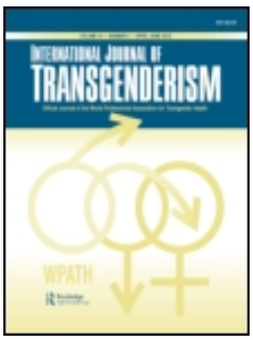

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The Cultural, Psychiatric, and Sexuality Aspects of Hijras in India

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Nilesh Shah

ABSTRACT. The Indian hijra community encompasses persons with a variety of gender identities and sexual orientations, forming a culturally unique gender group. Although these communities have existed for ages within Indian society, hijras have been stigmatized and marginalized to a large extent. Such stigmatization may compromise the mental health of hijras possibly giving rise to various mental health issues. The sociocultural aspects of hijras have frequently been the subjects of research by anthropologists and sociologists, but there is a dearth of data regarding mental health problems in them. This study aims to understand the cultural, psychiatric, and sexuality aspects of hijras in the city of Mumbai, focusing on the prevalence of gender identity disorder and psychiatric disorders (if any) in them, their self-esteem, and their sexual practices.

KEYWORDS. Culture, gender dysphoria, Gender Identity Disorder, *gharana*, *guru–chela* relationship, hijra, India, *Nirvan*, psychiatric disorder, self-esteem, transgender, transsexual

Hijras are the transgender individuals found in the Indian subcontinent, popularly known as the "third gender," probably because these individuals do not conform to the conventional notions of male or female gender, but move between the two, challenging accepted gender definitions. The hijras are known as "*kinnar*" in North India and as "*Aravanis*" in South India. These individuals have rarely been the subjects of scientific and psychiatric studies, mostly those that have highlighted issues surrounding HIV/AIDS within this community. Sahastrabuddhe et al. (2012), for instance, reported that hijras were more likely to have received money for sex, to have had an earlier sexual debut, and to have a higher prevalence of HIV compared to heterosexual men and men who have sex with men (MSM). In an earlier cross-sectional survey of self-identified MSM in selected districts from four states in South India, Brahmam et al. (2008) reported higher prevalence of HIV (18.1%) and syphilis (13.6%) in hijra individuals compared to bisexual, *kothis* (anal-receptive), double-decker (both anal-insertive/anal-receptive), and *panthis* (anal-insertive) individuals. It has been suggested that such studies have increased the levels of awareness regarding AIDS and safe sex practices in this community.

Hijras have been known to live in Indian societies for ages with diverse lifestyles, customs, and traditions of their own. Although existing within the wider heteronormative social milieu,

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they have usually been looked down upon leading to their marginalization and stigmatization, often forcing them into professions such as sex work and begging (Bhugra, 1992). In fact such sex work may often undermine their culturally valued sacred role (Nanda, 1985). Such types of oppression may lead to low self-esteem and impair mental health in these individuals (Sagric, Radulovic, Bogdanovic & Markovic, 2007). Despite this, mental health is one area that has not yet been explored in this community (United Nations Development Programme [UNDP], 2010). Hijras are not known to seek any psychiatric consultation for mental health issues. In fact, the health care system in India including mental health care is not very hijra-friendly or sensitive to issues facing hijras. Many health care workers, for instance, may not understand the sexual diversity within hijra communities or understand hijras' health issues. In this context, many of these individuals are addressed using male pronouns or are verbally harassed by health care staff (UNDP, 2010). Recently however, the situation appears to have undergone some changes with the government of Tamil Nadu (a state in south India) having established a transgender welfare board in April 2008. Furthermore, in collaboration with the Tamil Nadu *Aravani* Welfare Board, hijras are able to avail of the facility free sex reassignment surgery (SRS) in select government hospitals (UNDP, 2010). Prior to this, hijras would usually elect to undergo *Nirvan*, the traditional emasculation procedure that is usually done without any medical supervision by a senior hijra. This procedure, which includes both penectomy and orchidectomy, modifies the genital region to a state intermediate between male and female genitals (Roughgarden, 2004). This crude surgery does not give the patient "the vagina" they "have longed for." The journey thus transforms the person from an "ordinary and impotent male" to a hijra (Nanda, 1999). It is a common understanding and belief among the hijras that this procedure makes it difficult for "fake hijras" to join the community and take undue advantage of the earning potential that exists within the the hijra clan (Nanda, 1999). Recently it has been seen that more and more hijras are accessing surgical interventions in public hospitals even in Mumbai.

In view of the lacunae in mental health research in this community and to explore further the hijra lifestyle, we tried to study whether some hijras have a gender identity disorder (GID)[1] and whether they have any psychiatric disorders. We also intended to assess their self-esteem and study the sexual practices they engage in.

MATERIALS AND METHODS

The study was conducted as a cross-sectional single interview in the psychiatry department of a tertiary care medical hospital between November 2010 and July 2011 after obtaining Institutional Review Board approval for the study (IEC/46/10). All interviews were primarily conducted by the first author (Gurvinder Kalra).

Participants

Fifty self-identified hijras who accessed the sexually transmitted infection (STI) clinics[2] (sexually transmitted infection clinics) of the hospital were briefed about the study and recruited after obtaining the hijra's informed consent. This clinic was part of the dermatology department in a hospital and was accessed by individuals with sexually transmitted infections that included MSM and hijras, among others.

The age range of our sample was 22 to 40 years with a mean of 28 and a standard deviation of 4.92. All but one was biologically male. One was of ambiguous sex at birth, as reported by the respondent. Only 35% of the participants were literate and more than half of the participants were migrants in Mumbai. In the case of participants who could not read, questionnaires were read to them by the first author and the participants' responses were recorded. Hinduism was the religion of the majority of participants (68%); there were also Muslim (28%) and Christian (4%) participants. After joining the hijra clan, all of the participants had changed their names and took on more feminine names; some of them changed their religions too. Forty of the 50 hijra participants had taken hormones at some time prior to the interview; however, none of them were taking hormones at the time of the interview. The hormones were over-the-counter medications,

being taken without any medical or endocrinological supervision; usually it was the participant's hijra friends who had advised the person to take hormones. The use of hormones was not regular and was mostly on an as-and-when-remembered basis. Our sample is representative of the wider hijra community—all of the participants had been affiliated with different hijra *gharanas* and considered themselves to be members of the hijra community. Some of those who were staying with their birth families or with partners would continue to participate in various customs of their *gharanas*.

Instruments

Self-Constructed, Semistructured Pro Forma

We used a self-constructed, semistructured pro forma that included a sociodemographic profile, work history, marital status, and questions pertaining to lifestyle and living conditions.

DSM-IV-TR and ICD-10

Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV-TR*) and International Classification of Diseases (ICD-10) diagnostic criteria were used to assess GID in the participants. Both diagnostic systems were used as *DSM-IV-TR* has a narrower approach to gender variance than the ICD-10 (see Discussion section for more details).

Participants were also asked about gender variant behaviors during childhood to see if they fulfilled criteria for GID or simply engaged in gender variant behaviors. This history was taken retrospectively from the participants.

Rosenberg Self-Esteem Scale

We used the Rosenberg Self-Esteem Scale (RSES) to evaluate participants' self-esteem. The RSES is a widely used, well-validated measure of global self-esteem (Blaskovich & Tomaka, 1991; Rosenberg, 1989). It captures subjects' global perception of their own worth by means of 10 items, five positively worded and five negatively worded. These items are answered using a 4-point scale ranging from *strongly agree* to *strongly disagree*. For items 1, 2, 4, 6, 7 the scale used is 3 = *strongly agree*, 0 = *strongly disagree*; for items 3, 5, 8, 9, 10 (reversed in valence) the scale used is 0 = *strongly agree*, 3 = *strongly disagree*. The scores range from 0 to 30, with a score range between 15 and 25 considered to be normal; a higher score suggests higher self-esteem.

Mini International Neuropsychiatric Interview

The Mini International Neuropsychiatric Interview (MINI; Amorim, Lecrubier, Weiller, Hergueta, & Sheehan, 1998) was used as a brief structured interview for diagnosis of psychiatric disorders. MINI can be administered over a short period of time and is divided into modules corresponding to diagnostic categories from the *DSM-IV-TR*.

Gender Identity and Erotic Preference Test Package

The Gender Identity and Erotic Preference (GIEP) Test Package consists of seven subscales. Six of these are concerned with the assessment of erotic preference and erotic anomalies; one is concerned with the assessment of gender identity. The Feminine Gender Identity Scale (FGIS) measures "femininity" occurring in homosexual males (Freund, Langevin, Satterberg, & Steiner, 1977). The Androphilia and Gynephilia scales measure the extent of bisexuality reported by androphilic males and the erotic interest in other persons reported by patients with cross-gender identity issues. The term *androphilia* refers to erotic attraction to physically mature males and *gynephilia*, to erotic attraction to physically mature females. The Heterosexual Experience Scale assesses sexual experience with women, as opposed to sexual interest in them. The Fetishism, Masochism, and Sadism Scales are self-report measures of these erotic preferences. The total scores for each scale are obtained by totaling the respondent's scores for each item in that scale. The total number of items and range of scores on each of these subscales is shown in Table 1. For all scales, high scores indicate that the relevant attribute (e.g., feminine

TABLE 1. Subscales in GIEP

Subscales in GIEP	Number of items	Score range
Feminine Gender Identity Scale	29	0–49
Androphilia Scale	13	0–13
Gynephilia Scale	9	0–9
Heterosexual Experiences Scale	6	0–6
Fetishism Scale	8	0–8
Masochism Scale	11	0–11
Sadism Scale	20	0–20

Note. GIEP = Gender Identity and Erotic Preference Test Package.

TABLE 2. Gender Dysphoria in Hijras

Diagnostic system	Diagnosis	Percentage
ICD-10	Transsexualism	80
	Dual Role Transvestism	20
DSM-IV-TR	GID in adults	80
	GID NOS	4
	No Diagnosis	16

Note. ICD-10 = International Classification of Diseases; *DSM-IV-TR* = *Diagnostic and Statistical Manual of Mental Disorders*; GID = Gender Identity Disorder; GID NOS = Gender Identity Disorder Not Otherwise Specified.

gender identity, sadism) is strongly present, and low scores indicate that the attribute is relatively absent.

Both the RSES and GIEP Test Packages were translated into Hindi by using the method of back-translation (Brislin, 1980) to ensure equivalence of meanings and to include non-English speaking subjects. As previously suggested, if precisely translated, a questionnaire in different languages would presumably be the most effective means for obtaining accurate data for cross-cultural studies (Gudykunst et al., 1992; Smith, Dugan, Peterson, & Leung, 1998). However there may be a question whether the translated instrument measures exactly the same thing in the new language, especially when used in a different cultural context to that from which it originated and has been tested. Data were pooled, and descriptive statistics were computed using SPSS v16.

RESULTS

A total of 50 self-identified hijra individuals participated in this study. At the time of the study, 96% of participants were working; their primary source of income[3] was begging alms (44%) in suburban trains (*mangti*). Other sources of income were commercial sex work (22%; *dhanda*), usually performed at night, and dancing (16%) at wedding ceremonies or baby births (*badhaai*). Some of the participants also worked at nongovernmental organizations (NGOs; 12%) in the city of Mumbai that cater to the lesbian, gay, bisexual, and transgender population, and some were freelancing as astrologers (2%).

Around 20% were married to men (such marriages being informal and not legal), while 2% were married to women. Thirty percent of the hijras were living with their male partners, while 32% were living with either their *gurus* (leaders) or *chelas* (followers).

Regarding gender identity, 84% participants met criteria for GID according to the *DSM-IV-TR*. According to the ICD-10, 80% had received a diagnosis of transsexualism (Table 2). Around 6% of them identified outside of the male/female gender dichotomy and claimed to belong to a third gender. Thirty-two percent of subjects had already undergone castration or emasculation (Nirvan), while a few others were waiting for this procedure.

The scores on RSES ranged from 4 to 29 with a mean of 17.98 ($SD = 5.80$), which indicates good self-esteem.

As much as 48% of the participants suffered from psychiatric disorders ranging from alcohol abuse and dependence to depressive spectrum disorders (Table 3). Help-seeking in times of stress was minimal and individuals preferred various means to cope with stress (Table 4).

Their scores on various scales of the GIEP Test Package are shown in Table 5.

Thirty-nine percent of the participants did not indulge in masturbation at all, either before or after joining the hijra clan. A meager 4% of the participants masturbated frequently (everyday/alternate days). The method most used

TABLE 3. Psychiatric Morbidity in Hijras

Diagnosis on *DSM-IV-TR*		Percentage
Alcohol Use Disorder	Alcohol Abuse	20
	Alcohol Dependence	10
Depressive Spectrum Disorder	Major Depressive Disorder	12
	Dysthymia	2
	Adjustment Disorder	4
	No Diagnosis	60

Note. A respondent may have more than one diagnosis. *DSM-IV-TR* = *Diagnostic and Statistical Manual of Mental Disorders*.

TABLE 5. Mean and Standard Deviation on Gender Identity and Erotic Preference Test Package

	M	*SD*
Feminine Gender Identity Scale	38.56	7.45
Androphilia	12.68	0.79
Gynephilia	0.76	1.15
Heterosexual Experience Scale	0.42	1.21
Fetishism	1.48	2.86
Masochism	0.22	0.67
Sadism	0.14	0.85

by them was masturbating with the fist of the hand. Fantasy while masturbating or indulging in sex was usually androphilic (98%). At the time the study was conducted, 92% of participants were sexually active exclusively with men, while 8% were sexually active with both men and women.

The preferred sexual activity by the majority of participants was anal intercourse (54%) where they were the passive partners. Twenty-two percent preferred interfemoral sex, while 8% preferred oral sex. Among the 16 Nirvan hijras, sex life had worsened post-Nirvan for around 22% (11), improved for 6% (3), and remained the same for 4% (2) compared to their sex life and satisfaction from sex before Nirvan. Questions about changes in sex life and satisfaction from sex was asked only to Nirvan hijras.

TABLE 4. How Hijras Cope in Times of Stress

Coping with stress	Percentage
Cry alone/Be to oneself	44
Talk to other hijras	16
Go to religious places	12
Talk to family members	6
Talk to partner	6
Cuts self	2
Others (meditation, music, movies, substance use)	14

Note. Only the most commonly used coping method is included in cases of participants who may have reported more than one method.

DISCUSSION

Findings from the present study focus on three broad aspects of hijras, including cultural, psychiatric, and sexuality aspects. Most of the participants who participated in this study had migrated to Mumbai from smaller towns or villages in order to escape from their families who had disowned them due to their gender variant behavior. While the remaining hijras who were natives of Mumbai, had renounced their traditional kinship ties (something that is expected of them) and joined the hijra clans. Mumbai was preferred over other Indian cities for the anonymity that it provided, and also this city had a well-developed hijra subculture. Anonymity has been considered an important factor that influences expression of one's sexuality in migration (Kalra & Bhugra, 2010). Apart from migration, religion among hijras is another interesting issue; while hijras from North India and other cities such as Hyderabad mainly follow Islam (Reddy, 2006), those in our sample from Mumbai practiced Hinduism. Some of them had changed their religion after joining the hijra clans for various reasons, including liking and preference for the adopted religion and wanting to affiliate with the partner's religion. Feminine names were commonly taken by these individuals after joining the hijra clan. It was interesting to note that names were given to them by their gurus or that participants chose a name with the same initial letter as their birth name (*Sonali* from *Sonu*, *Seema* from *Sinu*,

Ankita from *Ashok*) or that sounded phonetically similar to their past names (*Simran* from *Imran*, *Rajeshwari* from *Rajesh*, *Feroza* from *Feroze*).

Our participants were mainly involved in three types of work within their clans: *mangti* (begging), *dhanda* or *pun* (sex work), and *badhaai* (congratulating and dancing at celebrations of births and marriages). The hijras often refer to themselves as *sanyasin*, meaning one who renounces all material possessions to live like a holy wanderer and beggar. This is one of the contexts in which the hijras say they have abandoned their families, migrated to different places and live in poverty relying on the charity of others (Nanda, 1986), and hence "beg to live" (Allahbadia & Shah, 1992). On a different note, even though the core of positive meaning attached to the hijra identity and role is linked to freeing oneself from sexual desire (Nanda, 2007), a substantial number of the hijras do engage in sexual activities, either having relations with their male partners (in long term relations) or doing sex work as a means of earning a livelihood. *Badhaai* (literal translation for congratulations) is a role that has been culturally attributed to them over the ages, wherein they come to different households on occasions of marriage or childbirth and sing, dance, and bless the couple (for fertility within the first year of married life) or the child (for good luck). Although the hijras themselves are infertile, they are supposed to have special power to confer fertility onto others (DeMello, 2007). Whereas singing and dancing hold the highest status in the hijra community (Hanna, 1988), prostitution is counter to the hijra norms and lowers their status in society (Nanda, 1986). Our participants informed us that their age-old occupation of *badhaai* was slowly disappearing, and people did not prefer them, especially in the urban areas—preferring modern-day DJs over the age-old hijras. Therefore, many of the hijras are *forced* to choose sex work to earn a living (Somasundaram, 2009).

Hijras, in general, are known to take a vow of celibacy but some have relationships with and even marry men (DeMello, 2007). In our sample, 30% were living-in with their male partners, of which 20% had married other men. This is also significant in light of the current legal controversies in the country, wherein certain archaic laws that criminalize homosexual behavior, such as Section 377 Indian Penal Code, are being challenged in the Supreme Court of India (Kumar, 2009). Thirty-two percent of the participants in the study were living-in with either their gurus or chelas. To understand this further, we need to look at the structure of the hijra clans (Kalra, 2012) that has a strict hierarchy with large groups of hijras from different areas forming different dynasties, or houses, called *gharanas*, which are in effect organizational divisions. In Mumbai, there are seven gharanas: *Dongriwala*, *Poonawala*, *Hajibarmanwala*, *Lashkarwala*, *Chakalawala*, *Bullockwala*, and *Lalanwala*. These gharanas have equal status except for *Lashkarwala*, which mediates disputes arising among others (Nanda, 2007). The names of these gharanas may differ in different parts of the country but their organizational structure remains almost the same. Each of these gharanas is headed by a *Naayak*, who is the primary decision and policy maker for that house. Thus the seven *Naayaks* from all the gharanas make and maintain the rules and regulations of the entire community from that city. It is believed that these *Naayaks* are very powerful persons, and it is not easy to arrange for a meeting with them. Each *Naayak* may have a number of *gurus* (literal translation for "teacher") under her. These gurus help the new hijra recruits to get acquainted with the customs of hijra gharana, who later on become her *chelas* (literal translation for "followers"). One guru can have a number of chelas below her and this guru–chela relationship is a lifelong bond of reciprocity in which the guru is obligated to help the chela in times of need and, in return, the chela is obligated to be loyal to the guru (Nanda, 2007). As part of this loyalty, many chelas are expected to donate a share from their earnings to their gurus. It is also interesting to note that several different chelas under the same guru refer to each other as sisters and to their guru as *guru-maa*, or mother, and to their guru's guru as *guru-naani*, or grandmother. Thus, the hijra gharanas actually resemble heteronormative family systems and relations to a large extent. Hijras are usually forbidden to have contact with their birth families once they

join the clan, but this rule doesn't apply rigidly to all: those (in our study) with unaccepting families seemed to abandon them permanently, while those who had more accepting families continued to visit them intermittently (either in the attire of hijras or dressed as males) or even stayed with them. Around 10% of our participants were staying with their families of birth.

Eighty-four percent of participants in our study met criteria for GID according to *DSM-IV-TR*, while 16% of the participants had received no diagnosis. However using the ICD-10, all participants received a diagnosis of Transsexualism or Dual Role Transvestism. It was slightly difficult to apply *DSM-IV-TR* criteria to those hijras who did not report gender dysphoria but were still identifying as hijras and also did not fall into the transvestic fetishism category. There was also a problem with those hijras who did not identify with the opposite sex but claimed to belong to the third sex (referring to themselves as the true hijras and not as women trapped in men's bodies!). In this context, the Dual Role Transvestism diagnosis using the ICD-10 could very well cover these individuals, but the same could not be done with Gender Identity Disorder Not Otherwise Specified (GID NOS) using the *DSM-IV-TR*; hence, such participants were not given any diagnosis using the *DSM-IV-TR* (see Table 2). The *DSM-IV-TR* category of GID NOS includes gender dysphoria that accompanies intersex conditions, transient stress-related cross-dressing behavior or a persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other (biological) sex. However, it does not mention anything about individuals who would prefer wearing clothes of the opposite biological sex merely to experience the membership in the opposite sex temporarily without any sexual motivation or a desire for a permanent sex change. This lacuna was compensated for by applying the Dual Role Transvestism category from the ICD-10. The *DSM-IV-TR* thus seems to have a narrower approach than the ICD-10 toward gender variance and fails to acknowledge the diversity that is seen in this important cultural group of gender-variant individuals compared to the ICD-10, which seems more suitable for use in the Indian hijra context.

TABLE 6. Outcome of Self Reported Gender Variance from Childhood

	Diagnosis in adulthood	
Diagnosis in childhood	Transsexualism	Dual Role Transvestism
GID of childhood (78%)	70%	8%
GID NOS (2%)	2%	0%
No diagnosis/Gender-variant behavior (20%)*	8%	12%

Note. GID = Gender Identity Disorder; GID NOS = Gender Identity Disorder Not Otherwise Specified.
*These participants reported some gender variant behavior and could not be given any diagnosis.

There has been a debate concerning the gender identity of hijras. Sinha (1967) described hijras primarily as homosexuals who join the community specifically to satisfy their sexual desires while Freeman (1979) referred to them as transvestite prostitutes. However, Nanda (2007) rightly points out that the term *hijra* is usually translated as "eunuch" and never as homosexual. The relative security of this organized community along with the opportunity that the hijra role provides individuals to engage in sexual relations with men may be one of the few reasons that effeminate homosexual men join hijra clans. Hence, it is likely that hijra gharanas consist of a range of gender variant individuals. This was reflected in our sample too.

We explored the outcome of possible gender dysphoria in childhood (elicited by retrospective history from the participants; Table 6). We found that there was a higher likelihood of developing transsexualism as adults, when the respondent would have been eligible for a diagnosis of GID of childhood (as suggested by their self-reports). In the case of mere gender-variant behavior in childhood (reported by the participants), there were more chances of developing dual role transvestism in adulthood.

A high percentage of our participants had already undergone Nirvan—the emasculation operation (a secretive custom signifying the

journey between genders)—a journey that started but not yet ended as a hijra can never become a complete woman and *must* stay in between the two genders. There were participants in our study who claimed they were of the third gender but still refrained from undergoing Nirvan, saying that they did not feel the need for it. Although the hijras were reluctant to tell the explicit details of the procedure, they did tell us that this procedure was done by a senior experienced hijra, called "*dai-amma*," who examines the hijra and fixes a time and date for the procedure that is usually done late at late night or in the early morning. After the procedure is completed, the hijra (now Nirvan-hijra) is not allowed to go out of the house for about 40 days. A ceremony called "*Jalsa*" marks the end of this 40-day period, which is attended by all hijras who sing, dance, and offer gifts to the newly-born hijra. This operation is completely voluntary and renders the uniqueness to hijras (Nanda, 2007); we were told by some of the participants that in modern times, a lesser number of hijras opt for emasculation, and the ones who do, prefer to undergo SRS conducted by a professional in a hospital. This calls for a further exploration of the effect of modernization and globalization on the life of hijras and especially their age-old customs, rituals, and traditions.

Our sample had fairly good self-esteem according to RSES, despite social marginalization and exclusion that they may face in the wider society; this could be due to their assimilation into an entire subculture of their own, which seems to overcome their social marginalization. However it is not known how effective is the gharana or the guru–chela system in helping distressed hijra individuals to cope with problems in life. To this effect, only 8% of hijras said they would discuss their problems with other hijras while the rest said they would avoid doing so as there was a tendency among the hijras "to gossip and laugh at each other's problems."

Around 18% of hijras in our sample had depressive spectrum disorders (major depressive disorder, dysthymia, and adjustment disorder). Other depression studies done in primary care clinics/centers in India have estimated a prevalence rate of 21% to 40.45% in the general population (Amin, Shah, & Vankar, 1998; Kishore, Reddaiah, Kapoor, & Gill, 1996; Nambi et al., 2002; Pothen, Kuruvilla, Philip, Joseph, & Jacob, 2003). This comparatively low rate of depression may reflect the benefits that hijra individuals gain after they join the hijra community and are able to express their gender variance despite being the target of social discrimination. The nationwide prevalence of alcohol use in India is about 21% as per the National Household Survey of Drug Use in the Country (Ray, 2004), while alcohol use was higher in our sample (30%, including both alcohol abuse and dependence). Most of this alcohol use apparently started at the time the participants began to realize their gender variance and were ostracized by their families. Despite the presence of psychiatric disorders in our participants, none had ever had psychiatric consultation for these issues. At this point, it is important to note that as more hijras opt for formal SRS in hospitals, their psychiatric consultations are increasing because the hijras seek a psychiatrist's opinion on the hijra's fitness for SRS and this entry point could very well be exploited to increase awareness and reduce stigma toward mental illness in these individuals. Only 8% of the participants had undergone professional counseling for various issues in life during the past 3 years. All these consultations were at counseling centers at various NGOs and none were at any of the public hospitals. This underscores the importance of NGOs in providing services to this marginalized community and also points to the poor access to health care services by hijras. Some participants in our sample feared that doctors and hospital staff may make fun of them or even abuse them, which reiterates what has already been mentioned in the literature (Khan et al., 2009). It is also important to further explore the level of knowledge of medical doctors about issues this community faces, along with different aspects of their lives, to know the reality on the ground.

The mean score on the FGIS was 38.56 with a standard deviation of 7.45, indicative of a high feminine identity in the participants right from childhood. Their childhood histories were also suggestive of more feminine behaviors, including feminine play with dolls and

identification with female characters in films. Similarly, their score on the Androphilia scale was highly suggestive of a preference for or attraction to biological males. Mean scores on other subscales of GIEP were low and indicated the relative absence of these erotic attractions, experiences, or behaviors in the hijras (see Tables 1 and 5).

All participants in the study were sexually active; however, interestingly, 39% did not masturbate at all. The reasons given by them were, for example, "I don't feel like touching my penis," "I hate my penis," and "I simply don't feel the need to masturbate." Reported sexual fantasies were primarily androphilic, which again corroborates high scores on the Androphilia scale. Similarly, their preferred sexual intercourse was anal where they were the passive partners (receptive anal sex).

As far as sex life was concerned in the Nirvan hijras, they reported an overall decrease in their sexual satisfaction. Sex life was better post-Nirvan only for 6%, which is much less than the post-SRS improvement in sex life reported by 75.8% of male-to-female transsexuals in the study by Decuypere et al. (2005). This could have been due to various reasons, such as hormonal changes after castration, functional loss of the genitals, and crude methods of emasculation employed by the hijras in Nirvan that do not preserve the neurovascular supply of genital areas. The hijras also do not take hormonal therapy prior to undergoing Nirvan and this could also be an additional factor for the lower sexual satisfaction post-Nirvan (Murad et al., 2010).

CONCLUSION

To conclude, the hijra clan has a strict hierarchy that mimics a heterosexual family system most like the Indian joint family system. A high percentage of hijras in our sample were suffering from GID and also scored high on the FGIS. Forty eight percent of these hijras met the diagnostic criteria for psychiatric illnesses such as alcohol use disorders and depression, but there was no formal help-seeking attitude or behavior in them. They had fairly good self-esteem. All of them were sexually active with men at the time of the study.

IMPLICATIONS AND LIMITATIONS

The study had certain limitations such as a small sample size and lack of culturally appropriate instruments. The majority of participants in our study could not read, which meant we had to read the questions to them. This is a significant limitation as many questions in the interview elicited intimate details, which might have been difficult for the participants to disclose to the researchers. It was also noted that some participants were not comfortable opening up about certain issues of their life, especially details surrounding Nirvan. However, this was a preliminary study and further issues facing the community regarding mental health need to be explored through future studies. This study also highlights the fact that the hijra community, although existing as a well-evolved and organized gharana structure in the Indian society, is vulnerable to various mental illnesses but there is hardly any help-seeking from these individuals; therefore, there is a need to further explore barriers to health care access in these individuals. Since our study shows that these individuals have good self-esteem, it would be worthwhile (especially for mental health professionals) to identify factors that override their marginalization and lead to good self-esteem. This would go a long way in helping this marginalized community attain a state of balanced mental health.

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NOTES

1. The term *Gender Identity Disorder* is used here to reflect the term as it was used as in the *DSM-IV-TR* and the ICD-10, the diagnostic systems that were used in the study. The authors do not recommend using the term today given the advances in our understanding of transgender issues.

2. Hijra individuals accessed this clinic for STI evaluation and treatment and for procuring free condoms since it was inside a public hospital. They were then referred from this STI clinic to the psychiatry department for inclusion in the study.

3. A respondent may have more than one source of income. But only their primary source of income is reported.

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