METHOD

Overview

Chapter 3 consists of research aim, objectives, orientation to the study design, participants, sampling and sample selection criteria, procedure, pilot study summary, tools and nature of the tools, Rationale for the techniques and outline of the techniques to be used in the analysis.

(3.1) Aim

The present research is exploratory in nature and aims at understanding the social life, transition from male to female, Sexuality issues, Health, Emotional intelligence, Personality, prevalence of addictions and subjective wellbeing of Hijras the Transsexuals.

(3.2) Objectives

To understand the following issues of transsexuals:

- Social life
- Community life
- Subjective wellbeing
- Personality factors
- Emotional intelligence
• Health issues and concerns

• Sexuality aspects

• Prevalence of various types of Addictions

• Relationship between the different variables.

• Factors which predict the well-being

• To get a developmental perspective

(3.3) Research design

Psycho social research on Hijras – the transsexuals from the realms of psychology is relatively unexplored. Considering the uniqueness of the sample population, feasibility, practicality, time limitations and the measures utilized for the data collection concerned mixed method design research that is triangulation of methods and analysis was followed. Specifically sequential explanatory design has been followed. The sequential explanatory method procedure flow chart is adapted from the work of Ivankova, Creswell & Stick (2006). Mixed method itself is an evolving paradigm which is believed to elicit complementary findings (Jeanty & Hibel, 2011). It allows the flexibility of including quantitative and qualitative data and analysis in a single study (Creswell, et.al, 2003).
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*Figure 3.1 Model of sequential explanatory design*

Source: Ivankova, Creswell & Stick, 2006
(3.4) Participants/Sample

Current research is exploratory in nature according to United Nations Development Programme (UNDP), India (2006) Hijra population in India is identified as 2,35,213. Peoples Union for Civil Liberties, Karnataka (PUCL-K) in 2004, documents prevalence of Hijras in India as one million. However, the survey also prescribes caution as there may be slight discrepancy between the survey assessment and actual estimation. Few other surveys also reflect similar caution. Hence, considering the nature of research and anticipating the availability of willing participants the sample was calculated based on online calculator (Raosoft, Inc.) with 10% margin error, 95% confidence interval and 50% chance of response distribution, and a sample size of 96 was obtained. Therefore a criterion (inclusion and exclusion have been specified below) based purposive sampling was adapted. 100 transsexuals (Male to female) residing in different areas and outskirts of Bangalore were selected for the study.

Operational definitions

Men and women

In this context men and women are not conflicted with their gender identity and confirm to the hetero normativity. Hetero normativity is to consider sexual preference for the biological opposite sex.

Hijras

Hijra is a term used to refer to a transgender or a transsexual male in a few Asian countries including India. Hijras are the male to female transsexuals, sometimes it is also used to refer to Transgenders and it does not involve female to male transsexuals. In the current research people identifying themselves as Satlahijras have been included. Satla Hijras undergo Nirvana (castration) always wear female attire, live like a women and perform female
gender roles. In the body of the text Hijra and transsexuals are used interchangeably and it refers to the Satlahijras.

**Inclusion criteria**

- Those who fulfilled the criteria for Transsexual individuals (male to female) according to ICD – 10 criteria
- The age range between 20 – 45 years.
- Only those who could communicate in English, or Kannada were included.
- Those who recognized themselves as Hijras (Satla type).

**Exclusion criteria**

- Transsexuals of female to male type.
- People with other gender identity disorders/ conditions.

**3.5 TOOLS**

Tools were selected after the pilot study with 15 participants. The tools (questionnaires) were reviewed for their relevancy and sensitivity and communicated to authors for permission. Semi structured interview schedule was devised based on the need of the research. In-depth Unstructured interviews were planned for qualitative data collection.

**Rationale for Selecting the tools and techniques**

Questionnaires were reviewed for the content and number of items. Identified experts/professionals from the field of psychology and also translators who were competent in 2 languages i.e., Kannada and English were contacted for translation and back translation. Translation was done by 4 individuals and back translation was done by 4 individuals. Final compilation was done by the primary investigator and the guide.
Emotional intelligence, wellbeing, personality and addictions were assessed using questionnaires, scales and inventories.

Semi-structured interview schedule

The semi-structured interview schedule was constructed to explore the social living and other relevant aspects of transsexuals. It covered areas like Socio-demographic details, childhood, period of transition, current status, community living, existing support system, and religious practices. Majority of the questions framed were open ended. Once the concepts were approved framed questions were reviewed by bilingual counselling Psychologists. Interview schedule was scrutinised to check for ambiguity and clarity.

Selection of Qualitative measures

During the plot study it was identified that using only the quantitative tools was not adequate to get in-depth information about the population under study. Questionnaires/inventories failed to cover issues beyond the purpose for which they were constructed, it also failed to elicit original and novel responses. Tapping the issues like life experiences, sex life, and views on commercial sex work as well as finer details of wellbeing could not be elicited using questionnaires. These issues were discussed with the experts in the field and decided to have qualitative measures also to collect the data. Unstructured interviews were planned in the Phase 2 of data collection.

Unstructured interviews

It is a qualitative research tool which eases the data collection. It provides the flexibility to explore the emerging newer concepts during the interview. However, researcher is free to carry few main research questions which often arise after the preliminary review into literature. These questions are usually broader and open ended. Few leads and concepts were elicited through analysing and administering the quantitative tools. During the unstructured interviews those leads and concepts were posed to the participants.
Some of the important advantages that the technique has are, it is cost effective and results in rich collection of data in relatively short time frame. It addresses how and why questions from the subjective experience perspective. It elicits perceptions, how they give meaning to and interpret their experiences on these subjective experiences. It is flexible and helpful in voicing the lay perspective and deal with sensitive issues in research (Low, 2007).

This research technique was adopted to explore the experiences of violence, markers of wellbeing, rituals of Nirvana, Transition, daily living, attitudes about society and sexuality and sex life. Drawings were used to get clearer information about some of the sexuality issues.

**Description of Quantitative research tools**

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<td>The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)</td>
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<td>Emotional Intelligence Scale (EIS)</td>
<td>Anukool Hyde and SanjyothPethe (2001)</td>
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**NEO 5 factor personality Inventory**

NEO-Five Factor Inventory (NEO-FFI) was developed by Costa, P. T., & McCrae, R. R. (1992) based on 5 factor model. The 5 domains on 5 factor model are Neuroticism, Openness, Extraversion, Agreeableness, and Conscientiousness. Copy right authority – Psychological Assessment Resources, Inc. (PAR). Inventory consists of overall 60 items—
12 items per domain. Items are rated on a 5 – point scale. The Big Five are five broad factors (dimensions) of personality traits. They are: Extraversion, Agreeableness, Conscientiousness, Neuroticism and Openness. Correlations are in the range of .77–.92 for the NEO–FFI with the NEO PI–R domain scales. Internal consistency values range from .68-.86 for the NEO–FFI.

*The dimensions of NEO – five factors of personality inventory are characterised as follows.*

**Neuroticism**

Neuroticism depicts the degree to which a person is able to cope with his/her own emotions (sometimes reversed and called Emotional Stability). Includes traits like tense, moody, and anxious. On the extremes one depicts being emotionally composed, self-confident, calm and able to handle the insecurity. On the other extreme person would be experiencing emotional ups and downs. Experiencing extreme emotions like fear, anger, sadness, embarrassment, distress and mistrust.

**Extroversion**

This factor sometimes is called as Surgency. The broad dimension of Extraversion encompasses qualities like being talkative, sociable, energetic, and assertive. Higher the scores higher the tendencies of assertiveness, being active, leader like qualities and talkative. Lower scores signify quite, withdrawn, reserved. These are few features of introversion but not diagnosable as such.

**Openness**

Openness to Experience is sometimes called Intellect and Imaginative. It includes traits like having wide interests, and being imaginative and insightful. Willingness to be open for newer, unconventional, novel ideas and values is the characteristic of openness. Openness also can mean person being imaginative, curious. Persons scoring low on this
dimension tend to be more conventional, limited in thinking and also appreciate the concreteness.

Agreeableness

Agreeableness is a tendency of being altruistic. It includes traits like being sympathetic, kind, and affectionate, having empathy for others feeling, cooperativeness and being helpful. Persons scoring low on agreeableness could be inflexible, unpleasant, disagreeable, uncooperative and strong headed.

Conscientiousness

This factor includes traits like being organized, thorough, planned, lawful, careful, responsible, dependable, self-disciplined and controlled by internal locus of control. On the extreme person could be impulsive, lazy, lethargic, less organized, careless and lacking in self-discipline (Costa and McCrae, 1992; Vogt & Laher, 2009).

Subjective Wellbeing Inventory (SUBI)

It was developed by Nagpal, R. & Sell, H. (1985, 1992) The tool consists of 11 dimensions. Subjective wellbeing dimensions are General wellbeing positive, expectation achievement congruence, confidence in coping, transcendence, family group support, social support, primary group support, inadequate mental mastery, perceived ill – health, deficiency in social contacts, general wellbeing negative. It consists of 40 items. It can be scored by attributing the values 3, 2 and 1 to response categories of the positive items. 1, 2, and 3 to the negative items. The minimum and maximum scores that can thus be obtained are 40 and 120 respectively. Cut-off score is 81 for an Indian adult. Lower score (< 81) is indicative of lack of feeling of wellbeing. Re-test reliability which was done after 18 months was statistically significant below 0.002 levels. Tool is mentioned to be sensitive to differentiate meaningfully between happy and unhappy persons belonging to high and low socio economic groups.
The 11 factors of subjective well-being are:

**General wellbeing positive (GW+)**

This factor could be understood as perceiving one’s life as functioning very smoothly and joyfully. This could be comprehensive of every aspect of life not only specifically job satisfaction or family life. Higher score indicates higher general wellbeing.

**Expectation achievement congruence (E.A.C)**

This could be characterised by satisfaction achieved through the standard of living achieved by a person. There will be harmonious balance between achievements as per their expectation. Higher the score higher is the expectation achievement congruence.

**Confidence in Coping (C.C)**

This factor depicts the perceived personality strength i.e., the ability to master critical or unexpected situations. It also reflects the positive mental health showing ability to adapt to the change and face adversities without break down. Higher score shows better confidence in coping.

**Transcendence (T)**

Factor transcendence is related to life experiences that are beyond the ordinary day-to-day material and rational existence. It is a spiritual wellbeing. Higher score indicates higher spiritual wellbeing.

**Family group support (F.G.S)**

The characteristics of Family group support show positive feeling derived from wider family support, cohesiveness and emotionally being attached. Higher score shows better family group support.
Social support (S.S)

This is also indicative of security and density of social networks. Generally feeling supported and mostly in crucial situations and crisis. Higher score shows greater social support.

Primary group concern (P.G.C)

Primary group concern indicates feelings about primary family which is part of overall well-being. Higher score indicates the positive feeling that primary group support is contributing to the well-being whereas lower score shows poor primary group concern.

Inadequate mental mastery (I.M.M)

This factor describes an insufficient ability to handle certain aspects of everyday life as well as maintain the equilibrium by not getting disturbed. High score indicates better mental mastery and lower scores shows difficulty in handling difficulty in day to day life and maintaining the psychological equilibrium.

Perceived ill health (P.I.H)

It is extreme concern on health either being perceived as having worries and concerns on health as factor contributing to ones wellbeing and on the other extreme, perceiving health as not a worry or not experiencing ill health. Low score indicates the worry over health and high score indicates the absence of worry over health.

Deficiency in social contacts (D.S.C)

This item is constituted based on person’s positive or negative feelings on how one has been accepted in their social circle and the feeling of missing friends. High score indicates the satisfactory social contacts and low score indicates deficiency in social contacts.
General wellbeing negative affect (G.W.B -)

This factor shows the overall perception about life. Persons who have less score tend to have depressed outlook about life and those scoring higher have a positive view of life (Sell & Nagpal, 1992).

Emotional Intelligence Scale (EIS)

Developed by Anukool Hyde and SanjyothPethe in 2001. The factors of EIS are; Self-awareness, Empathy, Self-motivation, Emotional stability, Managing relations, Integrity, Self-development, Value orientation, Commitment, Altruistic behavior. There is no time limit to complete the scale, manual scoring can be done. Each item or statement should be scored 5 for strongly agree, 4 for agree, 3 for neutral, 2 for disagree and 1 for strongly disagree. The reliability of the scale was determined by calculating reliability coefficient on a sample of 200 subjects. The split – half reliability coefficient was found to be 0.88. Besides face validity, the scale has high content validity. It is evident from the assessment of judges/experts that items of the scale are directly related to the concept of emotional intelligence. In order to find out the validity from the coefficient of reliability (Garrett, 1981), the reliability index was calculated, and it is found to be 0.93 which indicates high reliability. The 10 components of emotional intelligence are:

Self-awareness

Self-awareness means being aware of one’s own emotion, recognizing feelings as they occur and discriminating between them as being emotionally literate. Identifying and labeling specific feelings in self and others, being able to discuss emotions and communicate clearly and directly. The ability to make intelligent decisions using healthy balance of emotions and reason. This could be described as being neither too emotional nor too rational. This is the ability to manage, to take responsibility for one’s own emotions; especially the responsibility for self – motivation and personal happiness.
**Empathy**

Is characterised by the ability to feel and understand the other person, pay attention to the worries and concerns of others. It is the ability to recognize the feelings in others and tuning into their verbal and non-verbal cues. It is a greater ability to see other’s point of view, improved empathy and sensitive to others’ feelings and better at listening to the others. Those with high empathy are friendly, sociable, helpful, skillful in dealing with people and open about their feelings. Empathic persons are able to derive gratification and reward from their interpersonal contacts, and can be source of happiness to others.

**Self-motivation**

This can be characterised as being motivated internally and also being able to inspire others. Making intelligent decisions using healthy blend of emotion and reason, able to assess the situation and act accordingly. These persons will be able to focus on task at hand in spite of the disturbances, have a belief that one should manage his/her emotions, able to extend a good self-control and being less impulsive.

**Emotional stability**

Having emotional stability is indicative of not mixing unnecessary emotions with issues at hand. Emotionally stable persons stay composed in both good and bad situations. These people will be able to be comfortable and open to novel ideas and new information and able to persistently pursue the goals despite hurdles and setbacks.

**Managing relations**

This measures the qualities like being perceived as friendly and outgoing. These people are good at conflict resolution and good at handling interpersonal relations. They have increased ability to analyse and understand the relationships.
**Integrity**

Integrity means qualities like being aware of oneself which includes both strengths as well as weaknesses.

**Self-development**

This is a need for growth. People who score high on self-development are able to identify and separate the emotions and focus on developing themselves with internal motivation though the job does not demand the same.

**Value orientation**

This is a moral dimension where the person is able to maintain the standards of honesty and integrity. These people are able to confront the unethical actions of others.

**Commitment**

Committed individuals are organized and careful at work and are able to meet commitments and keep promises.

**Altruistic behavior**

This dimension refers to the people who are able to encourage others to take initiative. They are generally considered to be selfless and helpful.

**DUKE health profile**

The 17-item Duke Health Profile (DUKE) was developed as a refined version of the 63-item Duke-UNC Health Profile (DUHP) using a methodology based upon a balanced clinical and statistical rationale. The result is a brief, valid functional health measure with 11 subscales. Instrument contains 6 health measures (physical, mental, social, general, perceived health and self-esteem) 4 dysfunction measures (anxiety, depression, anxiety and depression, pain) and one disability score. This tool is useful for brief clinical screening.
Primary developers are Parkerson, G.R, Broadhead, W., and Chiu-Kit, J Tse. Reliability was supported by Cronbach’s alphas (0.55 to 0.78) and test retest correlations 0.30 to 0.78 (Parkerson, et. al., 1990). The copyright owned by Dr. Parkerson Department of Community and Family Medicine, Duke University Medical Center. Raw Score = last digit of the numeral adjacent to the blank checked by the respondent for each item. For example, if the second blank is checked for item 10 (blank numeral = 101), then the raw score is "1", because 1 is the last digit of 101. Final Score is calculated from the raw scores as shown and entered into the box for each scale. For physical health, mental health, social health, general health, self-esteem, and perceived health, 100 indicates the best health status, and 0 indicates the worst health status. For anxiety, depression, anxiety-depression, pain, and disability, 100 indicates the worst health status and 0 indicates the best health status. Missing Values: If one or more responses are missing within one of the eleven scales, a score cannot be calculated for that particular scale.

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

This tool was developed by W.H.O in 2008. The questionnaire covers screening: tobacco, alcohol, cannabis, cocaine, amphetamine type stimulants, sedatives, hallucinogens, inhalants, opioids, and other drug use and dependency. The ASSIST provides information about: the substances people have ever used in their lifetime; the substances they have used in the past three months; problems related to substance use; risk of current or future harm; dependence; injecting drug use. The ASSIST can help warn people that they may be at risk for developing problems related to their substance use in the future and it can provide an opportunity to start a discussion with a client about their substance use. The permission and approval on the tool was communicated by Department of Mental Health and Substance Abuse, World Health Organization.
(3.6) Pilot study

A pilot study was conducted to understand the sensitivity, feasibility and appropriateness of the tools. Initially few tools were selected namely Thematic apperception test (TAT), Gender identity scale (formulated for the purpose of current research), NEO-5 factor personality inventory, Duke health profile, Subjective wellbeing inventory, Emotional Intelligence Scale, The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and semi-structured interview schedule. 15 candidates were selected using convenient sampling. This exercise revealed that the data generated using TAT was less useful as the stories that emerged were descriptive, superficial and very brief. Hence TAT was omitted from the final list of tools selected for the study. Gender Identity Scale was also found to be not eliciting much information about the gender specific tendencies which could help in identifying the masculine and feminine characteristics. Hence GIS and TAT were omitted from the final list of tools. Subjective wellbeing questionnaire, NEO-5 factor personality inventory, Emotional Intelligence Scale, Duke health profile, ASSIST and semi-structured interview schedule were retained for the study.

(3.7) Procedure

The Gurus (Heads of Hijra community) of Hamams (dwelling places of Hijras) in and around Bangalore were met and were explained about the aim of the research and Oral consent was taken. They were assured of confidentiality of the information divulged by them. Later Participants who volunteered for the study were screened based on ICD-10 criteria. They were explained about the study briefly and written consent was obtained. The Complete protocol consists of data from semi-structured and unstructured interview and questionnaires and inventories. Data was collected over 2 to 3 continuous sessions or different sessions on consecutive days. Depending on the requirement of the participants few short breaks were given in between long assessment sessions.

Based on the data generated by analyzing participants response to subjective wellbeing they could be grouped into 3 categories—low, moderate and high wellbeing. The
researcher was interested in finding out the specific markers for low and high wellbeing. Hence, it was decided to consider a qualitative line of enquiry. Eight participants—three with high wellbeing and five with low wellbeing—who volunteered were further interviewed. Out of eight participants five—two with high subjective wellbeing and three with low subjective wellbeing—were willing to divulge information related to specific markers of wellbeing. These 5 participants were interviewed individually using unstructured interview technique. Each interview session took around 180 minutes. To get a developmental perspective of hijras life case study method was adopted and for this purpose two willing participants were selected. The responses of the participants were written verbatim.

(3.8) Data analysis

As the present study adopts mixed method approach both the quantitative and qualitative data were analysed using suitable techniques. The quantitative data was obtained from the Inventories, screening tools, and rating scales. The responses from the semi structured interview were utilized for both quantitative and qualitative data analysis.

Quantitative data analysis:

The quantitative data was analysed using appropriate descriptive and inferential statistics. Regression analysis was performed to understand the predictors of wellbeing.

Qualitative data analysis:

Qualitative data was analysed based on thematic analysis model or method. Thematic analysis was developed by Braun and Clark (2006), which allows the analysis of various themes. The uniqueness of this method is that by itself it is designed to give minimal structure to the generated qualitative data. It allows interpretation of various aspects of research.