often an arduous and emotionally challenging time. Coming out as different to the cis-normative concept of what and who an individual should be as either a male or female may be isolating and lead to interpersonal conflicts. It was apparent from an examination of the participants’ lives that

although they had already come out as transgender individuals, the journey that led them to this point was fraught with conflict that still affected them.

Always knowing.

In Devor’s (2004) Stage 1, *Binding anxiety*, individuals experience anxiety about knowing that they are different, but do not have language to understand what this difference is and how to express it. These individuals tend to seek companionship from others who are not in their gender group assigned at birth or engage in activities that are considered to be for the other gender. This theme is also related to Devor’s Stage 2, *Identity confusion about gender assigned at birth.* In this stage, individuals tend to hide their feelings from others and will not talk about their confusion for fear of stigmas and rejection from society.

The participants stated that they always felt that they were somehow different. This was an important story that they had to tell and in most cases, it was where their story began. One participant related knowing that he/she was in the wrong body from early childhood. Many shared that they just felt different to other children. All of them acknowledged that they did not know why they felt different or what it meant.

This sense of somehow being different to other children was often confusing, but they had no idea or conceptualisation of why. Young children who realise that they are different struggle with gender constancy, which is the ability of a young child to understand the biological permanence of gender (Berk, 2013). Epistemologically, gender is socially constructed as a means of culturally knowing and understanding the attributes that constitute one of the gender binary categories (Hausman, 2001). Children are taught from birth that there are two genders, male and female, and that they belong to one of those. However, the participants who felt they were different had a tumultuous journey through childhood and adolescence because they did not know how to express that they felt different and they did not know why they felt different.

Sexual orientation and adolescence.

Gender identity tends to remain stable during adolescence for most children even if some of their personality traits and interests change (Steensma et al., 2013). However, because these participants did not have the language or knowledge to understand why they felt different, they used the socially constructed idea of sexual orientation to help them navigate adolescence. This is probably because sexual orientation has been understood for much longer than gender identity in mainstream culture. For example, whereas homosexuality was removed from the DSM-II in 1973 (Drescher, 2015), gender identity disorder is in the current DSM-5 (American Psychiatric Association, 2013). Many of the participants came out to their families and friends as either gay, lesbian or bisexual. They used this framework to help navigate teenage romances and to find social groups which to belong.

In Devor’s Stage 3, *Identity comparisons about gender assigned at birth,* some individuals seek to find socially acceptable ways to express themselves, which are safe enough to display in public, but free enough to allow them to present differently to cisgender and heteronormative individuals. This stage is viewed in conjunction with Stage 2 as the feelings of confusion remain.

Research has shown that the many realities that transgender individuals may face include bullying and stigmas (Nel, 2014; PsySSA, 2013; Theron, 2011). This is also in accordance with Stage 2 of Devor’s (2004) model in which individuals fear stigmas and rejection, and often hide their feelings because of this. One participant was so badly bullied that his parents removed him from the school he was at and placed him in an all-girls school.

It was apparent from the data that language and understanding are crucial concepts that are undeveloped in children and adolescents. The participants used sexual orientation to help them understand what they were feeling during adolescence. They stated that they did

not know that there was such a thing as *transgender.* This indicates that there is a general lack of understanding in the adolescent population about gender identity. Organisations such as Gender Dynamix and Section27 in South Africa focus on the education of adolescents and adults as a means of advocacy (www.genderdynamix.org.za; www.section27.org.za). However, it is only recently that some schools in the Western Cape in South Africa have begun to address transgender issues in the adolescent population (Mafolo, 2019). Minton (1997) and Nagoshi and Brzuzy (2010) noted that queer identity as a social construction appears to be an area that still requires much attention. By providing children and adolescents with an understanding of gender identity and the many forms it can take, the stigmas, bullying and misunderstanding that are experienced by many could be mitigated. Furthermore, Prosser (2006) stated that not all transgender individuals identify as gay, lesbian or bisexual, but rather heterosexual; in this study, once the participants came out, their sexual orientation remained largely heterosexual.

Work.

Coming out as transgender in the work environment proved very difficult for some individuals. This is despite the protection of South African law, which is set out to protect them (Theron, 2011). Recently, the South African Workplace Equality Index (SAWEI) has provided South African companies with a means to gauge their progress against independently determined and research-based practices concerning LGBTI policies in the workplace (LGBT+ Forum, 2018). However, to date, this has only included 17 companies as the project is still very new.

In Devor’s Stage 9, *Acceptance of transgender identity,* individuals have accepted their identity as transgender and have become comfortable enough to disclose this to significant others such as colleagues and employers. However, the stigmas attached to being transgender are always present. Consequently, some of the participants did not come out to

everyone at work for fear of being ridiculed and/or rejected. Instead they chose select people to whom to disclose this information.

The participants’ comments regarding coming out at work related to safety, ridicule, discrimination, fear, rejection, misidentification, which is not knowing that the individual had changed names, using dead names and misunderstanding what being transgender is. Having an understanding and accepting the work environment and culture made a difference to the participants. F and H found that coming out at work was not problematic when there was acceptance.

Despite the laws in South African, which protect individuals who are transgender (Theron, 2011), it appears that there is still discrimination towards transgender individuals in the workplace. This led to a sense of insecurity and fear in the transgender participants’ lives. Even P1, who was transparent about her gender identity, felt that she had to protect her clients from receiving any unwanted attention.

Discovery of self and coming out.

Some participants described how they came to understand the concept of gender identity and being transgender. According to Minton (1997) and Nagoshi and Brzuzy (2010), transgender individuals come to understand themselves as being non-heteronormative and non-cisgender in both their sexuality and their identity. This is achieved through critical self-reflection and self-construction of what it means for them to be transgender.

When the participants identified themselves as transgender, they often likened it to a weight being lifted from them. They also felt congruent in who they were. The shifts in their wellbeing are in accordance with Ryan and Deci’s (2001) self-determination theory. This theory posits that eudaimonic wellbeing is achieved as individuals become more congruent with their values and become more engaged in what they are doing.

It took some time for the participants to discover that they identified as transgender. Devor (2004) stated that whereas the discovery of what being transgender is and means to a person often takes time, for some it can be a moment of sudden insight or discovery. It is noteworthy that once the participants had come out to themselves and others, they felt that they needed to explore their identities even more. They said that after years of struggling with body image and mental distress they felt happier than they had ever been. Devor (2004) asserted that this can lead to individuals finding their space in the world and having a language to describe what they are experiencing.

Relationships

When the participants discussed their relationships in great depth, they revealed their sense of belonging and acceptance relied a great deal on how they were perceived by others.

The participants’ relationships can be related to Devor’s (2004) Stage 8, *Delay before acceptance of transgender identity,* where individuals use their close relationships as a means of reality testing. Individuals in this stage seek validation from others to help them identify that what they are feeling is also what is perceived by others. Furthermore, they seek others who are similar to them to get confirmation that they are like other transgender individuals. This theme can also be related to Stage 9, *Acceptance of transgender identity* (Devor, 2004) in which individuals have come to accept their identity, but may struggle to share this information with loved ones. Consequently, although there is some relief at knowing who they are and what they need to do to move forward, there are also complications and risks involved. Those who are close to the individual may resist the individual’s new identity and may struggle to come to terms with the losses that will occur when the individual is no longer who they knew before.

Fathers and mothers.

Although not all participants described identical stories about their parents, there were some interesting insights that they provided. The fathers of these participants generally tended to have a more accepting view of their children coming out as either gay/lesbian/bisexual and/or transgender. They described their relationships with their fathers as loving, accepting, affirming and warm. Some described looking to their fathers to learn how to be men or being able to mirror themselves by watching their fathers (Devor, 2004).

However, some of the participants described having poor relationships with their mothers or being rejected by their mothers when they came out. Two transmen felt that their mothers had behaved this way because their mothers had wanted the daughters to whom they had given birth. One transwoman said that she had always had a poor relationship with her mother. There was only one participant who said that his mother was supportive of him. However, his father was deceased so he could not confide in him.

Children who are pressurised to conform to their gender roles by parents and peers are more likely to be dissatisfied and distressed (Egan & Perry, 2001). In addition, Devor (2004) stated that people who are close to the individual may struggle to come to terms with their new identity and may grieve for the loss of the person they knew before they came out. Providing parental support for those families with a transgender member may mitigate some of the parental alienation that was experienced by participants. Interventions could centre around helping parents to connect to their children, assist them through the grieving process and help them to accept the changes that are to come.

Siblings.

When the participants came out to their siblings, the participants and their siblings experienced mixed reactions, which were not differentiated by the sibling’s gender identity or the participant’s gender identity. Relationships remained intact when siblings accepted the

participant’s disclosure. Feeling supported meant that some participants were grateful for this support and felt that they were not being judged. However, even though some siblings had accepted the participants’ gender identity, they either took time to accept it or struggled with using the correct pronouns and chosen names. One participant even described his sister-in-law as being supportive when his brother was as yet not supportive.

Some siblings rejected their transgender siblings completely. This concurs with previous research that has shown that siblings reacted to their transgender siblings differently after coming out, which led to difficulties within the sibling group and larger family structure (Factor & Rothblum, 2007; Nuttbrock et al., 2009). The participants acknowledged losing their sibling relationships was difficult because they had been very close to their siblings before disclosure. Two of the participants’ siblings did not accept them because of their religious beliefs. Furthermore, some of the participants noted that their siblings made no effort to understand them by using their new names and the correct pronouns as well as finding out more about being transgender. Family therapy for families with a transgender member could provide the safe and supportive environment needed to help with sibling relationships.

Romantic relationships.

There were several layers of complexity when the participants discussed their romantic relationships that accords with what Nuttbrock et al. (2009) purported. The relationships that participants had with others when they first identified as gay, lesbian or bisexual led to them to feel they could never be happy and were not worthy of being loved. Their partners often stated that they wanted to end the relationship because they could not be romantically involved with the participant’s affirmed gender and wanted to remain true to their own sexual orientation. One lesbian partner ended the relationship because she did not want to be with a man once her partner had transitioned. One transman said that he would

have fought for his relationship if his partner had accepted him and had wanted to be in a gay relationship. Furthermore, before affirming their gender, some of the participants felt that they struggled to be intimate in their natal bodies.

Despite longing to be in a relationship, one participant found it difficult to find a partner and she felt this was because she was HIV positive. Another participant found that coming out to his long-term partner was difficult as she had not been supportive initially. This lack of support was ascribed to her family being religious and the difficulties the couple had gone through when they disclosed their lesbian relationship. The partner felt that her family would not accept another immense change He also described his partner as being supportive thereafter even though his partner was struggling to use the correct pronouns and misnaming him.

Helping couples adjust to the changes in their gender roles within the relationship is an area that needs to be addressed. Furthermore, helping transgender individuals cope with body image issues during the transition phase could further support them as they seek intimacy with their partners or seek new romantic relationships.

Friends.

The participants described their friends as being very close or like family. When the participants spoke about their friendships since coming out, they stated that these friends, who included both cisgender and transgender individuals, kept them sane, were their biggest support and acknowledged who they were. They felt that having transgender friends meant that they had someone to be with socially who understood them. They met some of these friends through activist groups and support groups (Galupo et al., 2014).

When the participants spoke about their friendships prior to coming out, they related that some of them used to have the same circle of friends, but never knew each other. However, some friends from the past no longer interacted with them because they no longer

recognised them. One participant shared that he had struggled to make friends prior to coming out because he had not trusted many people then.

It is noteworthy that one participant, P5, brought a cisgender friend with him to his interview to support them. P6 and P3 disclosed that at the time of the interviews that they were best friends. The support that the participants received extended to feeling supported during the research for this project. Support from friendships should be encouraged when treating a transgender client in therapy. The participants found it comforting to know they could experience a social connection with their peers. Therefore, connecting individuals to other transgender people may be a worthwhile endeavour.

Wellbeing

Like balancing on the middle of a seesaw, individuals need to navigate the balance between their resources and challenges (Dodge et al., 2012) if they are to achieve wellbeing. These include psychological, social and physical challenges.

Psychological wellbeing.

In line with Murad et al.’s (2010) research, some of the participants suffered pre-existing psychological disorders such as bipolar, depression and suicidality. However, once the participants came out, the majority of their psychological symptoms appeared to either dissipate or go into remission. However, the participants were still affected by various psychological issues, which had an effect on their overall wellbeing (WPATH, 2011). Generally, the participants had all sought counselling or psychological services to assist them with both pre-existing or pre-morbid psychological distress and to help them navigate their transitions. The Psychological Society of South Africa (PsySSA, 2017) has revealed seeking psychological care can help with issues arising from the transition process.

During the interviews, several psychological factors were discussed. Depression was predominantly apparent. Although this depression was related to damaging experiences with

psychologists, gender dysphoria and fear of rejection, it was also associated with managing other issues that did not relate to gender identity such as dealing with childhood sexual abuse, family problems and marital problems.

The participants also mentioned self-harm. While some participants no longer self-harmed since coming out, other considered it.

One participant had been diagnosed with Bipolar I Disorder. However, she stated that since she had come out she was not sure that this diagnosis was correct and believed that she had rather been feeling gender dysphoric. Some participants still felt somewhat dysphoric. The reasons for this ranged from not being able to use their assigned gender’s facilities at the gym to not being sure if they would be given clearance for surgery owing to prior medical conditions.

It is noteworthy that two participants who were in relationships acknowledged not being able to be intimate with their partners. Both were transmen and because they had not undergone top surgery yet, they were unable to take their shirts off when intimate. One transwoman also acknowledged her insecurity about her body because she felt insecure about still having male hair growth patterns that were at times visible.

Furthermore, suicide was very prevalent. The participants’ reasons for attempting suicide included not understanding who they were as transgender individuals, an inability to manage past trauma, perceiving others would not understand them, not wanting to disclose their transgender identity to family members, being rejected by peers, fear of being unable to have surgery due to a prior medical condition, and a family history of suicide. One participant acknowledged using alcohol to self-medicate.

In Devor’s (2004) Stage 11, *Transition,* the period of transition is described as being either exhilarating and/or trying because there may be periods when individuals as well as others cannot recognise their gender. Devor (2004, p. 61) stated that this can be “extremely

unsettling and difficult.” Conversely, moving towards one’s affirmed gender means leaving behind a past that is full of anxiety and adopting a lifestyle that is more authentic and congruent, which often leads to fulfilment and happiness.

It was apparent that many of the participants needed support when they were coming out. Body image was one noticeable area, particularly when they were being intimate with romantic partners. Addressing body image with these individuals in therapy could assist individuals and their partners who have to navigate several sexual and emotional challenges in their relationships. Those treating transgender individuals should also pay heed to substance use, especially if there is a familial or genetic history of substance use. Finally, suicide ideation was prevalent among the participants. Because it poses a life-threatening risk to transgender individuals, attention should be paid to it. Not feeling supported and facing many physical and psychological challenges may be isolating. Including individuals in groups could help alleviate this isolation and subsequent suicidality.

Eudaimonic wellbeing.

As noted in the literature (Ryan & Deci, 2001; Ryff & Singer, 2006; Waterman et al., 2010), eudaimonic wellbeing is related to a sense of feeling congruent and self-actualised. This comes from within a person as opposed to hedonic wellbeing, which involves seeking happiness through external activities and pleasure. Ryan and Deci’s (2001) self-determination theory posits that autonomy, competence and relatedness lead to psychological growth and wellbeing. Ryff and Singer (2008) noted six factors that contribute to wellbeing: Self-acceptance, positive relations to others, personal growth, purpose in life, environmental master, and autonomy. According to Waterman et al. (2010), eudaimonic wellbeing is achieved through self-discovery, perceived development of one’s best potentials, a sense of meaning and purpose in life, intense involvement in activities, investment of effort, and employment of activities as personally expressive.

The ability to feel congruent, self-actualised and self-determined in life to experience psychological wellbeing is common in theories. This is echoed in Devor's stage model (2004). Aspects of wellbeing are evident in Stage 3, *Identity Comparisons About Gender Assigned at Birth*, which focuses on a need for self-expression; Stage 6, *Identity Comparisons About Transgender*, which involves finding congruence within oneself through mirroring and being validated; Stage 7, *Tolerance of Transgender Identity,* which involves acknowledging one's true self and developing self-determination; Stage 8, *Delay Before Acceptance of Transgender Identity* during which one becomes vulnerable in order to grow personally and self-actualise and relates to others as oneself; Stage 9, *Acceptance of Transgender Identity,* which is characterised by acceptance of self; Stage 10, *Delay Before Transition,* which is marked by intense involvement in activities, seeking self-knowledge, competence and mastering one's environment; Stage 11, *Transitioning* during which one feels authentic and fulfilled; Stage 12, *Acceptance of Post-Transition Gender Identity* during which one lives authentically and experiences self-actualisation; Stage 13, *Integration,* which is characterised by congruency of self; and Stage 14, *Pride,* which comprises mastery and competence, purpose in life, meaning in life and autonomy.

Eudaimonic wellbeing is characterised by inner strength, feeling congruent and authentic, and seeking long-term reward over immediate gratification. The participants in this study appeared to have achieved a sense of eudaimonic wellbeing through their own efforts. Rather than giving up when they were faced with challenges, they found that through the process of becoming congruent and authentic, they developed their own psychological wellbeing.

Misgendering/Misnaming

Nuttbrock et al. (2009) found that disclosing one’s transgender identity in the workplace poses unique challenges including a fear of losing one’s employment, failing to pass at work, name changes and being accepted.

Several participants indicated that they had been misgendered and/or misnamed. This had occurred unintentionally as well as intentionally. Being misgendered included being forced to use facilities that did not match the individual’s affirmed gender and not passing for one’s affirmed gender in public.

In Devor’s (2004) Stage 9, *Transition,* challenges to transitioning may be evident as others may not recognise the changes the individual is going through. Normal activities such as shopping and using public restrooms can be difficult and create anxiety. Devor stated that if a person is unsympathetic or ignorant of transgender individuals, then those going through this stage may experience uncertainty of how they will be received and acknowledged. They may face hostility and experience fear. Consequently, some individuals may isolate themselves or become anxious or defensive. Those who do not experience misgendering or misnaming often experience a smoother transition experience.

Several areas of difficulty were shared when the participants spoke about being misgendered and/or misnamed. These difficulties included being placed in a female ward for surgery (for transman); fear of using a male toilet or change room; fear of safety in public; not feeling validated as their affirmed gender when their ID did not reflect their name or gender; avoiding activities to prevent being misgendered; not shaving to be able to pass in public; isolating oneself to avoid the pain felt when misgendered or misnamed; not standing up to others who misgendered or misnamed them; difficulty dealing with companies who required proof of identification; and being ridiculed or laughed at. The participants also shared areas of coping including feeling appreciative when others realised their mistake and

corrected it immediately; feeling protected by others when they did not feel safe, for example, when the nurses closed the curtains in a hospital ward; feeling acknowledged when colleagues, friends and family used the correct name and pronouns; and the feeling of acknowledgement when their name was changed at Home Affairs.

Misgendering and misnaming appeared to be very emotionally difficult for the participants. Having secondary sex characteristics that were still visible from their gender assigned at birth caused significant worry and created a sense of isolation. Time limits of how long an individual has to wait for surgery would be beneficial. However, in South Africa's current climate, this is not likely to happen. To assist in mitigating these effects, individuals could be invited to support groups run by other transgender individuals to help them through this time. Naming policies could be developed to help workplaces make the transition as smooth as possible for the individual. Therapy for families and significant others could focus on the effects of misgendering and misnaming these individuals.

Support

According to Dentice and Dietert (2015), during the liminal stage of transitioning, individuals form supportive communities. These can take the form of family and/or friend support as well as more formal supportive structures such as support groups. Forgeard et al. (2011) described social support as feeling that you are cared for, loved and valued. It is through relationships that one gains social support, which, in turn, influences one's subjective wellbeing. Devor's (2004) Stage 8, *Delay Before Acceptance of Transgender Identity* proposes that individuals in this stage may seek support from other transgender individuals both socially and through support groups. In Stage 10, *Delay Before Transition,* those individuals who have strong support systems tend to move quickly through this stage.

The participants in this study relied on support from friends and family. They also received support from formal structures such as support groups and NGOs. However, one

participant stated that despite having the support of his partner and friends, he was still concerned about not having anyone to help him during the recovery period once he had had surgery. A home care system to provide support for individuals post-surgery could be established to ensure that transgender individuals have the resources they need to heal adequately should they not have any support at home.

Public or Private Medical Care and Medicals Aids

Several sub-themes related to seeking treatment privately or via public medical services emerged from the data. Cost was a potential barrier to treatment. Nkoana and Nduna (2012) revealed that having to seek the services of a private psychiatrist could be barrier to treatment for those who do not have access to private medical care because of the high costs. Furthermore, psychological services can prove costly should the individual require therapy (Healthman Psychology Costing Guide, 2019). Additionally, the cost of surgery and hormonal treatments, which may be exorbitant, are not covered by medical aids (Wilson et al., 2014). Moreover, there are lengthy waiting periods at state hospitals (Bateman, 2011; Furlong, 2015). In Devor’s (2004) Stage 10, *Delay Before Transition,* the cost of procedures is listed as a factor in this stage.

The themes that emerged when discussing private medical care as opposed to going through a state hospital included: Not being able to afford the surgery; medical aids’ view that the surgery was a cosmetic procedure; poor level of care in state hospitals, which included infections and hacking of the chest; misinformation about fertility options in state hospitals; uncertainty about the cost of surgeries in private care; poor understanding of how medical aids work; long waiting periods, which led to feelings of powerlessness and hopelessness; depathologising gender identity and the impact of how medical aids view gender identity; and medical aids’ view that individuals sought surgery to re-assign their genders and not affirm their genders, which led to frustration.

Muller (2013) found that there is a need for initiatives within the health and medical sector which could alleviate some of these issues. Some initiatives that would help individuals seeking surgery could include creating training for medical students on how to address transgender health issues and how to provide care to these individuals. Plastic surgeons could be mandated to train in gender affirming surgery techniques, which would enhance the availability of doctors who can perform these procedures. Dedicated surgery centres where transgender individuals seeking surgery are treated exclusively could be established. A funding model from private companies, which would help pay for these surgeries regardless of whether individuals seek care privately or through the state could be developed. Medical aids could also provide a share-payment scheme where individuals could opt to pay for part of their procedure, with medical aids covering the balance. It is unknown how the proposed National Health Insurance will view gender affirming healthcare. Finally, surgery and hormonal treatment for transgender individuals needs to be advocated for as a necessity owing to the high levels of comorbid psychiatric disorders that are experienced when individuals are not able to affirm their gender.

Liminality

During the analysis, two sub-themes related to liminality emerged. The first pertained to taking hormones and the changes the participants had experienced, having surgery and their dreams about how it would feel after they had completed their transitions. The second theme involved the rites and rituals they had already performed, were performing or were planning to perform post-transition.

Liminality: Surgery, hormones and dreams.

All the participants discussed how being in the transition stage had affected them. These included beginning to take cross-sex hormones, having surgery (hysterectomy) and how they would feel once surgery was completed.

The themes that emerged when discussing liminality varied. At the time of the interviews, all the participants had begun taking cross-sex hormones and only one participant had had any surgery.

When asked what it felt like in this stage of their transition, the transmen discussed the changes that they had experienced since beginning hormonal treatment. They noted male pattern hair growth was affirming, they had more physical stamina, they did not have to shave, they thought about the type of man they wanted to be, they experienced emotional changes even though they did not yet pass, and they believed they could focus more, but could no longer multi-task. The transwomen shared that since beginning hormones they felt fantastic, had experienced good and bad changes, they likened their mood changes to a 28-day menstrual cycle; felt happier now than previously, had growing pains and swollen nipples, and experienced testicular atrophy.

The participants were asked how they experienced life in this stage of their transition. The transmen noted that wearing a binder was frustrating; they did not enjoy wearing larger sized tops and shirts in order to hide their binders; spending time in private with their shirts off was freeing and liberating; they were unhappy about being unable to be shirtless when being intimate with a romantic partner; they experienced waiting for surgery as infuriating, frustrating and exhausting; they had financial concerns about saving for surgery; tracking the physical changes over time was rewarding; they wondered if their health would affect their ability to have surgery; they felt that there would be no point in living if they could not have surgery; and those who had had a hysterectomy felt amazing. The transwomen felt impatient having to wait for surgery; they had financial concerns; they worried about the type of hormones they were prescribed; they had to decide which surgery they wanted first (one said top surgery and one said bottom surgery); and those who felt their breasts had not grown were disappointed.

When asked what it would mean for them to have had the surgery, the transmen shared it would feel like freedom; they looked forward to being able to take their shirts off; they would feel a sense of accomplishment and achievement; they would be able to look at themselves in the mirror; they would not feel uncomfortable with their bodies; and they would not get misgendered. The transwomen related that it would make them feel like the woman they are and that being able to dress and pass was already rewarding.

Providing psychological support for individuals in this liminal stage remains vital. Individuals were at times misinformed and felt that they had nowhere to turn to for help. Providing access to support groups and trans-friendly shops could also help alleviate their distress. However, it was apparent that focusing on the end of their transition provided a sense of comfort as they were able to imagine what life would be like for them after surgery.

Liminality: Rites and rituals.

The participants in the liminal stage of transitioning were asked if there were any rites of passage or rituals they had already performed or would perform once their transition had been completed. Dentice and Dietert (2015) and Wilson (2002) stated that within the rites of passage that transgender individuals undertake during transitioning, several rituals are undertaken symbolically to move through this stage.

The themes that emerged when discussing rites and rituals were twofold: The first concerned those performed just after coming out and during the liminal stage, and the second, those that were planned for post-transition. After coming out and within the liminal space the themes included: Holding a wake to kill off their dead name; dressing as their identified gender; shopping for shoes and clothes; doing make-up; feeling a sense of a symbolic rebirth; giving away clothes that no longer matched their identified gender; not shaving; caring for beards with beard oil; going to the barber; keeping fit to enhance body shape; using a male bathroom when nobody was looking; and celebrating after a year of taking cross-sex

hormones. The planned rites and rituals for post-transition included: Having a bonfire to burn all things that symbolised the person they were before the transition; having a vagina shower; having a birthday to celebrate being reborn; going to the barber to get their beard trimmed; taking their shirts off in public; sleeping without a shirt on; getting a tattoo on their chest; keeping up with self-development; and generating an income by mentoring other transmen who were seeking surgery.

It was apparent that all the participants used some form of ritual in their transition. Many stated that they had ritually rid themselves of their previous identity in order to rebirth themselves. Most said that they were planning to commemorate their journey after surgery by doing something meaningful. Therefore, during this period of uncertainty, the participants were still able to maintain their wellbeing by shedding their old selves and planning the rebirth of their new selves.

Limitations

This study was conducted on a small sample. The study was limited in that it did not represent the demographics of South African experiences, more specifically, the experiences of Black, Asian and Coloured transgender individuals. The study is also limited in that it only included two transwomen. Finally, this study would have been enhanced if more individuals who were seeking treatment via state hospitals had participated which would have provided a more accurate understanding of their lived experiences. It is recommended that future studies include a broader demographic profile.

Conclusion

This study highlighted not only factors involved in the wellbeing of South African transgender individuals in the liminal stage of transitioning, but also provided insight into how their childhood and past experiences still affected them. Family relationships, romantic relationships and friendships formed a major part of the stories that were told. It was apparent

that receiving medical and psychological care that is ethical and empathic is important to these individuals’ wellbeing. Furthermore, being treated fairly in the workplace would allow these individuals to feel that they can be authentic and congruent in who they are. Providing access to trans-friendly facilities would also help alleviate some of the distress these individuals face. Financially, the participants felt they were unable to move towards their goals, and providing financial support and advice certainly seems to be an area that may help them achieve their goals in a shorter period. Although limited in its scope, it is hoped that the insights provided by the participants could be used to develop better programmes of support and provide a more affirming way of treating clients in psychological settings.

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Appendix A

Consent Form

Transgender Liminal Experiences in South Africa

Student number: 30859077

Researcher

I, Kirsten Lee Miller, have discussed the proposed research project with the participant and in my opinion the participant understands the benefits, risks and volunteerisms in the study. This includes the freedom to stop participation at any point should he/she/they decide to do so.

..... ……..

Signature of researcher Date

Participant

I, ..., hereby confirm that I am over 18 years of age, and have volunteered to participate in the study. I understand the benefits, risks, and my rights in relation to this study. I have read, and understand the information regarding the study and why it is being conducted.

..... ……..

Signature of participant Date

Appendix B

Information Sheet

Transgender Liminal Experiences

The purpose of the study:

You are being asked to participate in this research study, which is aimed at gaining an in-depth understanding of the personal experiences of transgender people who are awaiting surgery in South Africa. I would like to invite you to volunteer to participate in the study to assist in gaining an understanding of your lived experiences of awaiting surgery. This information will be used for research purposes and to advocate for transgender people's rights.

You will be asked to fill a consent form to ensure that you are comfortable with and have been informed of the benefits, risks and procedures involved in this study. By signing this consent form, you understand your role and rights as a participant in this study, as outlined below:

Your Role and Rights as a Participant, and Ethical Considerations:

- You are free to withdraw from the study at any time without any recourse towards you.
- You agree to engage in a one-on-one interview with Kirsten Lee Miller regarding your experiences of waiting for surgery.
- A tape recorder will be used to assist the researcher to transcribe all the information necessary for the study and to compile a report.
- This research will be conducted in Pretoria, Cape Town and Johannesburg.
- Any information provided to the researcher will be held in strict confidence, and will

only be shared with individuals who are working on this project and who are also bound by strict confidentiality.

- No information that will identify you will be shared with anyone other than the researcher. Your name and identifying information will not be used, and instead the researcher will use initials or change your name to protect your identity.
- The information provided will only be used to provide data for this study and thereafter will not be made available for any other purpose.
- The information that is gathered in this study will be kept in a secure, encrypted file for which only the researcher will have the password.
- You have the right to ask the researcher to explain anything you do not understand and you have the right to refuse to answer any question should you wish.
- You have the right to personal safety during the interview process and you agree to inform the researcher if at any time you feel unsafe or wish to change locations.
- The information gathered for this study will be included in a research report and may be made public. However, due to the protection of your identity, you will not be identified as participating in this study. This information is used to assist professionals in better understanding your lived experiences and may benefit future interventions or programmes for those individuals awaiting surgery.
- You understand that this research is being conducted in part as fulfilment of the requirements for a Master of Arts in Clinical Psychology and that the researcher is affiliated to the University of South Africa. You also understand that the researcher is working under the supervision of Professor Juan Nel.

Potential risk and discomforts:

The information arising from the interview may be sensitive and trigger past memories of discrimination and adverse experiences. If you perhaps feel that you need someone to talk to after the interview, the researcher will set up an appointment for you to see a counsellor or therapist at one of the allocated clinics in your area. This will be provided free of charge should you require it. The researcher will also provide a de-briefing after the interview to ascertain if this is required using her sound professional judgement. This option is not compulsory, but is made to assist you should you feel you need it.

Potential benefits:

You will be offered refreshments (tea, coffee, soft drinks, water) and will be afforded an opportunity to express or your experiences of awaiting surgery. Your contribution to the study will help inform affirmative practice for psychology professionals and will assist in understanding the areas of wellbeing which the profession of psychology could focus on during the period when individuals are awaiting gender affirming surgery.

Contacts for further information or questions

Researcher: Kirsten Lee Miller

Cell: 072 690 3836, email: kirsten@kirstenmiller.net

Supervisor: Professor Juan Nel

Email: nelja@unisa.ac.za

Participant Signature: …….. Date: ……

Appendix C

Biographical Questionnaire

Name of Choice: …… Contact No: …….

Email: …… Age: ……

Preferred Pronouns: ……. City: ……

At which hospital are you on the waiting list for gender affirming surgery?

……..

When were you placed on this waiting list, and for how long have you been on the waiting list?

……..

With whom do you live?

…….

What is your relationship status?

…….

What is your occupation?

…….

Are you a member of any support groups or other activities that support individuals who are awaiting surgery?

……

……

Appendix D

Interview Schedule of Guiding Questions

- In your own words, can you tell me about your journey so far and how you got to be where you are now?
- Since you made the decision to inform those who are closest to you of your journey towards gender affirmation through surgery (coming out), what has your experience been like with your social groups including family, friends, and colleagues?
- What types of things do you do to create a sense of wellbeing while you are waiting for surgery (e.g. exercise, self-care, meditation, etc.)?
- What factors support or prevent you from experiencing wellbeing?
    - These can include factors such as having a purpose in life; feeling independent; feeling that you are competent in your activities; being aware of the present moment and how that affects you; accepting yourself as you are right now; being able to be authentic; feeling that your values are compatible with who you are; and feeling that you are connected to others in a meaningful way.
- What challenges do you face in trying to maintain your personal wellbeing?
- A rite of passage is something that is undertaken when a person goes through a change or transition in life. What types of things that you can think of can be considered a rite of passage in this space after coming out and before you receive surgery?
- Are there any actions or rituals that you undertake to help you feel more like your experienced gender? These can include things such as shopping for new clothes, seeking out support from friends or networks and participating in social activities.
- What will it mean to you to complete your transition surgically?

- Have you thought of any types of activities or rituals that you may want to do to symbolically mark the end of your gender affirmation once your surgery is complete?
- Do you foresee any challenges to your wellbeing once your surgical affirmation is complete?

Appendix E

Letter of Consent: Stakeholders

To Whom It May Concern:

Kirsten Miller is currently studying for a Master of Arts in Clinical Psychology at the University of South Africa. Kirsten has received ethical clearance to conduct this study from the University of South Africa. She is conducting research on how transgender individuals awaiting gender affirming surgery experience the stage of transitioning prior to surgery. Furthermore, she is interested in understanding how the rites and rituals undertaken during this stage contribute to these individuals' psychological wellbeing?

It is therefore requested that Kirsten be allowed to advertise for participants through your organisation, and that you act as gatekeeper to help provide an ethical recruitment of participants. If you agree to allowing Kirsten to access participants through your organisation, whose details you may provide at your discretion and based on their voluntary participation, please could you sign your permission in the space provided below?

Sincerely,

Kirsten Miller, Student Clinical Psychologist, University of South Africa

Supervisor: Professor J. Nel

I (NAME) on behalf of (ORGANISATION NAME) hereby give permission for Kirsten Miller to advertise for participants for her research project though our organisation.

Signed: …… Date: ……..